

## **“HOW RESIDENTS KNOW BEST”**

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### **Introduction**

Regeneration and renewal initiatives are the cornerstone of Government policy to tackle deprivation and promote social inclusion. Central to this is improvement in the health and well being of those who live in the poorest neighbourhoods and who experience the greatest inequalities. In all policy areas there has been an increasing focus on putting the public and users at the centre of all processes, on modernising services and challenging the way in which services are designed and delivered.

Whilst there are numerous examples of good practice in this area many of the community members and professionals interviewed as part of the research for this paper expressed frustration that members of the community are often engaged too late in the process when key decisions have already been made; that standard solutions are offered by professionals to the problems articulated by community members; the leaders of regeneration do not always see health improvement as a key goal and the regeneration process itself may disrupt the well-being of community members both in the short-term and long-term.

This paper argues for a new relationship between community members and professionals engaged in the regeneration process. It proposes ways in which new approaches to help all involved in the regeneration process – professionals, politicians and community members. These approaches would allow all involved to explore different scenarios, to establish plans that allow for the flexibility and adaptability that is necessary in any regeneration process to be adopted and to explore the use of some of the new policy frameworks to deliver long-term sustainable health gain.

### **Background**

Government policy has emphasised the need to consider the health impact of all public policy and regeneration is no exception (DH, 1999). There has also been an increasing recognition of the role that the NHS can play as employer and land user as well as service provider (Samson–Barry 1999).

This was not always the case. As recently as 1997, the Single Regeneration Budget Round 1 guidelines did not refer to ‘health’ although they did refer to ‘well-being’. The involvement of health in regeneration initiatives has been slow to develop. Even where health organisations were involved they have been relatively minor players in the process and even now, as their involvement has increased, health issues are often ‘chimney-stacked’ onto existing regeneration and renewal programmes.

Regeneration money traditionally targeted at the physical fabric of an area is now targeted more and more in developing capacity in individuals and communities. In 1998, the Social Exclusion Unit Report called for a shift away from regenerating the physical environment to “tackling poor schools, inadequate adult skills, lack of job opportunities and childcare, improving health and providing attractive and affordable local leisure activities for children and teenagers” (SEU, 1998).

Much of this work has been done through 'innovative' projects looking at fuel poverty, asthma or the provision of repairs through prescription (Molyneux, 2001). There are few formal mechanisms to join these initiatives up but, understandably, little appetite to set up more liaison groups or task groups. Rather there will be natural points of connection where there is a genuine need for a multi-agency or multi-disciplinary response. Inevitably this will be where the systems for planning regeneration, housing and health care overlap (Goldup, Molyneux and Palmer).

Whilst no one would question the value of these projects, there is a need not merely to promote extra activities, but to challenge organisational cultures and systems so that they can live up to the principles of partnership and joint working (Cave and Curtis, 2001). A key issue is to ensure that health becomes more of an overarching goal in regeneration (Russell and Killoran, 2000).

## **Health and Regeneration**

Much of the activity carried out in the name of 'regeneration' has been built on the premise that the renewal of the built environment in deprived areas can be exactly equated with improvements in quality of life. There has been a tendency to assume that if the housing is improved and the built environment renewed then all will be well. Certainly, local people consulted about proposed regeneration and renewal initiatives, when asked about what impacts negatively or positively on their health, will often identify housing or environmental issues as being of paramount importance.

However, as a number of recent reports have indicated it is not and must not simply be a question of refurbishment, redevelopment or re-housing. Consideration has also to be given to issues of quality - design, internal air quality, cost and type of heating, space etc; the relationship between the dwellings; and the way in which people use the internal and external spaces and how safe they feel. Concerns have also been expressed about the way in which redevelopment often leads to lower densities and lower space standards. This can lead to anxiety for tenants where it is not clear that they are going to return to a particular area and the size of the accommodation they may return to.

Additionally concerns have been highlighted about rising costs associated with estate or housing improvement. Ambrose and Randall sought to identify whether the regeneration process led to higher costs in terms of rent, Council tax, utility bills, and insurance and to assess the impact of this on the broader goals of regeneration and renewal. Although there were substantial health gains and higher resident satisfaction levels arising from the regeneration process there were also negative impacts arising from an increase in non-substitutable household costs.

Resident concerns are often met with standardised professional solutions, for example, concerns about noise are met with a proposal to install double-glazing. Through the process this can get even further reduced to the statements that "the residents want double glazing". In fact the residents concern is about noise. There is a need to look at the underlying concerns such what is the source of the noise – traffic, young people, neighbours (beside, above and below). There is then a need to look at different scenarios, some of which may need input about evidence and what has worked elsewhere. As one resident put it, "I went to the public consultation. I suggested that if we installed solar panels on the roofs in my road we might be able to sell energy back to the grid. The facilitator told me that this suggestion was too

ambitious”.

In another public consultation residents wanted to explore the options of different types of heating and insulation. Here, they were told that decisions on heating types and insulation types had already been taken at the earlier bidding stage of the project. Sometimes residents find it difficult to engage with issues because there is a dominant anxiety about whether buildings are going to be pulled down, people may be required to move out and they don't whether they are going to return and if so, at what cost.

One attempt to manage these problems is to use the process of Health Impact Assessment. (HIA) aims to estimate the effects of a specific action on the health of a community and to ensure that both the potential positive and negative impact of a particular development on people's health is taken into account. It has the advantage of i) explicitly focusing on issues of social justice; ii) encouraging a multi-disciplinary, participatory approach; iii) giving equal status to quantitative and qualitative methods and iv) making issues of principle and of politics explicit and open to greater scrutiny and there are a number of examples where this has had a positive impact on the development of proposals and programmes. However, it can only screen proposals that are already in existence – and can still fall foul of the decisions that were made before the public became involved.

### **What You Have to Understand Is.**

One of the key problems is that despite the recognition that local people have a very good understanding of what has a negative and positive impact on their health and well-being, many decisions have already been made at the pre-consultation stage and appear to be sown up.

Unfortunately, the results of any prospective HIA may be of limited interest to decisions makers within the regeneration process charged with meeting key regeneration or renewal deliverables. Even where health colleagues are involved the focus may be on achieving, say, Local Modernisation Review Targets rather than finding new ways of improving the public's health.

Problems identified by residents are too often met with well-established and unimaginative responses by the different professionals involved. As one community member said, “residents know they're on to something when the Local Authority or Regeneration Company says ‘what you have to understand is’” They then went on to say, “It's really difficult to get beyond their unimaginative and limited ‘menu’ of choices to get to a proper understanding of why residents consider something to be a problem”.

A different approach was taken by Women 20:20. In order to express ideas in a way that is manageable and understandable they worked on four different futures scenarios. They then added to the work of the focus groups a literature search, interviews with key ‘experts’, and advisory group and a web-site. They ensured that all ideas were incorporated and that as ideas were developed the group monitored them and fed-back on progress to check that it matched up and that nothing had been missed out (Women 20:20, 1999).

So, including community members in a partnership does not, by itself, ensure that there will be any meaningful involvement any more than parachuting in experts will. There may be real issues about how people will stay involved beyond any problem-setting and direction setting phases to the implementation phase may depend on their initial motivation for getting involved (Margerum, 1999). This argues for a high degree of community control, flexible structures and a meaningful link to the process of governance (Williams, 2000). It also argues for a continual checking back to the issues or problems that encouraged someone to get involved in the first place and to check that these are being addressed.

## **Dealing with Complexity**

There is a need for a different approach that recognises that people rarely behave “according to plan” and that decisions taken in one place will lead to unforeseen actions elsewhere. Two different individuals presented with the same data may draw very different conclusions from it. This ‘diagnostic uncertainty’, as it would be called in the medical sphere, is common and diagnostic disagreement between clinicians is understood as a necessary part of the process. This is no less true in other areas such as housing or regeneration. Poor housing has been used both as an indicator of poverty and as a target for interventions to improve public health and reduce inequalities in health. Although housing has a prime place on the health inequalities agenda in its own right, it also has wider implications because interventions can have a large impact at a population level (Thomson et al,2001).

Newton’s ‘clockwork universe’ in which big problems can be broken into their constituent parts, analysed and solved by rational deduction has strongly influenced both the practice of medicine and the leadership of organisations (Plsek and Greenhalgh, 2001). Much current organisational thinking is based on the assumption that intricate planning provides the best way of making progress involving as it does planning, specifying in great detail and then consistently implementing the same detail across the board. This type of thinking fails to take advantage of the natural creativity embedded in any group and fails to allow for the inevitable unpredictability of events.

New conceptual frameworks that incorporate a dynamic, emergent, creative and intuitive view of the world must replace traditional “Reduce and resolve” approaches to planning and service design. A more creative way of moving towards a difficult goal is to develop a good enough vision and some simple rules (Zimmerman, Lindberg and Plsek 2001). These simple rules typically include :-

- Direction pointing – vision, purpose or objectives or strategic outcomes;
- Absolute boundaries – may be geographical area or a timeframe;
- Resources and permissions – the amount of time someone may spend without question or the budget.

These can then provide the environment in which innovative behaviours can emerge (Institute of Medicine,1998).

Ultimately, the only way to know exactly what is needed in a particular area or what will happen is to observe it : it is not a question of better understanding of the agents of better models or of better analysis but of ensuring a proper compact between different types of expert and proper exploration of different scenarios and a recognition of the need to be adaptable and to respond as things change. .

## **Conclusion**

Traditional methods of consultation are often hindered by decisions that have already been made. The NHS and regeneration companies operate a model with only one rationality accepted. Health gain will only be delivered if all 'rationalities' are acknowledged. Current policy requires user involvement to be on every one's agenda – but there are no formal mechanisms for joining it up. Inevitably there are going to be tensions and paradoxes to be managed. Some people will want to be involved whilst others just want the people they're paying to get on with it or, perhaps, community views versus the strategic overview of the local authorities.

There is a need for a new relationship between professionals and community members. Problems identified by residents are often met with 'standardised' responses by professionals which makes it difficult to establish a proper understanding of why something is important and find sustainable solutions.

Health gain depends on all 'rationalities' being acknowledged. New frameworks that acknowledge that such systems are complex and adaptive must replace traditional "Reduce and resolve" approaches to planning and service design. Diagnostic uncertainty, common in primary care, is no less true in other areas such as housing or regeneration. Ultimately, it is not a question of better understanding of the agents, of better models or of better analysis. Instead a proper compact between different types of expert and local community members with both engaged in exploring different scenarios and a recognition of the need to be adaptable and to respond as things change is required. Only then will those who 'know best' have a useful and fulfilling involvement in strategies to deliver health gain.

Improving the health of those who experience the greatest inequalities is central to regeneration programmes in the UK. Local community members can become champions for health and well-being and can be genuinely engaged if all engaged in the process, residents, policy makers and professionals adapt their approaches in such programmes.

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#### **About the Health and Regeneration Programme**

The King's Fund established a Health and Regeneration Programme in late 2000. The programme is informing and supporting policy and practice on :

- The role of the NHS and local authorities as employers and purchasers of services and goods in the regeneration of the local economy
- The reduction of inequalities in health and health care through regeneration.

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