3 FIELD ASSET BASED COMMUNITY DEVELOPMENT

Developing a community based 'village' programme supporting health provision

Discussion paper

Not so much answers but asking the questions

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INTRODUCTION

This paper explores the positive contribution Voluntary and Community Sector (VCS) Organisations can have on public services in the current environment of public sector expenditure reduction. This reduction, since 2008, has placed an increased financial pressure on the VCS as well as developing an environment where the use of volunteers to 'prop' up / maintain services is increasing, with encouragement from public bodies predominantly.

In our experience, volunteers who believe in supporting services come forward and take over a service - library, local shop etc. and the cash-strapped public sector is just relieved that the problem is 'off their hands'.

This doesn't need to be the case. Local volunteers can be used to support services, ensuring that 'the public' benefits from those who are willing to give their time for the benefit of the many.

In this paper we aim to outline a framework in which the development of VCS activities and volunteer engagement can be strategically planned and implemented to complement and enhance other services. We outline issues that we believe need to be addressed to create a commissioning environment that enables volunteers to be recruited and trained, within a strategic framework, and where there is some form of progression and personal development.

However, in order that the outlined process has maximum benefit any project needs to be:

- Implemented strategically by the public funding body
- Implemented to complement and enhance current services which may be funded from a variety of sources.
- Developed in true partnership with the communities it is working with

It also needs to be acknowledged that a one size fits all approach is not appropriate. Whilst large programmes benefit public sector commissioning, the development of community response, volunteer focused services, needs to be developed, and subsequently rolled out, at the community's pace and level of engagement.

This paper seeks to identify a model of development, a model that recognises the importance of the various service providers by clearly defining the role. We have segmented provision into 3 Fields outlining roles of providers and potential partnerships that individual users of services will have contact with.

- **Field One** is the formal public sector intervention Field - Health, Care, Local Authority Services etc. These are developed and lead by 'public sector' professionals delivering legally required or essential services.
- **Field Two** includes services that support public services, funded from additional sources, Big Lottery Fund, charitable trusts etc., predominantly through VCS organisations. Development of projects is not standardised nor covered by legislation as are services in 'Field One'. They are, however, increasingly related to need identified through public sector statistics and delivered with agreed milestones and outcomes.
- **Field Three** includes community activists and volunteer support as individual assets within a developmental provision, not as individual volunteers, but rather linked and supported by a community focused provision.

It is important in each 'Field' that we acknowledge the characteristics and related activities of the recipient/beneficiary of services, and how they engage with providers within the Field.

PART ONE: OUTLINE OF PROGRAMME AND WHAT THE FIELDS DO

Outline of Programme aims and developments

The 3 Field programme *see fig 1* aims to develop a non-medical professional neighbourhood / community response programme / team serving specific localities to complement statutory and traditional health and social care intervention *see fig 2*

The programme can target specific groups within a community that require additional support to that provided by health and care professionals. The 3 Field process aims to address and ameliorate identified medical issues in community and social settings by developing community assets that can provide support to identified individuals and families, reducing the need for medical intervention, and slowing down the acceleration to greater intervention and treatments by identifying and developing community based 'social support' solutions[1]

The programme can have specific targets: [2]

- to maintain the individual in the community as long as possible
- to prevent admission to acute units as an emergency
- to prevent readmission following acute intervention for whatever purpose

While the process in the 3 Field programme can work across all areas, the development of 'community relevant and appropriate' support, through organisations coordinating activities and volunteers, will differ. Organisations and partnerships that undertake to develop such a programme need to acknowledge that one service(s) / proposal(s) do not fit all communities.[3] Neighbourhoods are at different levels and standards of volunteer activity, therefore a differentiated development process for differentiated communities needs to be undertaken.

It needs to be appreciated that the development of appropriate and 'fit for purpose' services within identified communities will take place at different rates. This will include:

- Recognising community actors and initiators in specific areas.
- Developing quality standards of delivery in association with partners rather than as an imposition. [4] This means appreciating that 'quality standards' and a 'standardised service' are not the same thing. Communities will develop at different rates. However there needs to be baseline agreed standards within which they operate - confidentiality, ethical practice, etc
- Development of training and information sessions for volunteers.[5] Basic awareness and information, including issues to look out for, needs to be provided to organisations and volunteers. However, how they look out for them is not a medical training, it is a community development process e.g. during general conversation, through chatting rather than direct questioning

Recognition of community development, peer learning and co-production is essential for this programme to succeed, ensuring that volunteers have the appropriate skills in responding to referrals when they are made, and in reporting any identified issues (essential to the success of the 'prevention' agenda) [6]

- In addition to the information and training referred to above, community groups need to be encouraged to meet and share experiences and services. This ensures that practice, processes and solutions are shared at a community level and not imposed through commissioning or a participation agreement. This can be achieved through the development and facilitation of inter community, peer to peer support and development activities [7]

- Some communities will need to identify and be supported around how they develop practices within these parameters, rather than being refused services until they can comply.
- Standardisation of services should be seen as an evolutionary process rather than an imposed standard for participation from the start.

The Three Fields and how the segments interact with each other see *fig1*

Field One - Statutory provision: formal health intervention

Field One is the formal public sector intervention Field - Health, Care, Local Authority Services etc. Services are developed and lead by 'public sector' professionals delivering legally required or essential provision. 'Formal Health Provision' includes Targeted and funded NHS funded intervention Acute Care, Specialist care, Primary care, Community Trust Provision, Community Provision, Community Care - *see fig 2*

In health-related activities a simpler definition can be adopted – we've called this "Feeling Fine" and "Not Feeling Fine". When we're "Feeling Fine" we tend not to use the service. When we are "Not Feeling Fine" we do use the service.

There are, however, exceptions. The health and care provision for people with vulnerabilities, including elderly people, can be considered as one such exception. When older adults are "Feeling Fine" the role of the statutory provision, Field One, is to monitor and maintain an individual's status quo, referring to provision, developed in partnership with other agencies, in Fields Two and Three, where and when appropriate to maintain this "Feeling Fine" status.

When older adults are "Not Feeling Fine", and there is a need for medical intervention, then Acute and specialist services, community care and support are used as traditional referral processes to treat and aid recovery of individuals. Having the additional resources of Field Two and Three available to practitioners widens the services that can be offered to an individual as part of treatment, to aid recovery or recuperation and prevent re referral. *See fig 1*

Field Two – Additional Funding provision

This Field focuses on group or project activity, developed by a wide range of VCS organisations.

The intervention of activities provided within Field Two is based on the same principle outlined in Field One of "Feeling Fine" and "Not Feeling Fine"

Under the "Feeling Fine" status, activities should be developed that ensure the status is maintained.

Within this Field activities are communal-, resource- and need-based projects, offering community-based and accessible intervention and support. Recreational, supportive or therapeutic projects ensure that an individual's status of independence and "Feeling Fine" is maintained. Such activities can also benefit an individual during or following Field One medical intervention as part of a community-based recovery or support programme.

Participation in these activities is by choice, medical practitioner's referral, or, in some cases a prescribed engagement in activities. As the activities take place in community venues predominantly, word of mouth and 'going with a friend' are important engagement processes, as is Field One staff awareness of such activities and project leaders networking with other, similar, but distinctly different activities within Field Two to engage likely participants.

Activities should be welcoming, small- and medium-need based intervention, project focused, enhancing and complementing Field One and Three services, offering a place to go and/or things to do.

Field Three – Community Support Provision – Neighbourhood / Individual focused.

Field Three covers a wide range of activities but is predicated on volunteers providing support on a local / neighbourhood basis. Volunteers do not undertake one specific task, but rather offer a variety of services and support activities, dependent on an individual's need.

As part of the monitoring and maintaining individual's "Feeling Fine" status, a structured volunteering programme, developed in partnership with Field One services, visits and 'keeps an eye' on vulnerable individuals. This process complements other Field One interventions, nurse visits, care in the home etc. It can also form part of supporting an individual in accessing Field Two activities as part of a recovery programme as well as part of the "Feeling Fine" process, through the development of a buddying / befriending process whereby volunteers initiate and support attendance and involvement.

Field Three activity is not intended to, and should not be used to, replace intervention and support offered in Field One. However, developing activity in Field Three acknowledges that such support can only cover a limited number of days in the week. Field Three programmes provide community asset based support, ensuring that individuals are able to remain in their own home for as long as possible and can, when volunteers are given appropriate training, act as an early warning process for symptoms[5]

fig1 How the fields interact with each other

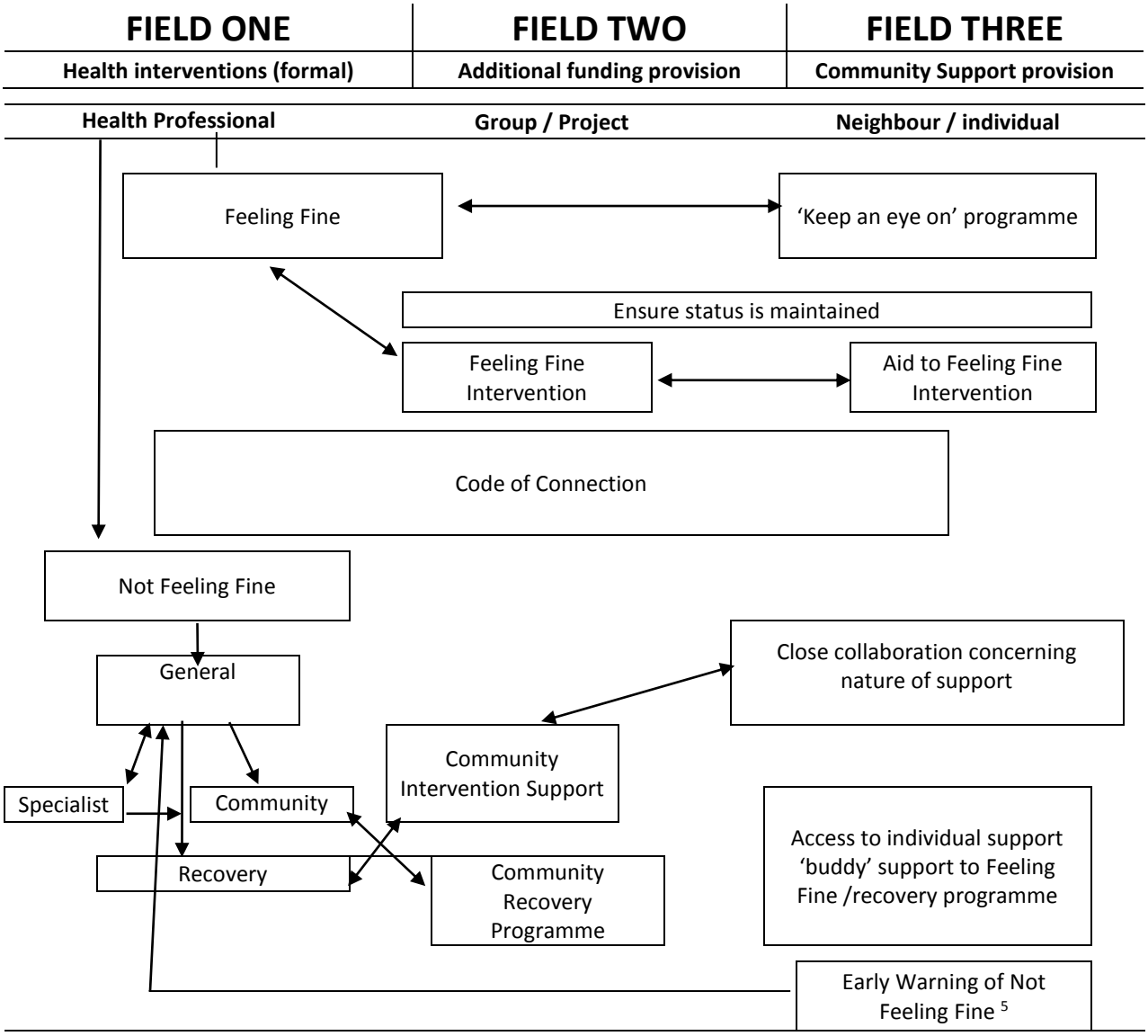


fig 2 Outline of current funding structure and how these are accommodated within a 3 Field model

Current activities

FIELD ONE	FIELD TWO	FIELD THREE
NHS Funded	External Funded Programmes	
'Formal Health Provision'	Project focused	Neighbourhood
Targeted and funded NHS funded intervention	Value added community organisation programmes - externally funded	Community volunteer provision

Accommodation of structures within 3 Field Mode

FIELD ONE	FIELD TWO	FIELD THREE
Health interventions (formal)	Additional funding provision	Community Support provision
Targeted and funded NHS funded intervention	*Value added community organisation programmes - externally funded*	*Community 'village' asset development and support*

Outline of provision

FIELD ONE	FIELD TWO	FIELD THREE
Acute Care Specialist care Primary care	Enhancement and complementary activity	Buddying services Visiting & befriending
Community Trust Provision	Resource and need based project	Supporting projects
Community Provision Community Care	A place to go, things to do – Small- and medium-need based intervention	Benefitting from projects

PART TWO: IMPLEMENTATION & RELATIONSHIP ISSUES

Having identified how the model can operate, this part of the paper explores organisational and structural relationships that would need to be identified, modified and, in some cases, reconciled, in order for the model to be implemented and developed.

We recognise that the process is being developed neither in a vacuum nor on a blank sheet of paper. We have focused on strategic, operational and institutional processes that need to be addressed at the outset in order for a 3 Field model to reach implementation stage.

We have not attempted to provide templates and pro formas concerning engagement, training and monitoring, and measuring outcomes, outputs and cost benefit analysis as there are already acknowledged processes and materials available to fit this need.

The exploration of these issues in this section is in 4 parts

The first is how communication, a 'Code of connection', is developed and managed between the three Fields concerning an individual's needs and activities, and how information is shared and retained.

The second, fiscal relationships, explores how the financial structure of the model needs to be reconciled to prevent the whole process being dominated by funding sources and outcomes. This section explores the traditional 'purchasing' relationship between funders and providers of services, as well as the need to interpret the 'currency' utilised to drive activity in each Field and how the three Field model requires mutual appreciation of the differentiated definition of 'currency'

The third, reciprocal knowledge, concerns the reciprocal assumption and knowledge of participating sectors, organisations and agencies, within each Field i.e. what do individuals within each sector know, or believe they know, about other participating sectors, and the perceptions which organisations within each sector, within the process, may have of others. This is an important issue to address as it drives assumption, expectation, outcomes, outputs and relationship development. Some aspects are related to the second element, fiscal relationships, as it explores how current funding programmes and the environment has effected VCS provision, and explores how 'mission drift' has influenced how organisations modify their activity to accommodate funding criteria, sometimes at the cost of their initial aims.

The fourth, challenging the data, explores how much public sector provision is dominated, possibly restricted, by internal data and data analysis. The public sector needs to be more open in how they share anonymised, non personal, data. VCS organisations need to be encouraged to manage and use their own data and the public sector needs to be encouraged to accommodate other datasets in their presentation and analysis, thus providing a more comprehensive picture of neighbourhood provision and requirements.

Code of connection

As the 'management' of each Field is grounded within a variety of organisational structures and funding mechanisms, there is a need to establish very clear communications between each participant organisation involved in a specific Field delivery. This process of communication needs to be rigid enough to comply with medically sensitive information but flexible enough so that smaller community organisations, capable of delivering Field Three activities can be involved. We have used the term 'Code of Connection' as it describes a process in IT whereby a formally accredited 'known' information system, in this case health professional and the information they hold, wishes to connect to another 'unknown' information system, community groups. The three Field Provision provides very clear reasons for wishing to connect information systems together, to share and exchange data and information. The 'Code of Connection' will develop protocols, processes and expectations and check procedures beyond a memorandum of understanding, but falling short of a system of accreditation

Financial relationships

There is a danger that any new or innovative process is stifled because of the unequal relationship between partners in delivery. The delivery of services and support within all the Fields is either funded by Field One organisations, or the justification for funding them from other sources has an interdependency with Field One provision and data analysis.

There is a danger, therefore, that the whole developmental process becomes dominated by the financial process, and driven by the funding organisation's requirements of compliance. VCS organisation that receive public funding are expected to comply with identified financial regulations, requirements and reporting within public sector definitions.

Differentiation in asset / currency fig 6 **(awareness raising)**

The relationship between Public sector and VCS organisations can be measured in fiscal terms (currency transaction). The Public sector, and some grant funders, view the relationship as linear and transactional - provider and beneficiary organisation: money provided , services developed, outcomes / outputs measured. Such a relationship is closely linked to tenders and contracts.

While the importance of funding to all VCS organisations is not to be ignored, there is a need to discuss and acknowledge the 'informal' economy that exists within some VCS groups and provision that does not exist within the public realm.

VCS organisations that participate in service provision have variable fiscal requirements. Some organisations however have a fiscal and non fiscal 'asset / currency' that enhances their capability. This non fiscal asset / currency widens the definition of the relationship between organisation (provider) and beneficiary.

In VCS organisations an individual can be a beneficiary of a project as well as being a volunteer / activist within the same project. The non fiscal asset is not just 'free' staff and volunteers.

This practice also exists within some of Field Two activity but it is core to Field Three delivery and needs to be appreciated and understood by public sector organisations if the 3 Field process is to be successful

Fig 6 Differentiation in Asset / Currency

Sector	Asset / Currency	Actions based on Asset and Currency
Public Sector	Linear and Transactional 'Formal Currency' Linear and Transactional	Projects funded Provision developed
VCS	VCS community groups – wider definition of engagement (asset , currency)	Volunteer in projects / programmes can be beneficiary as well as volunteer / supporter

Reciprocal knowledge *fig 3*

The development of reciprocal knowledge of participants within the 3 Field process is essential. While we use generic terms to describe 3 Field sector participants, Health (NHS), Council (local authority), VCS, each sector has a variety of components that make up the 'whole'. While partners do not require full knowledge of the minutiae of services, a basic awareness is essential to aid development.

As a recipient of funding from the public sector, VCS organisations have to have knowledge of public sector activity and structures in order to comply with tendering compliance / requirements.

While this knowledge may be restricted to the relevant sections of health, often related to funding, some organisations will have a wider knowledge based on lobbying, campaigning and representational activities. This knowledge is not uniform or comprehensive across the VCS, and does not necessarily need to be, as it is dependent on the services an organisation delivers.

Public sector knowledge and comprehension of what is referred to as the Voluntary / Third Sector, VCS or community activity can be within similar parameters - people understand what they fund or other organisations they come across or are engaged with.

There is potential for health 'community provision' such as liaison groups, patient in control, expert patient programmes to be confused as Field Two or Field Three activity. They are not. They are consultation and delivery processes within Field One

Procurement of services provides commissioners with some knowledge, understanding and a 'view' of VCS provision. This is often of organisations that comply with tender requirements and receive contracts, or organisations that provide complementary, charity, services within health provision e.g. the NSPCC, MIND, Macmillan etc. There is often a lack of distinction between Local Groups / National Groups /Organisations – some organisations have a local name but are linked to or franchised by a national organisation.

A number of terms to describe organisations in the VCS are used inter-changeably: Charity, Community Group, Voluntary and Community Sector / Social Enterprises (VCS –SE), Interest group. The breadth of the sector, its services and organisational turnover is immense. VCS organisations vary from large provision well-staffed charities like Macmillan, Barnardo's, other lobbying, information and support groups, e.g. Lymphoedema or Haemophilia Societies, to small, community focused, volunteer-run, provision.

Health professionals knowledge and awareness of this breadth of provision will be limited, often based on contact, contract and provision. For the 3 Field process to succeed, this awareness amongst health professional not only has to develop but also a parallel appreciation of potential delivery and impact on service needs to be developed and acknowledged. This may run contra to current beliefs.

Some health and public sector staff may sit on boards or committees of VCS organisations. They may believe in the service offered by that organisation, and/or that their knowledge of contracts and services is seen as useful to the organisation. They have an understanding what is provided (service provision) and how the VCS organisation can deliver activities within identified provision.

While this involvement should be respected and encouraged, it may have an impact on how individuals within the public sector view provision within the VCS, creating an 'informed' but 'limited knowledge' perspective of what is out there, who does what and consequently who is the most appropriate organisation to develop and deliver activities within individual Fields Two and Three.

fig 3 Reciprocal Knowledge

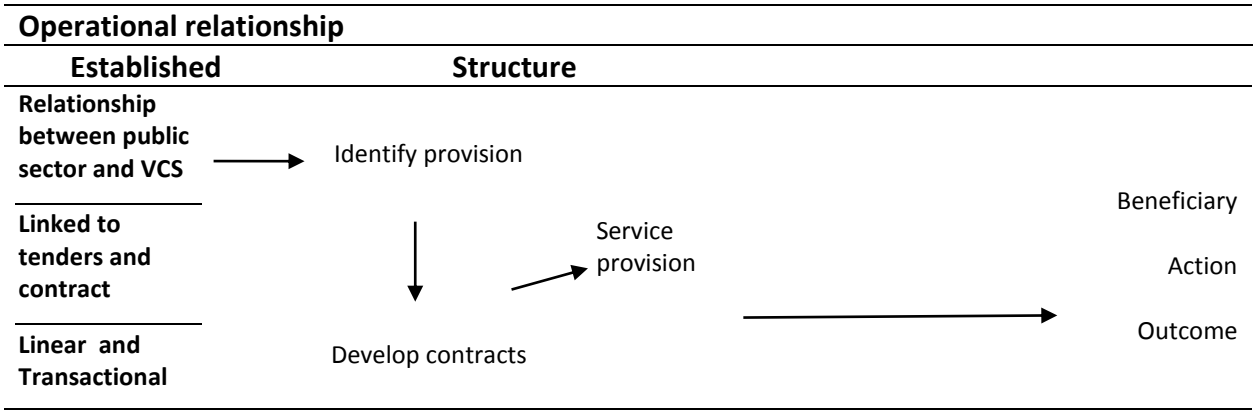
<table>
<tr><th colspan="3">Reciprocal knowledge of each other</th><th>Operational impact</th></tr>
<tr><td rowspan="2">VCS</td><td colspan="2">VCS expected to have knowledge of public and private sector activity and structures</td><td rowspan="2">VCS modelled its governance, employment and delivery structure to replicate public sector structures
Contracts and tenders may change VCS practice, Policy, HR, Finance and Pensions</td></tr>
<tr><td>Funding based knowledge</td><td>VCS applies for public funding</td></tr>
<tr><td rowspan="6">Public Sector</td><td colspan="2">Public sector has some knowledge , understanding and 'view' of VCS provision 'Limited knowledge' of complete picture – what is out there</td><td rowspan="3">Issues about the breadth of sector, use of words inter-changeably
Community Group
Charity
3rd Sector
VCS –SE
Interest group</td></tr>
<tr><td rowspan="5">Some may sit on boards or committees</td><td>Understanding what is provided (service provision)</td></tr>
<tr><td>Knowledge of Contracts</td></tr>
<tr><td>Knowledge of and development liaison groups, patient in control, expert patient</td><td rowspan="3">Difference between Local Groups / National Groups (Organisations)
Local Name / Franchise</td></tr>
<tr><td>Knowledge of lobby groups</td></tr>
<tr><td>Charity provision NSPCC, MIND, Macmillan etc</td></tr>
</table>

Operational relationship

Capacity building programmes have tended to focus on VCS organisations' ability to engage with public sector by acquiring knowledge of public sector activity, structures and compliance within procurement and delivery processes. In some cases this has caused community organisations and groups to 'drift', moving away from their 'original mission' in order to seek funding. This does not have such an effect on larger, national and specifically focused organisations.

Some VCS organisations have become subservient to commissioners, becoming a provider of services based on funders 'operational' parameters. This has the impact of VCS organisations becoming provision and process driven. *Fig 4*

Fig 4 Process driven (operational) relationships



Tender 'chasing' and compliance has had an influence on VCS governance and probity. In applying for contracts and tenders some VCS organisations have had to modify some practices, re write policies to comply with public sector requirements, change HR processes and in some cases, adopt financial and pension processes that may not be sustainable. Some VCS organisations have gone bankrupt because of TUPE contracts and pension requirements. .

Smaller VCS organisations have had to re-model their governance, employment and delivery structures to replicate public sector structures. This has lead to the development of a 'shadow public sector' not a responsive, complementary sector.

Larger VCS organisations benefit from contracts and tenders as contract compliance is easier for them because of their governance and finance structures, cash flow and critical mass of support.

Tendering and market lead development can, therefore, have an adverse effect on community action. The activities outlined above have reduced community action by some VCS organisations in favour of community (VCS) provision.

Reciprocal knowledge and the 3 Field model will have a beneficial impact on this situation as it provides a clear distinction between activities to be funded in Field Two and Field Three, accompanied by a process of organisational assessment for organisations as to their potential and capacity for delivering a community asset based service in Field Three. This, in time, will enable community focused organisations to concentrate on what they do best, work with their communities, developing the assets to enhance and enrich the lives of people within the community.

Capacity building therefore becomes a two way process, not as currently a VCS deficiency amelioration activity. VCS practice can still be targeted in any capacity building activity as can public sector awareness, appreciation and engagement activity.

Changing the Data[8] - Health Data led programmes, Demographic led programme

The development of funding contracts and tenders is dominated by public sector data. Service development is therefore influenced by the data gathered by the sector and analysed by public sector analysts. There is a danger that such analysis is undertaken within rigid or predetermined structures, parameters or expectations.

This does not mean the analysis is wrong, just restricted, developed within an environment of what can be offered and developed, cross referenced with what can be afforded.

Service development through such analysis is often focused on Fields One and Two only, developing health data led programmes or demographic or issue based priorities. These leads to services that are little more than provision with outcomes predominantly based on public sector data.

If a 3 Field model is to be developed, truly engaging the capability and assets of Field Three, wider datasets need to be incorporated into analysis and a wider range of analysts need to be involved, moving to increased data sharing and use of 'open data' principles.

While it is appreciated that some data held by health services is personal and confidential, widening the use and availability of data sets to include community data, and engaging such groups in a wider analysis, may provide different solutions.

There are issues of confidentiality and skill sets to be addressed but the whole 3 Field process would benefit from a more 'open approach' to data sharing and analysis, creating protocols and processes that accommodates as wide a range of data as possible, and as wide a range of analysis processes as possible

Additional Outcomes *fig 5*

This section explores how the 3 Field programme can have additional and equally beneficial outcomes in other sources of funding. Reciprocal knowledge and wider datasets analysis, may impact other funding programmes benefiting Field Two activities in the main but also funding Field 3 and thereby adding value to Field 1 services and the success of the programme as a whole.

Larger grant funders, BBC Children in Need, Big Lottery Fund, Comic Relief, etc., have tended to develop programmes along themes that are influenced by public sector data, and therefore identified services. Applicants find it necessary to justify their application using available public data and identified need - this tends to focus applications on specific public sector identified issues, and can potentially reduce the impact of small community initiatives that may not be able to justify their need with empirical or public data.

While grant funders need to be assured that the recipient of grants are capable of managing and delivering the project, they too have rigorous financial and governance requirements that are akin to public sector processes.

Changes in practice like those outlined in this paper will have an impact on organisational 'mission drift' which, due to issues in public sector finances, external funders have inadvertently reinforced, and provide concrete foundations for community focused VCS organisations to develop more robust and sustainable structures for successful service delivery and essential community development.

Fig5 Additional outcomes

Outcomes	Impact on VCS organisations
Larger VCS organisations benefit from contracts and tenders	Contract Compliance
Larger funders BBC CiN, Big Lottery Fund , Comic Relief, etc. Focus on public sector identified issues – using public data	Outcomes of need predominantly based on public sector data
Development of 'shadow sector' not complementary sector	Funders reinforces drift to public sector structures for successful delivery.
VCS in subservient role – becoming a provider of services based on funders 'operational' parameters	
VCS becomes provision and process driven Tender compliance influences Governance, Probity and reinforced by evaluation and outcomes	
Mission drift Community organisations and groups 'drift', moving away from 'original mission' to seek funding	Tendering and market forces can have an adverse effect on community actions
	Reverse the reduction in community action in favour of community (VCS) provision.

PART THREE: FIRST STEPS NEXT ACTIONS RESOLUTION STRUCTURE

The 3 Field model needs to work with as wide a partnership group as possible to develop contracts that enrich public sector provision through the recognition of the specific roles of Fields One, Two and Three.

Many public sector VCS partnerships are dominated by procurement and capacity building elements that focus on the 'development of VCS organisations to comply with public sector requirements (Part 2). For this programme to work there needs to be a mutual recognition of the need for growth and awareness from both sides. Public sector staff development and awareness raising of the specific roles of the values added by Field Two and Three, together with a comprehension of the difference between the organisations that are capable of delivering such a differentiated service is essential, if contracts are to be developed that enrich public sector provision by encapsulating Field Two, as a value added service, and Field Three as an asset based community focused provision.

While it is essential for VCS organisations to be aware of their roles and responsibilities within the 3 Field process, developing services and support that adhere to defined standards, the procurement specifications and contracts developed need to acknowledge the 'currency' differentiation and community 'eco system' necessary for Field Three to succeed.

The roles we have 'segmented' into Field One, Two and Three need to be identified and acknowledged. The whole process needs to be recognised as cyclical and not linear- or silo-based. There are times when they will operate as individual Fields but always within a wide 'eco system' of Community support.

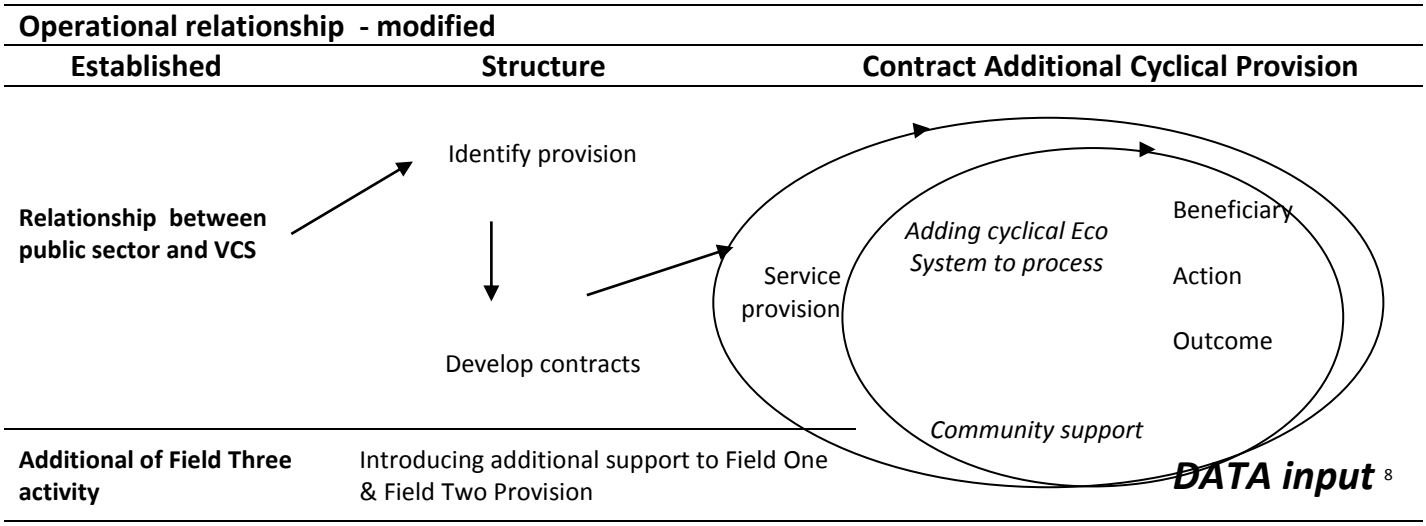
This requires an acknowledgement of the different asset / currency / outcome / expectation definition and developments.

The 3 Field process will only succeed if the wider definition of engagement / asset and currency within community focused VCS projects and programmes is acknowledged and observed, recognising that an individual can be both a beneficiary, receiving services and support, and be an active volunteer, providing support. *Fig 7*

If contracts focus on the traditional linear and transactional currency only, the process will not work. To succeed, the traditional number related outcomes and outputs must be complemented by measurements of “Feeling Fine”, “Not Feeling Fine”, purpose and actions.

This will require recognition within contracts, the development of staff awareness training, and trust and confidentiality, the development of a ‘Code of Connection’, mutual respect for whichever direction in which the referral is ‘travelling’, and a recognition that without Field Three the demands on Field One and Two will only continue to increase.

Fig 7 Operational relationship – modified



REFERENCES

1 **Social support** is used as a descriptor of community and neighbourly support. It acknowledges that such non medical support takes place on either a formal (organised volunteers) or informal (neighbours support) basis

This process begins the recognition of that level of support within any form of 'medical' intervention.

There is also an argument that such a service cannot be developed within the traditional 'medical model' but as a partnership with community organisations that develop and 'manage' the volunteers / neighbours.

The role of social support is not to provide medical related care. Volunteers will not be expected to undertake invasive medical procedures.

Volunteers would be coordinated through a community organisation providing low level support that provides regular contact, social support and potentially recognising issues which may need immediate intervention, reporting to a medical professional.

Support and intervention would take place within a planned and mutually developed programme.

Mutual respect of skills and services is essential, plus the recognition that this type of activity is not a 'medical model' of health professional-lead activity.

2 **Slowing down/diverting acceleration into greater health intervention**

This type of programme can be utilised within most 'medical' conditions.

What needs to be acknowledged, as identified in [1] is the social support / non medical role it, and the community groups and community assets, delivering it, will play.

3 **Differentiated approach – one approach does not fit all**

Irrespective of the 'equality' measurement issues, it needs to be acknowledged that not all communities are ready for full participation within such a project, and that the approach to, and speed of, engagement would need to be differentiated between groups.

Groups and communities should not be excluded from the project just because they are not ready.

Involvement in peer support [7] would be mandatory, prior to any pilot or service being developed.

This may also include a peer assessment of readiness for delivery - this places the emphasis on the community skills rather than a professional medical assessment, working with community groups to ensure that such standards are relevant and adhered to.

4 **Quality standards**

Just because there needs to be recognition of differentiation, there needs to be some basic quality standards to which all participating groups would need to adhere as part of their involvement.

However, quality standards should be developed as a process, enabling groups and individuals to appreciate the need for such standards and protocols, rather than by imposition. This process recognises the importance of partnership, skills, experience and knowledge of community participants and embeds it in practice. It may take a little longer than traditional training and informing processes and still requires continual monitoring and possible modification from issue to issue, e.g. social support for elderly and vulnerable people may require different 'standards' to a community support programme to combat obesity.

5 **Training and information / Early warning**

Each organisation and volunteers would be expected to undertake basic training which is developed and refined as the programme grows.

This is not an expert patient or patient in control programme and therefore the information is more akin to a 'first aid' for observation and action. Having such a provision that complements Field One intervention may identify early signs of symptoms that would then be reported to health professionals, Field One, who would check and resolve, as necessary. This process may prevent escalation of symptoms that necessitate acute care intervention. It does not imply that health professionals may have or would miss symptoms but recognises that Field Three assets can visit and see an individual on a more frequent basis than would a professional within a Field One intervention.

It is important to acknowledge that such training already exists in asset based community and heath development programmes – this should be researched and utilised to prevent the 'reinvention of the wheel'

Training providers should not be limited to 'primary care' practitioners but should focus on a wide range of skills e.g. appreciating first signs of a wide range of symptoms and issues that may, if notified early enough, prevent escalation to acute intervention, to issues of finance, socialisation etc.

This training does not have to be too onerous but thorough, informative and, most importantly, enjoyable.

6 **Mutual recognition of skills**

While the medical knowledge will always remain with health professionals, how communities respond to and develop services needs to be a community development model and its efficacy needs to be respected by the health professionals

Skill sharing and development activities need to acknowledge the breadth of skill, information and knowledge that each participant group brings to the programme.

This reduces the 'medical model' domination and focuses on co production and development.

7 **Sharing development and peer learning** is the cornerstone to the success of engaging communities and individuals in Field Three development. This process is often 'alien' in medical model provision and intervention. Assets in any community provision can bring a wide range of skills and experiences. Beneficiaries of one project in one Field can be a lead or provider within another.

It is crucial that the role of participant, either as recipient, beneficiary or provider is not seen within 'deficiency model' terms, needing training support or problems solving. Assets are exactly that, an asset to a service or process and that needs to be recognised and acknowledged.

8 **Data Sharing** Recognising that data is the core to development of any services but that communities have relevant data that could augment project and programme development

Explore open data principles or data sharing protocols that enable data analysts to provide all parties with a comprehensive picture of the issues and potential resources.

Remove the dominance of public sector data and recognise the strength of data sharing and cooperation.