Health and Social Care Board

Public Health Agency

Community Development Strategy for Health and Wellbeing

Health and Social Care Board

and

Public Health Agency

Northern Ireland, 2011

FULL VERSION

Contents

Introduction

Legislation enacted on 1st of April 2009 created a new commissioning system for health and social care in Northern Ireland. It established the Health and Social Care Board (HSCB), including five Local Commissioning Groups (LCGs) and the Public Health Agency (PHA). This strategy sets out the community development commissioning priorities for the Health and Social Care Board and the Public Health Agency.

Over the past few years successive governments have come to recognise that the demands of good health and wellbeing go well beyond the provision and the capacity of health and social care organisations. Prevention, public health and social inequality have become central issues which need to be tackled strongly in a variety of ways. Community development is one of the most important approaches that should be applied, as it is a meeting point for many inputs both from communities themselves and from a variety of public agencies.

This strategy will be a significant way to deliver the Commissioning Plan, in particular on prevention, involvement and tackling inequalities, informing commissioning processes and practice on the ground. This approach enables local people to address their own health and social wellbeing needs and develop and improve co-operation with health and social care agencies, leading to better outcomes. The Board and Agency see community development as a key instrument to improve health and wellbeing, drive us towards health and social wellbeing equality between different communities and help to ensure the most effective use of the health and social care budget. The purpose of this strategy is to provide guidance and direction on how community development approaches are to be taken forward within health and social care. They therefore expect every health and social care agency to incorporate a community development approach into their programmes.

The draft document has been informed by pre consultation events and discussions across all Trust areas and it is proposed to issue it for a formal 12 week consultation period.

This paper sets out the strategy for community development. It briefly sets out:

- How community development works;
- Why community development is needed for health and wellbeing;
- A selection of varied case studies ;
- The challenge faced by health agencies, and the basis for their commissioning plans;
- Relevant targets and objectives;
- The performance management framework and how it should be implemented;
- The final section combines references and suggestions for further reading.

How Community Development Works

What is Community? Community is the web of personal relationships, groups, networks, traditions and patterns of behaviour that exist amongst those who share physical neighbourhoods, socio-economic conditions or common understandings and interests. Community tends to exist in three broad categories: firstly those based on locality or territory; secondly those based on a shared experience or interest group such as Black and Minority Ethnic groups. The third category is not necessarily in itself a community but a group composed of people sharing a common condition or problem such as a disability, drug and alcohol dependency or cancer. People in such conditions may in time come to identify and associate with others in order to share information, support and efforts, and thus become a community. All three types of grouping are, of course, not mutually exclusive but can overlap and intermingle.

What is Community Development? Community development is a process which focuses on people - their needs and assets - and aims for better health and wellbeing. It works primarily by bringing people together in groups around a common interest or concern, or in strengthening the capacity of groups which already exist, or bringing groups together in networks to achieve a common goal. Such groups and networks are necessary to enable a community to form partnerships with public agencies. For people in disadvantaged situations partnership working is often not possible without community development as it enables people to identify themselves as a community and to find a place at the table through a process of empowerment.

Community development is therefore an essential complement to consultation, involvement or engagement, which are applied from the top down. Public agencies carry out consultations or seek to engage with communities in order to improve services, but these mechanisms tend to capture only a snapshot of a limited section of public opinion which is already well geared to respond. While community development is much more than engagement and “Personal and Public Involvement” both concepts need to connect well and work in harmony.

The principles of community development are:

- Social justice, equality and human rights;
- Empowerment of individuals, families and communities from the bottom up;
- Maximising the participation of service users and communities;
- Partnership approaches between the community and the voluntary sector, health and social care, and other agencies;
- Bringing about a sense of local ownership and control, through groups and communities taking action together;
- Tackling the root causes of inequalities, poverty and exclusion and strengthening prevention;
- Strengthening the social fabric and support systems within disadvantaged communities and groups.

'Community Development is about the strengthening and bringing about change in communities. It consists of a set of methods which can broaden vision and capacity for social change and approaches, including consultation, advocacy and relationships with local groups. It is a way of working, informed by certain principles which seeks to encourage communities – people who live in the same areas or who have something else in common – to tackle for themselves the problems which they face and identify to be important, and which aim to empower them to change things by developing their own skills, knowledge and experience, and by working in partnerships with other groups and statutory agencies' (DHSSPS 2002).

The Community Development National Occupational Standards (2010) defines community development as;

"A long term value based process which aims to address imbalances in power and bring about change founded on social justice, equality and inclusion."

"Strengthening communities and encouraging personal responsibility requires a community development approach. However this should not be confused with the running of public services by voluntary organisations and social enterprises." Chanan (2010)

Future Direction. There is a need to work at a range of levels: with individuals and at neighbourhood level, as well as with specific communities or groups in particular need, such as Black and Minority Ethnic Groups, Travellers, Looked After Children, Lone Parents, Homeless People, Lesbian /Bisexual /Gay/ Transgender Groups, Ex Prisoners, Children and Young People and others. Work is often undertaken with local government on joint arrangements for community development. This approach guides intervention and practice to ensure the active engagement of those who are most marginalised. Significant resources have been invested in community development programmes over the years and it is important that the Public Health Agency and Health and Social Care Board support a clear position in order to shape future commissioning and planning of services.

A needs and asset-based approach. An 'asset-based' approach to community development has gained ground in recent years as a corrective to the more familiar 'deficit' approach, which focuses on the problems, needs and deficiencies in a community such as deprivation, exclusion, crime, anti social behaviour, illness and health-damaging behaviours. Focusing entirely on deficits can create a sense of hopelessness amongst communities and resignation amongst professionals. As a result, a community can feel disempowered and dependent; people can become passive recipients of services rather than active in their own and their families' lives. Clearly it remains important to be aware of needs and disadvantages and to narrow inequalities, but emphasising assets gives a better balance and generates confidence and aspiration.

What is an Asset? In the context of health, an asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and wellbeing and meet identified needs. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses.

Assets may include:

- the practical skills, capacity and knowledge of local individuals, families and groups;
- the passions and interests of local people that give them energy for change;
- the networks and connections – known as 'social capital' – in a community, including friendships, neighbourliness, volunteering;
- the effectiveness of local community groups and voluntary associations;
- the resources of public, private and voluntary and community sector organisations that are available to support a community;
- the physical and economic resources of a place that improve wellbeing .

(National Institute for Health and Clinical Excellence, 2009)

The asset based community development approach is a set of values and principles and a way of thinking about the world which:

- 'identifies and makes visible the community based health-enhancing assets in a community;
- sees people and communities as the co-producers of health and wellbeing, rather than the passive recipients of services;
- facilitates the formation and supports and promotes community groups, networks, relationships and friendships that can provide caring, mutual help and empowerment;
- identifies needs and values and supports what works well in an area and invests in it;
- identifies what has the potential to improve health and wellbeing and supports this through building self esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources;
- empowers individuals, families and communities from the bottom up to take control of their lives and their futures and create tangible resources such as services, funds and buildings'.

(Foot and Hopkins, 2010)

While these principles are not new they can lead to new kinds of community based working. They could also be used to refocus many existing health and social care programmes to make them more relevant to service users. At the same time we do not overlook the fact that in order to reduce inequalities and overcome disadvantage and exclusion we still need to be aware of differences and sometimes need to target resources on this basis. To avoid the implication that we are advocating an approach that is diametrically opposite to previous practice we therefore prefer to describe our approach as 'needs and asset based'.

Why Community Development is Needed for Health and Wellbeing

Community development has a strong contribution to make to achieving health and wellbeing outcomes and to doing so with maximum economy, thus facilitating savings to the health and social care budget. Diabetes, obesity, cancer vie with poverty, teenage pregnancy, road accidents and violence in making exponential demands on health and social care services. These have to be alleviated as much by action and prevention in the community as by health agencies and clinical treatments. Community development is the main practice which fosters health-giving action in the community and links it to decision-making and effectiveness in health and social care agencies.

Sir Michael Marmot's review of inequalities, 'Fair Society, Healthy Lives' 2010 stresses the links between social conditions and health and the need to create and develop healthy and sustainable communities in order to reduce health inequalities and promote wellbeing. Marmot recommends moving beyond mortality as the main measure of health inequality and focusing on the inequalities in 'being well' and 'wellbeing' and on 'the causes of causes', that is invest more on the material, social and psychosocial roots.

> **'Inequalities in health arise because of inequalities in society - the conditions in which people are born, grow, live, work, and age are responsible'.**

Marmot says that that current approaches are 'not working, or are not working well enough'. According to Marmot the approach needs to:

- Put the empowerment of individuals and communities at the centre of action to address inequalities and promoting equity by providing new ways of working;
- Concentrate more on the "causes of causes" that is investing more in the material social and psychosocial determinants of health and wellbeing;
- Combat social exclusion and poverty;
- Value resilience and support the role of local people in communities and their groups and organisations in promoting health and wellbeing through a community development approach;
- Promote partnerships and collaborative intersectoral working;
- Co-ordinate and maximise the use of resources;
- Be consistent with Government and Regional policy.

The greatest demands on health and social care services often come from people and groups who do not easily or spontaneously respond to general consultation. Community development goes more deeply into the situation of people under multiple stress or who are not using the health service to best effect. By starting with their concerns whatever they may be, community development enables them to establish their priorities, work towards improving their own health and wellbeing and have the confidence to reach out to agencies about changes they may seek so that services fit their needs better.

Some of the kinds of health and social care issues which can ultimately be improved by better community activity include:

- Depression
- Isolation
- Falls amongst elderly people
- Child protection
- Teenage pregnancy
- Obesity

- Diabetes
- Cancer
- Poverty
- Childhood asthma attacks
- Breast feeding
- Postnatal depression
- Drug and alcohol abuse

How community development works. Community development requires specific skills and aptitudes, and organisations should therefore appoint or confirm some specialist staff, but also need contributions from all staff that interact with communities. The role of the specialist staff should therefore be both to take the lead on direct work with groups and communities and also to guide other staff on how to contribute from within their particular responsibilities.

Community development improves health and wellbeing by a variety of mutually-reinforcing effects, direct and indirect, notably:

- supporting people to be more active in their communities – this in itself improves their health and wellbeing;
- greater activity also leads to wider social networks which reduce isolation and depression;
- more effective and inclusive community groups provide better channels for dialogue between communities and health and social care agencies, thus enabling communities to participate in shaping and influencing services;
- better networks and activities foster better spread of health information, norms and reassurance, thus encouraging people to take better care of their own health, eat better, exercise more, give up smoking and make better use of health services, which also improves early diagnosis of treatable conditions;
- Better health awareness and community activity enables people with serious or long term conditions to spend more time at home and less in hospitals, which they prefer and which economises on budgets.

How community development underpins other processes. Community development is a well established process with a long history of effective results in many communities in Northern Ireland. Over the past ten years a number of related processes have grown up as part of the clinical and social care governance agenda. It is important to recognise the importance of these processes while understanding that they do not replace community development which is capable of delivering on broad themes for communities within the context of their day to day life.

These processes are often about providing checks and balances within systems to promote safe, quality services or about making services as effective as possible to promote good care and effective use of resources. These approaches include Personal and Public Involvement (PPI), self-directed care and person centred planning. These tools offer the potential to improve individual care by taking a holistic approach to the service user by improving communication, service improvement, promoting respect, and so on. The importance of understanding what the different approaches and processes can deliver is to ensure that the right tool is selected for the current need.

Why is it important for the Health and Social Care Board and Public Health Agency to embrace this approach? There is a strong social and economic case for increased prevention and tackling inequalities, whereby people take more responsibility and ownership and feel empowered to take control of their health and social care needs. This improves overall wellbeing and is especially important in disadvantaged areas, amongst regular health and social care users, or groups facing multiple deprivation, poverty or exclusion. Improvement in wellbeing reduces excessive demand on health and social care services and thereby reduces costs. The main instrument for increasing prevention and tackling inequalities is community development.

This work cannot be achieved in isolation: partnerships are needed with the community and voluntary sector and with local councils and other agencies and networks. The relationship with users of the services and community and voluntary sector organisations needs to be underpinned by the values and principles of community development. These relationships will be empowering and work in partnership. They will contribute to tackling inequalities and poverty and improvement in the health and wellbeing of the population.

As society has become more complex and demanding the need for work in partnership between public bodies, service users and the community is required. This needs to be further supported and developed and a greater consistency sought in the way in which partnership and collaboration work to produce better outcomes. The most critical agencies in the first place will be the Trusts who have been active in this field for many years and have a wealth of experience in providing community based services. It is acknowledged that Trusts have significant experience in the field of community development and their actions have informed learning and practice over the years. Trusts are required to develop their services in partnership with the many diverse groups, service users and communities within their respective geographical areas

This challenge requires skilled community development staff who typically work in the background facilitating and enabling community and group leadership. It also needs mature health and social care agencies who understand and fully commit themselves to the process. The journey from powerlessness to empowerment can go from blame and protest to confidence and partnership working. Health and social care agencies must understand this process and not react defensively or negatively when criticised in the early stages. Community development staff must be able to deal with tensions and dilemmas while keeping focused on the wider picture and maintaining a sense of optimism.

> *"Considerable work has been carried out by voluntary, community and statutory child care agencies in Northern Ireland to develop services to build on the strengths of families. It is important to link this work with a core objective of community development which is to strengthen social networks and promote social cohesion – in other words to build and sustain social capital. Strong communities are built on strong families."*
>
> *(McTernan, 2010, Children's Services Planning Presentation)*

A range of *mini case studies are included in the text to illustrate community development practice and outcomes.*

MINI CASE STUDIES

"Changes do not require large sums of money but rather a commitment to using resources better". Urban Forum (2009)

The following are a range of case studies which illustrate the various aspects of community development across the region.

1. Southern Area Action with Travellers Partnership Achievements (2001-2010): (Multisectoral Partnership)

- Travellers residing in Trust area; 1,200 or 200 families.
- School attendance increased from 45% to 70%.
- GP registration from 46% to 100%.
- HV registration from 92% to 100%.
- Immunisation rates increased from 45% to 100%.
- Preschool attendance from (no children) to 70%.
- After school attendance increased from 25 to 45%
- Youth club attendance increased to from 10 to-50%.

2. Community Sector Training; Child Protection and Community Development

- Community based child protection training sponsored by the Southern Area Child Protection Committee. (RCPC).
- Engagement of Community and Service Users, Church Groups, Bands, Early Years Groups, Youth Clubs.
- A flexible community based approach across the Trust area.
- Delivered training to more than 6,000 people in 8 years.
- Independent evaluation found that; 80% of groups had made substantial changes improving practice and procedures as a result of the training.
- People felt more confident about child protection issues and about approaching social workers with any concerns.

3. Building Community Pharmacy Partnership

The Building the Community-Pharmacy Partnership is a partnership between the Community Development and Health Network (CDHN) and the Pharmaceutical Branch of the Department of Health, Social Services and Public Safety (DHSSPS). It aims to establish stronger partnerships between local communities and community pharmacists and to address local health needs using a community development approach. One such example is the **ARC Healthy Living Centre** in Irvinestown which aims to improve the wellbeing of local people by bringing together a partnership of community health activities and services. The Healthy Living Centre delivers a range of services to address this aim over eight rural wards in Fermanagh, with high levels of deprivation and poor access to a range of services.

- The local pharmacist has become an integral part of the range of support being provided through the Healthy Living Centre, in particular the parent-craft classes, the obesity programmes and the youth programme.
- People have been referred to the pharmacist for medicines management, smoking cessation and the prescribing for minor ailments being offered through the pharmacy.
- Communication has improved across the range of health staff and with their interaction with the wider community.

This has created a much more integrated approach across health disciplines and has brought about greater understanding in the community of the roles and remits of each.

4. Rural Priority Areas Project / Warm Zone Pilots

The legacy Western Investing for Health and Health Action Zone developed a model, which identifies vulnerable households using a community development approach. Vulnerable households are identified by the local community, contacted by trusted contacts and signposted to key services/grants and initially supported by trained enablers in the community.

This model has been tested in a number of projects in the West, initially in rural priority areas in Strabane and Fermanagh and more recently in Warm Zone Pilots in Derry, Strabane and Fermanagh.

Outcomes include:

- Increased access to and uptake of a range of grants and benefits.
- Leverage of £6 in benefits/grants for every £1 invested.
- Increased social capital.
- Further recognition of the key role played by the community in addressing inequalities.
- Increased capacity within the community.
- Recognition of the model by Department of Agriculture and Rural Development and a scoping paper to extend this model regionally has been accepted in principle.

5. User Engagement and Personal and Public Involvement

The Community Development Unit of the legacy Western Board developed a strong partnership arrangement with Community and Voluntary Sector networks in each Council area. They were engaged on a contractual basis to advise on appropriate methodologies for engagement, to help develop appropriate documentation/communication information on the issue to be discussed. They then facilitated the engagement, be that surveys, open public meetings, targeted focus groups and wrote up their findings. These were then shared with those who initiated the consultation and a mechanism agreed for feedback to those who had contributed.

Outcomes include:

- Significant increased levels of user involvement and engagement with the wider community.
- A sense of genuine partnership working with community and voluntary sector and service users.
- Improved understanding by health and social care staff and managers of the needs of people.
- More tailored and targeted services.
- Partnership in policies and service developments by staff and service users.
- Other statutory bodies recognise the value and benefits of this approach.
- This approach provided direct access to over 2,000 organisations on the Networks database. It also facilitated engagement with service users and the wider public, who often preferred to talk to/share information with the Network rather than those they perceived to provide/commission health and social services.

6. Social Economy

The South Eastern Health and Social Care Trust is currently working with both the Colin Neighbourhood Renewal Partnership and the Kilcooley Neighbourhood Renewal Partnership to develop new social economy initiatives. This builds on the partnership between the Colin Partnership and the Trust in developing Colin Care - a social enterprise company, owned by the Colin Partnership, delivering domiciliary care across Lisburn and Belfast. This scheme now employs 30 members of staff, most of whom were long term unemployed people from the Colin area.

7. Children and Young People's Locality Partnership

- Involving communities in the planning of services is one of the foundations of the Northern Ireland Children's Services Plan. Locality partnerships with membership from the Statutory, Voluntary and Community sector organisations have been and are being developed across Northern Ireland. They monitor and aim to improve the six high level outcomes for children as set out in the OFMDFM 10 year strategy for children.

- The Larne Children's Locality Partnership has been developing "local solutions to local need." The partnership's mission statement highlights the key role the local community plays in the drive to improve outcomes for children and young people:-

"Our aim is to raise the educational, health and social development of our children in the Larne area and the environment they live in by:-

- listening to them to find out their views and needs;
- building on existing social partnerships;
- developing stronger community ownership; and
- providing a needs led range of leisure, social, health, educational and housing services in locally agreed and accessible locations."

8. Empowering Travellers in Health and Wellbeing

The All Ireland Health Study has been the biggest health research project ever undertaken in Ireland on Travellers' health. The success of the project has rested on the engagement and participation of Travellers to promote, carry out and take part in the key research stages. To ensure maximum participation and engagement, the process was to empower Travellers to lead on the study, agree the research methodologies and questionnaires carry out the research and to gain the trust and confidence of family members to take part. The study used methodologies which were culturally appropriate and which were respectful of Traveller values and beliefs.

Peer researchers drawn from the Traveller community played a key role in data collection - only Travellers could do the work and this led to the highest return of questionnaires of all Traveller health studies to date.

In NI teams of peer researchers were set up in eight different localities. In total 78 Travellers were trained in research methods including protocols around confidentiality and consent: they were also trained to use laptops with the census and health questionnaires using appropriate methods of collating information – e.g. a Traveller's voice was used to ask the questions, using culturally appropriate language etc. Four peer researchers across NI were supported to become co-ordinators of their local team.

Travellers promoted the study widely within their own community and highlighted the importance of the study is trying to bring about change in health and social care services and uptake. In areas where there had been no existing infrastructure of Traveller support, the empowerment of Travellers created a legacy of confident Traveller activists, who now act as advocates on health issues awaiting the outcomes and recommendations of the study in order to lobby for improved health services. Ultimately the hope is that this study will provide the tools needed to narrow the gap between the poorer health and wellbeing statistics of Travellers and those of the majority settled population.

9. Reform of Northern Ireland Wheelchairs Services

In 2006 it was acknowledged that the Northern Ireland Wheelchair Service was experiencing increasing pressure. There were increasing numbers of children and adults, some with extremely complex disabilities, who required specialist individualised wheelchairs and or seating systems to gain or regain mobility and independence. In order to address these issues it was recognised that wheelchair users needed to inform and drive the process. An all inclusive planning workshop was held of which almost 60% of the participants were wheelchair users.

Aim

To develop a person-centred, accessible, responsive and equitable service so that people are provided with a wheelchair as soon as possible after assessment.

Objectives

1. To redesign the Wheelchair Service (i.e. referral, assessment, prescription, delivery, review, repair and maintenance) based on models of good practice.
2. To establish a framework for assessing need, including a baseline of current service users.
3. To promote capacity building for all wheelchair users, to enable them to be actively involved in the planning, delivery and evaluation of services.
4. To develop staff expertise to involve individuals who use the service and the wider public.
5. To develop new and better ways of working to meet the changing needs of people with severe mobility problems.

Methods of Engagement

A wide range of stakeholders participated in a workshop facilitated by two Person Centred Planning Trainers using the 'Path Process'. Six key themes emerged during this workshop. Stakeholders were asked to volunteer to take forward the work around the specified themes. Wheelchair users were integrated in all the work streams. Wheelchair users were given the necessary support to enable them to participate in the different work streams i.e. funding for travel and additional care arrangements to enable them to attend meetings.

The Project Manager /Co Chair had formal and informal discussions with individual wheelchair users and groups of wheelchair users in order to learn from their experiences. Focus group discussions were found to be most helpful as they inspired confidence in participants as they expressed their views. The synergy developed in these discussions often culminated in the recommendations for the reform of the Wheelchair Service.

The involvement of service users working alongside professionals and managers from the beginning of this project was vital to its success.

10. Newry Neighbourhood Renewal project - Emotional Overeating

A member of the Newry community who was overweight/ obese approached the Trust's Community Development Worker to create a profile on her in order for her to kick start a healthier lifestyle as she wanted to lose weight. Other women in the area were identified who would also be interested in a programme that would address the emotional aspects of overeating and they advised that they wanted something more than "Eat less, exercise more" as most of them had been on yo-yo diets that were not working.

A planning group made up of women who experienced emotional overeating was set up. Funding was secured for the project from Department of Social Development (DSD) Neighbourhood Renewal funding. The BEAM project was commissioned to work with a small group of women to develop a project that would examine the implications of emotional overeating. It was agreed to develop a DVD on Emotional Overeating to be used as an educational tool in the Health Service. It was also agreed that this would be the first step to develop a programme that would benefit people in Newry Neighbourhood renewal area to address their emotional overeating practice.

10. Newry Neighbourhood Renewal project - Emotional Overeating (Continued)

- Since the inception of the project, a small group of members of Newry NR areas have been involved in the planning and wanted a range of strands to the project including the making of an educational DVD on emotional overeating.
- The planning group met with a local provider to develop a 12 week pilot self-esteem course that would examine many aspects of emotional overeating with a view to providing skills and tools to break this cycle. The planning group have discussed the possibility of setting up an Emotional Overeating Group – (OA) Overeating Anonymous following the self esteem course.

The launch and the new group will follow after.

The planning group is ongoing and as the course develops other interventions may be developed in conjunction with health service colleagues.

Working together for the participants has created a synergy that is inspiring, willing and encouraging and it is hoped that the outcomes of the project will be healthier members of the community and shared learning about emotional overeating and its impact.

11. The Pathways Project

The Belfast Trust Community Psychiatric Service identified increasing numbers of former combatants/ex paramilitaries living in Greater East Belfast referred by their GP to mental health services. Reasons for referral included depression, anxiety, social isolation, drug and alcohol abuse, self-harm, suicide attempts, and seeking mental health advice.

The CPN service felt that mainstream services were not the most appropriate support for many of these people, that one to one counselling/community support was probably more appropriate.

Following a series of meetings and conversations organised and facilitated by the Community Development Unit with a wide variety of individuals and organisations who work with ex prisoners/combatants as well a ex prisoner groups a number of issues were highlighted:

- Many of these people were inappropriate referrals to mental health services but due to lack of support systems within the community, appeared be the only point of contact for GPs who were the referral source.
- Confidentiality was perceived to be a problem for some who preferred to access community led/voluntary ex prisoners organisations.
- Anonymity was also important to some who preferred to access services on the other side of town.

There was a consensus that because of the multiplicity and the complexity of issues for this group, one service' didn't fit all.

A counselling model was developed based in community settings, working in partnership with statutory agencies now known as the '**Pathways'** Project.

The overall aim of Pathways is to provide and signpost counselling services within a community setting, where the client group feel at ease and confidentiality is secured. The partner organisations operate in an environment created and managed by ex-prisoners, ex-combatants, and their families. They have established credibility with the client group, which reduces the stigmatisation and sense of isolation.

Outcomes include:

- Earlier recognition of mental health issues and more appropriate support services tailored to the needs of client group;
- More co-ordinated, effective, accessible response;
- Reduction in numbers of referrals to Primary Health Care services freeing up time to deal with more acute cases;
- Improved information for the client and service provider;
- Improved mental health and emotional wellbeing for ex prisoners and former ex combatants and their families.

12. East Belfast Men's Health Clinic

East Belfast Men's evening Health Clinic operates from Holywood Arches Health and Wellbeing Centre every fortnight. The clinic is a partnership between the Wise Men Of the East Network, an active group of local men affiliated to the east Belfast Healthy Living Centre, the Belfast Health Trust, and local GPs. The clinic was established in response to men who felt there was a need for an accessible health service tailored specifically to the needs of men living in east Belfast. The service aims to pick up potential health problems such as diabetes, hypertension, obesity, high cholesterol, COPD, stress, depression, etc much earlier and refer them onto appropriate help and support.

Most of the men presenting are targeted via their GPs. The service targets men between 35-85yrs who haven't been seen by their GP in the last 2 years. Men can also access the service by ringing in themselves and asking for an appointment. A follow up phone call is made to each of the men several days prior the appointment to ensure they are coming and to allay any fears.

The clinic is staffed by 2 nurses from the Trust and 2 local male volunteers from the Healthy Living Centre and it operates on an appointment system. Male volunteers meet and greet men as they arrive offering refreshments, volunteers are trained to provide opportunistic health promotion and a sign posting service to local health programmes and activities. Men are offered a half hour appointment, which includes screening and an opportunity to discuss general health and wellbeing, including mental health. Assessment results are sent onto the GPs informing them of any concerns or advice given.

The clinic has proved very popular. Feedback from users and staff has been very positive. A number of men have been referred on to other services and several are receiving smoking cessation support.

13. Children and Young People's Locality Partnership

- Involving communities in the planning of services is one of the foundations of the Northern Ireland Children's Services Plan. Locality partnerships with membership from the Statutory, Voluntary and Community sector organisations have been and are being developed across Northern Ireland. They monitor and aim to improve the six high level outcomes for children as set out in the OFMDFM 10 year strategy for children.

- The Larne Children's Locality Partnership has been developing "local solutions to local need." The partnership's mission statement highlights the key role the local community plays in the drive to improve outcomes for children and young people:-

"Our aim is to raise the educational, health and social development of our children in the Larne area and the environment they live in by:-

- listening to them to find out their views and needs;
- building on existing social partnerships
- developing stronger community ownership; and
- providing a needs led range of leisure, social, health, educational and housing services in locally agreed and accessible locations."

14. Co-operation and Working Together (CAWT) Adopting Community Development on a Cross Border basis

People living in border communities have close family and community ties which span the border region. They also share similar health and demographic status. Since 1992 Co-operation and Working Together (CAWT) the statutory partnership of the health services within the border area, have been working to improve the health and wellbeing of the border population, tackling health inequalities and promoting better access to services.

CAWT are progressing 12 large-scale EU INTERREG IVA cross border projects on behalf of the DHSSPSNI and the DOHC. A number of these projects have adopted a community development approach working jointly with the community and voluntary sector.

Management and Prevention of Obesity
The Management and Prevention of Obesity adopts a community/primary care partnership approach to targeting families and young children at risk from obesity. The project targets up to 1800 individuals, offering a multi-level programme based on education and behaviour modification towards healthier physical and mental wellbeing.

Outcomes

- A maintenance/reduction in weight/BMI in relation to appropriate age/sex weight status;
- An increased awareness of health effects of obesity;
- An increase in healthy self-esteem;
- An increase in physical activity levels;
- Healthier food choices;
- Introduction of a referral pathway for overweight/obese children.

15. Multi-level Alcohol Harm Reduction

The Time IVA Change Border Region Alcohol Project has established a multi-level approach to addressing alcohol culture. It combines a model of intervention and prevention by implementing clinical approaches to early intervention, collaborative working for family support, and community mobilisation around alcohol. The significance of the project in community development terms is that it successfully combines action at local community level (community mobilisation and locally-accessible early intervention supports) and at statutory policy and service planning/delivery levels.

Outcomes

- enhanced partnership working between early intervention workers and community-based health initiatives and services – recognizing the need for people to access Early Intervention support in a setting and at a time that is appropriate for them and best meets their needs;
- development of a cross-border community mobilisation toolkit which can be adapted by any community interested in addressing the negative impact of alcohol on their local community;
- a community-based model for the delivery of the Strengthening Families Programme;
- a greater collaborative partnership between statutory and local community stakeholders which can deliver results on the key issues of Hidden Harm, family support, and family/community resilience in the context of alcohol harm.

16. Dove Gardens, Derry – 'Heaven'

This report details the findings of a Health Impact Assessment (HIA) carried out on a housing redevelopment project in Derry in 2005. The HIA was carried out by Co-operation and Working Together (CAWT) in partnership with the Northern Ireland Housing Executive (NIHE), local community groups and representatives from statutory and voluntary sectors in the context of the *Investing for Health* Strategy. HIA facilitates cross-sectoral working and has a particular focus on Health Inequalities. It requires participating organisations to consider the impact on health of a particular project (in this case a housing redevelopment) or programme and influence the project so that the health of affected communities is improved as a result. The first phase of the CAWT project consisted of multi-agency training in HIA that was the catalyst for bringing together the different agencies to undertake and complete this HIA. The report contains a huge amount of information about the needs and difficulties faced by families and residents living in Dove Gardens. It identifies strategies that could improve the health experience of people living in the area. It contains a challenging agenda for services planners in a range of statutory providers from health, housing, planning and also community groups.

"Heaven" - That's how a resident summed up her new home in Dove Gardens in Derry. Born and reared in the Bogside estate, she lived elsewhere for five years while it was demolished and completely rebuilt. She was among the first families to move back in - just in time for Christmas. "My family were one of the first to move into Dove Gardens, and it has a lot of memories for me. One of the best-known estates in the city, it was a state-of-the-art development when it was built in the 1960's, but by the 1990's had become run-down and was notorious for anti-social behaviour. "There was drinking on the steps, there was drugs, and they were torturing the old people. It was no place to bring up children.

"Things came to a head when the block of flats I lived in got burnt down. We were lucky to get out alive. We knew then it was time for the flats to go. To see the sitting room I'm in now, and the kitchen, and to have a garden it's lovely getting up in the morning and knowing this is your house.

International Examples

1. Building partnership: the Beacon Estate project, Falmouth, 1995-2010

The Beacon estate (pop. 6000), in Carrick District in Cornwall, was among the most deprived 10% of wards in England. Its illness rate was 18% above the national average. In a climate of mistrust between the police and community, violent crime, drug dealing and intimidation were rife. With little central heating, the cold, damp homes were associated with high levels of childhood asthma and respiratory problems. Over time the estate felt abandoned by statutory agencies. In 1995 two health visitors created a twin-track approach of developing resident leadership and mobilising fresh interest among public agency professionals. A new dialogue with public agencies established a resident-led neighbourhood partnership and gradually converted anger and frustration into positive energy. A regeneration grant was unlocked, housing improved, and a raft of community activities sprang up. In 1999 an audit revealed these changes over the preceding four years:

- Post-natal depression down by70%;
- Number of children on child protection register down 60%;
- Overall crime rate down by 50%;
- Childhood asthma rates down by 50%;
- Residents' fuel bills cut by a total of £180,000 p.a.;
- Unemployment rate down by 71%;
- Education: 10/11 yr old boys' SATS scores improved 100%, girls' 25%.

Over 10 years further on, the partnership continues improvements and is a main source for the development of the HELP model of community development in health (www.healthempowermentgroup.org.uk)

2. Entre Nous Femmes, Vancouver, Canada

Founded by lone parent women, this project in Vancouver Canada is an example of women in shared personal circumstances deciding to act collectively. It created safe and affordable housing in the area for families getting them out of poverty. The project developed seven group housing initiatives for 253 people demonstrating a remarkable integration of learning, empowerment, and social action. The project has developed partnerships and networks with many agencies and community initiatives during the past ten years.

3. Residents Making a Difference – Whitehorse, Melbourne Australia

People living in public housing are likely to experience higher levels of illness and chronic disease related to the social, environmental and economic conditions in which they live.

A consultation with community members in three public housing estates in the Whitehouse area identified lack of access to opportunities for physical activity as a key health issue. A number of barriers against participation were also identified, including: lack of knowledge of appropriate physical activity options for their age and states of health; lack of local and accessible opportunities for physical activity, poor access to public transport making it difficult to travel outside the estate and lack of 'control' over the estate environment, in particular the development and maintenance of gardens and access to an adjoining council parkland reserve.

A partnership between some key local agencies, such as the tenancy and housing support agency, the Council and local Community House now works with the community on improving neighbourhood and living environments to create a healthier, active community.

The project resulted in neighbourhood environment and safety improvements: footpath repairs, parkland access, path redevelopment, park bench installation, ramp installation at community hall, housing safety upgrades, improved estate signage and road intersection improvements. A weekly exercise program was developed in the local hall, provided by Council's Leisure Centre staff and fitness instructor. This helped to empower residents who are now more able to advocate to agencies and departments on their own behalf. Advocacy and significant consultation with council departments in the partnership recently culminated in the development of a ten-year Council plan for the neighborhoods and upgrading of local amenities.

The Challenge

Health and Social Care Services currently face a challenging policy arena, within a very tight financial framework, in which a common theme is evident. There is a drive towards fairness and inclusion so that all can become "full members" in our society and at the same time budgets are being cut. Ownership and participation are not just for the employed and the "better off" but also the excluded, disabled, the deprived and the disadvantaged. The Programme for Government (NI Assembly, 2008) and the Health and Social Care Board, Public Health Agency Commissioning Plan (2010) set out this approach, as a central vision running throughout all Government policy and across all Government departments.

Key Statistics

A useful measure of inequalities in health is the gap in life expectancy, and disability-free life expectancy, between those living in affluent areas and those in disadvantaged areas. Some key statistics in this regard are set out below: Within Northern Ireland there remains variation at geographical level in life expectancy. Belfast LGD at 73.4 is amongst the ten lowest male life expectancy local areas in the UK. Glasgow is the lowest at 70.7 and Kensington and Chelsea highest in the UK at 84.3yrs.

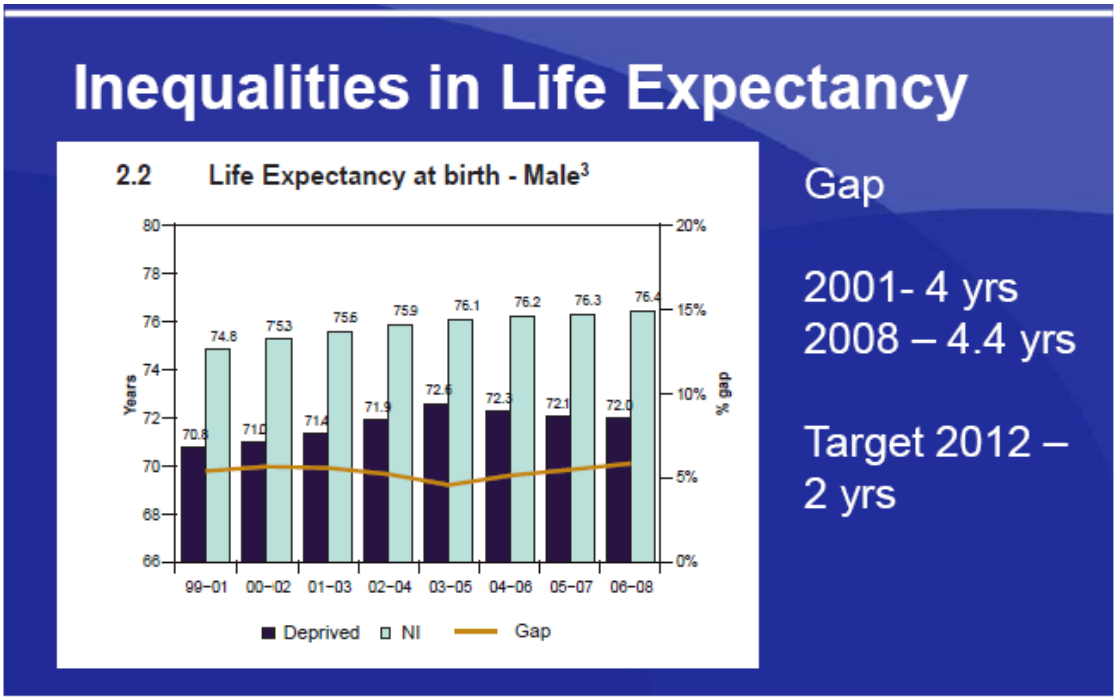
Table 1 Local areas with the highest and lowest male life expectancy at birth, 2006–08

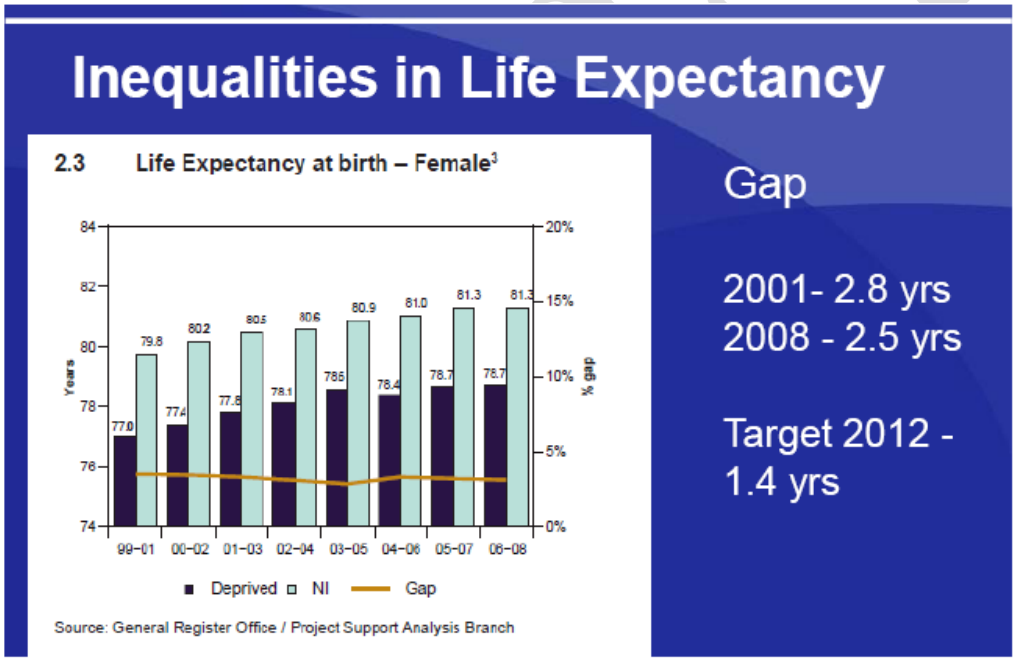
United Kingdom

Rank	Local area	Country/English Government Office Region	Life expectancy at birth (years)
Highest life expectancy at birth			
1	Kensington and Chelsea	London	84.3
2	Westminster	London	82.9
3	Fareham	South East	81.4
4	Hart	South East	81.3
5	Elmbridge	South East	81.3
6	South Bucks	South East	81.2
7	East Dorset	South West	81.2
8	Epsom and Ewell	South East	81.2
9	Wokingham	South East	81.1
10	South Cambridgeshire	East of England	81.1
Lowest life expectancy at birth			
1	Glasgow City	Scotland	70.7
2	West Dunbartonshire	Scotland	72.1
3	Inverclyde	Scotland	72.8
4	North Lanarkshire	Scotland	73.1
5	Belfast	Northern Ireland	73.4
6	Eilean Siar	Scotland	73.5
7	Blackpool	North West	73.6
8	Renfrewshire	Scotland	73.6
9	Dundee City	Scotland	73.7
10	Manchester	North West	73.8

Source : Life expectancy at birth and at age 65 by local areas in the United Kingdom, 2006-08

People who live in the most deprived areas of Northern Ireland have a life expectancy lower than the average (males 4.4 years less, females 2.5 yrs). For males this gap increased slightly between 2001 and 2008 and the target to reduce this gap by 2012 is unlikely to be met.





Source : Health Inequalities Monitoring System DHSSPSNI

The vulnerable position of Northern Ireland was highlighted in the report "UK Fiscal Restraint: Implications for N Ireland Community Organisations" Harrison and Morrissey, September 2010, as

- More than 200,000 benefit claimants;
- Public expenditure amounting to 67% of regional income.

More than 300,000 jobs in the public and voluntary sectors combined.

These statistics demonstrate that Northern Ireland is triply vulnerable to public expenditure cuts. The conclusions presented in the paper 'Who are the Vulnerable in this Recession? The Social Impacts of Recession in Northern Ireland' (Mc Donough, 2009) concluded that there were four particular areas of concern:

1. Increasing joblessness- with high levels of unemployment and inactivity likely to be around for a longer period of time.

2. Increasing levels of debt- together with the household and personal consequences.

3. Difficulties for young people, with unemployment in the 18-24 year old group at 18.6 % (2009) this is the highest of any region across the UK.

4. The impact of the recession on older people, lone parents.

The Office of the First Minister and Deputy First Minister (OFMDFM) Anti Poverty Strategy Lifetime Opportunities (2007) highlighted that there were 340,000 people in Northern Ireland living in relative poverty of whom 100,000 were children. Difficulties such as emotional and mental health may increase in other excluded groups.

By mainstreaming community development, service commissioners and providers will be responding to this challenging agenda by:

- identifying the needs of the most disadvantaged individuals, families, groups and the appropriate areas to work in;
- working with people and local communities to build knowledge and skills and build the energy of communities and volunteers;
- helping to strengthen communities and enable local people to take the lead (often by statutory representatives taking a step back from positions of power);
- working in partnership with communities and other public bodies to improve services.

The following statistics illustrate the scope of community and voluntary sector in Northern Ireland (NI). In 2008, these were:

Number of voluntary and community organisations	4,700
Numbers employed in voluntary and community organizations (representing 3.7% of NI workforce)	26,737
Total income of voluntary and community organizations	£570 million
Number of volunteers	87,723

(Source: NICVA, *State of the Sector*, 2008)

The community and voluntary sectors are therefore vital partners for health and Social care and other statutory agencies in taking forward a variety of initiatives. This approach is critical for public agencies if they are to achieve desired outcomes, through conducting their future business in this way.

Partnerships

Community development requires strong foundations to enable partnerships with the community and voluntary sector and other agencies. Community development has significance at policy, organisational and practice level. The strategy notes the relevance

of each of these levels and the need to create links between them. The most critical group in the first place will be the Health and Social Care (HSC) Trusts who provide community based services. In this regard the Health and Social Care Board, the Public Health Agency and the Local Commissioning Groups (LCGs) require HSC Trusts to develop their services in partnership with the many diverse groups, service users and communities within their respective geographical areas.

Whilst the HSC Trusts are an important way for the Board and Agency to implement its strategy there are a range of other organisations with responsibilities in this area, in particular, local Councils, Departments of Education, Social Development, Agriculture and their agencies, and others with whom partnerships are required to create a strategic approach and achieve successful outcomes. In developing these relationships the health and social care agencies have much to offer as well as to seek. The Patient and Client Council (PCC) has a duty to represent the interests of the public and promote involvement of the public. This includes advising the Department in relation to the approval of health body consultation schemes. Through its statutory duties the PCC has an interest in community development's contribution to the promotion of effective and genuine partnerships between those who use services and those who plan, manage and deliver those services. Successful partnerships are win-win mechanisms. With better health and wellbeing comes better ability for children to learn, with better community interaction come safer communities, and front-line staff of all agencies find their jobs easier when communities take greater ownership of their issues, conditions and greater care of themselves and each other.

In summary, as a more wide ranging view of health and wellbeing is increasingly being accepted, so too is the realisation that no one agency can improve this alone. A fundamental element of this will be the need to include meaningful cooperation with large and small communities and their groups (geographic and communities of interest) and voluntary sector organisations. This will enable the targeting of services to be 'tailored' to the articulated needs of specific communities and, in particular, excluded groups.

Commissioning Plan: Reducing Inequalities and Promoting Health and Social Wellbeing

Relative deprivation in Northern Ireland is assessed by looking at income, employment, education, health, including disability and early death, local environment, crime and proximity of an area to services such as GP surgeries, hospitals or shops. Individual areas are ranked across Northern Ireland based on these. The 20% of most deprived areas represent nearly 340,000 people.

Populations from deprived areas in Northern Ireland experience:-

- Lower life expectancy than the Northern Ireland average;
- 23% higher rates of emergency admission to hospital;
- 66% higher rates of respiratory mortality;
- 65% higher rates of lung cancer;
- 73% higher rates of suicide;
- Self harm admissions at twice the Northern Ireland average;
- 50% higher rates of smoking related deaths;
- 120% higher rates of alcohol related deaths.

It is clear therefore that we need to do more to narrow the gap in health inequalities and improve the health and wellbeing of our population. This means working to address the determinants of ill health and reduce risk factors, including those associated with poverty and social exclusion. This Commissioning Plan contains specific measures to address this

challenging agenda, but it is equally important that health prevention and improvement is actively considered as an integral part of all of our commissioning strategies.

The focus will be on the wider public health agenda, addressing the determinants of health that contribute to and sustain health and social wellbeing inequalities. Inequalities in health arise because of inequalities in society. Addressing inequality therefore requires co-ordinated action across many different sectors and government.

The reform and modernisation of the health and wellbeing commissioning process can greatly assist this goal. Firstly, by taking a leadership role championing the issue and working collaboratively with other sectors to address the challenge; secondly, by shifting resources and commissioning 'upstream' interventions; and thirdly developing exemplar roles in creating healthy workplaces and by ensuring that the entire health and social care workforce use every interaction with the public to promote health and wellbeing.

We will therefore aim to identify and encourage new models of care that facilitate the transfer of resources to this end. We will also consider the potential value of changes to relevant legislation where this may be a vehicle for promoting change. The aim will be to:

- Make tangible difference to health and wellbeing outcomes;
- Decrease incidence of major causes of ill health;
- Maximise independent living;
- Improve mental health scores of population;
- Reduce health inequalities gap;
- Build sustainable communities and increase social capital and community engagement;

Relevant Targets and Objectives

It could be argued that a community development approach could be applied to all targets. However the most relevant ones, where community development could have the greatest impact, are in relation to the following.

Priority for Action (PFA) Targets:

Priority 1: improve the health status of the population and reduce health inequalities.

Priority 2: ensure services are safe and sustainable, accessible and patient-centred.

Priority 5: Improve children's health and wellbeing.

Priority 6: Improve mental health services and services for people with disabilities.

Public Health Agency (PHA) Corporate Objectives

1.0 Addressing health and social wellbeing inequalities.

1.1 Implement programmes to support early childhood development.

1.2 Expand programmes that tackle poverty and maximise access to services and support for those who need it.

1.3 Engage communities and groups experiencing significant health inequalities in designing and implementing local community development plans.

1.5 Reduce health inequalities through cross-sectoral action and commissioning.

2.1 Increase the percentage of the population who do not smoke.

2.2 Increase physical activity levels and breastfeeding rates and improve nutrition, to increase the proportion of the population with a normal weight.

2.3 Reduce alcohol and drug misuse.

2.4 Improve the mental wellbeing of the population and reduce suicide and self-harm.

2.5 Reduce the incidence of births to teenage mothers.

2.6 Reduce the incidence of sexually transmitted infections.

4.7 Build effective public involvement into PHA work.

Public Service Agreement (PSA) Targets

These were originally tied to specific dates in 2010 – 2012 but continue to be relevant:

1.1 Increase average life expectancy by 2 and 3 years for women and men respectively, and facilitate a 50% reduction in the life expectancy differential between the most disadvantaged areas and the Northern Ireland average.

1.2 Reduce to 21% and 25% respectively the proportion of adults and manual worker subset who smoke.

1.3 Halt the rise in obesity.

1.4 Ensure a 5% reduction in the proportion of adults who binge drink.

1.5 Ensure a 10% reduction in the proportion of young people who drink and who report getting drunk.

1.6 Ensure a 5% reduction in the proportion of young adults taking illegal drugs.

1.7 Ensure a 10% reduction in the number of children at risk from parental alcohol and/ or drug dependency.

1.8 Achieve a reduction of at least 15% in the suicide rate.

1.9 Achieve a 40% reduction in the rate of births to mothers under 17.

5.1 Provide family support interventions to 3,500 children in vulnerable families each year.

5.2 Increase by 50% the proportion of care leavers in education, training, or employment at age 19.

6.1 Ensure a 10% reduction in admissions to mental health hospitals.

Conclusion and Recommendations

- There is a sound evidence base for community development and its potential positive impact on health and wellbeing. This strategy supports the current policy drivers for community development and has been developed following pre consultation stakeholder workshops held in all HSC Trust areas during 2011.

- The HSCB and PHA should adopt the Community Development Strategy.

- The HSCB and PHA should adopt the Performance Management Plan and ensure that it is taken forward by the HSC Trusts.

- A joint HSCB/PHA Community Development Action Plan should be developed following a formal 12 week consultation phase.

- The HSCB and PHA should establish a mechanism for supporting and monitoring the implementation of Community Development Strategy, Performance Management Framework and Action Plan.

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