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

SUMMARY VERSION

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1. Introduction

This strategy for community development in health has been jointly agreed by the **Health and Social Care Board** and the **Public Health Agency** of Northern Ireland. They want to see strong, resilient communities where everyone has good health and wellbeing - places where people look out for each other and have community pride in where they live. They seek a reduction in health inequalities, which also means addressing all the other social factors that impinge on health and working in partnership with the other public agencies that deal with those factors. 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.

The Board and Agency see community development as a key instrument to improve health and wellbeing, drive us towards health 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. To assist this process, they have produced the strategy which is summarised here. The full strategy can be found on the website www.hscboard.hscni.net

The Public Health Agency (PHA) and Health and Social Care Board (HSCB) have a key role in developing programmes to drive this agenda forward as part of the *Investing for Health* strategy, the Children and Young People's Plan, the Public and Personal Involvement agenda and other key strategies. Strong performance management will be central to achieving an outcome which is positive and publicly understood, and ensures compliance with standards, statutory obligations and targets set annually by the DHSSPS. The strategy therefore includes a performance management framework with specific outcomes.

The performance management framework was developed to provide strategic advice and guidance at management board level within health and social care on how to mainstream community development approaches. This ensures that user involvement and community development are at the heart of core business of health and social care organisations.

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The strategy and performance management framework support organisations to:

- take stock of their attitudes, aspirations, and practice in relation to community development;
- systematically develop needs and asset based community development approaches in all aspects of their business; e we're consistent in what we call it through the document – I'd favour 'community development' but explain early on what we mean by it.
- ensure a realistic progress route for community development;
- measure progress on mainstreaming community development approaches; and
- incorporate community development into overall performance management arrangements.

Definition
"Community Development is about strengthening and bringing about change in communities. It consists of a set of methods which can broaden vision and capacity for social change 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 aims 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)

2. How Community Development works

Community is the web of personal relationships, groups, networks, organisations, traditions and patterns of behaviour that exist amongst those who share physical neighbourhoods, socio-economic conditions or common understandings and interests.

Community development is a practice which assists the process of people acting together to improve their shared conditions, both through their own efforts and through negotiation with public services. Public service agencies, in turn, seek dialogue and cooperation with users in communities. This is generally called community engagement. So community development, working from the bottom up, links with community engagement, from the top down. In practice community development workers often need to advise agencies on community engagement as well as facilitate development in communities themselves.

So in a broad sense, as our examples later in this document show, community development drives both the bottom-up and top down efforts. Where there is tension between these viewpoints community development will stress the community’s perspective, because this is usually less visible and less powerful than that of the public agencies, especially in disadvantaged areas. But it will do so by showing that even disadvantaged communities have abundant human assets as well as needs. This human ‘asset-based’ or ‘strengths-based’ approach may contrast with the tendency of official profiles of disadvantaged areas to depict them in terms of inadequacies, which can inadvertently reinforce a negative message.

In the health context community development also links with tools created to improve individual care through a more holistic approach to the person, such as shared decision-making, Personal and Public Involvement (PPI), self-directed care and person-centred planning.

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 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, strengthening the capacity of groups which already exist, or bringing groups together in

networks to achieve a common goal. Such groups and networks are also necessary to enable communities to form partnerships with public agencies.

This requires skilled community development staff who typically work in the background facilitating and enabling community and group leadership. The journey from powerlessness to empowerment can go from blame and protest to confidence and partnership working. Health and Social Care agencies must understand and commit themselves this process, and 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.

Several mini case studies are included in the text to illustrate community development practice and outcomes.

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Mini case study: **Community Sector Training, Child Protection and Community Development**

Can we explain better how this is Community Development?

- Community development approach to child protection training sponsored by the Area Child Protection Committee. (ACPC)
- 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.

Mini case study: **Rural Priority Areas Project / Warm Zone Pilots**

Western Investing for Health and Health Action Zone developed a model in which vulnerable households are identified by the local community, contacted by trusted contacts and signposted to key services/grants, supported by trained enablers in the community.
The model was used initially in rural priority areas in Strabane and Fermanagh and then 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 with a view to extending the model regionally.

3. Why Community Development is needed for Health and Wellbeing

There are about 340,000 people in Northern Ireland living in relative poverty, including 100,000 children[1]. Under current economic pressures, difficulties of emotional and mental health may increase. People who live in the most deprived areas of Northern Ireland have a life expectancy lower than the average for the region (males 4.4 years less, females 2.5 yrs). Belfast is amongst the ten lowest life expectancy local authority areas in the UK, at 73.4. (Glasgow is the lowest at 70.7 and Kensington and Chelsea highest at 84.3yrs). Northern Ireland is particularly vulnerable to public expenditure cuts. There are more than 200,000 benefit claimants, and public expenditure amounts to 67% of regional income[2].
Compared with the regional average, populations from deprived areas in Northern Ireland experience:

- Lower life expectancy;
- 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;
- Double the number of self harm admissions;
- 50% higher rates of smoking related deaths;
- 120% higher rates of alcohol related deaths.

We therefore 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.

Community development has a strong contribution to make to achieving health and wellbeing outcomes. All constructive community activity is health-giving in itself, either physically or mentally, or both. Some of the activity, by influencing or collaborating with public agencies, also has the further effect of helping to drive improvements in services or local conditions. The benefit in disadvantaged areas is particularly concentrated since these are often also the areas with greatest health needs. Improvements here, again, have multiple value: they reduce health inequalities and alleviate pressure on the health and social care budget.

The kinds of health and social care issues which can be improved by better community activity include depression; isolation; falls amongst elderly people; child protection; teenage pregnancy; childhood asthma; postnatal depression;

[1] The OFMDFM Anti Poverty Strategy, Lifetime Opportunities (2007)
[2] *UK Fiscal Restraint: Implications for N Ireland Community Organisations*, Harrison and Morrissey, September 2010

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drug and alcohol abuse; and ultimately also long term conditions such as obesity, diabetes and cancer.

However, the effects may be indirect. Community development produces multiple health benefits precisely because it fosters the interconnections of all issues affecting a community. It therefore needs to be given the space to work with whatever issues emerge from dialogue with communities.

A more wide ranging view of health and well-being is increasingly being accepted, so too is the realisation that no one agency can improve this alone. A fundamental element of the strategy is to include meaningful co-operation with other public bodies and with large and small communities (geographic and communities of interest) and with their groups 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.

Successful partnerships are win-win mechanisms. With better health and well-being 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.

Sir Michael Marmot's review (*Fair Society Healthy Lives*, 2010) stresses the need to create and develop healthy and sustainable communities in order to reduce health inequalities and promote wellbeing: "Inequalities in health arise because of inequalities in society". Marmot seeks to:

- put the empowerment of individuals and communities at the centre of action to address inequalities and promote equity by providing new ways of working
- concentrate more on the "causes of the causes", that is invest a greater proportion of the Health Service effort 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, and co-ordinate and maximise the use of resources

4. What Health and Social Care Agencies should do?

Health and Social Care Services currently face a challenging policy arena, within a very tight financial framework. The reform and modernisation of the commissioning process can greatly assist these goals: firstly, by taking a leadership role, championing Community Development 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.

Service commissioners and providers are expected to mainstream community development 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 with other public bodies to improve services.

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. Existing partnerships should be supported with local Councils, Departments of Education, Social Development, Agriculture and their agencies to share this strategic approach and achieve successful outcomes, this approach will avoid duplication. In developing these relationships the health and social care agencies have much to offer as well as to seek. The community and voluntary sector, with 4,700 organisations and over 26,000 employees in NI, is also a source of vital partners.

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Mini case study: **Social Economy**
The South Eastern Trust works 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.

Community development must be integrated within existing resources. We expect Health and Social Care Trusts and organisations to allocate a specific percentage of resources overall to community development, distributed between headings such as:

- support to community sector
- appointment or deployment of specialist community development staff
- training
- evaluation of community development
- supporting locality planning and partnership processes

Community development requires specific skills and aptitudes. Organisations should therefore appoint or confirm some specialist staff, but also need contributions from all staff who interact with communities. The role of the specialist staff should 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.

We would expect to see an Action Plan which reflects the output and outcomes set out in this strategy and performance management framework. However it is recognised that there may be inequities across Trusts in terms of resources available for community development, and this will be considered within the proposed baseline audit.

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

- Make tangible differences 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;
- Impact on the pathway from community services to to statutory services.

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Conclusions and Recommendations

- The HSCB and PHA have a good evidence base for community development and its impact on health and wellbeing. The current policy environment drives the HSCB and PHA in this direction. The strategy has been shaped following pre consultation workshops held across all Trusts during 2011.
- The HSCB and PHA should adopt the Community Development Strategy.
- The HSCB and PHA should adopt the performance Management Plan and it needs to be brought forward by the HSC Trusts.
- A Community Development Action Plan will be brought forward following a formal 12 week consultation phase.
- The HSCB and PHA will establish a mechanism for supporting and monitoring the Community Development Strategy, Performance Management Framework and Action Plan.

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Appendix 1

Relating Community Development to official objectives. Community Development plans should take account of the most relevant health targets, notably:

Priorities for Action (PFA):

Priority 1: Improve the health status of the population and reduce health inequalities

Priority 2: ensure services are safe, 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.

PHA Corporate Objectives

1.0 Address 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.
2.7 Build effective public involvement into PHA work.

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Public Service Agreement (PSA) Targets[3]

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 workers 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.

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[3] Originally tied to particular dates in 2010, 2011 and 2012 but relevant for the foreseeable future

Mini case study: **Southern Area Action with Travellers (Multi-sectoral Partnership, 2001-10)**

- 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 0% to 70%
- After school attendance increased from 25 to 45%
- Youth club attendance increased to from 10 to-50%.

Mini case study **The Pathways Project, Belfast**

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. A series of meetings organised by the Community Development Unit with a wide variety of ex prisoner groups and organisations who work with ex prisoners/combatants revealed a number of issues:

- inappropriate referrals to mental health services were often due to lack of support systems within the community
- confidentiality was 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

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

Pathways provides counselling services within a community setting, where the client group feel at ease and confidentiality is secured. They 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 illness 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 combatants and their families

Mini case Study: **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."

Mini case study: **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. The networks were engaged on a contractual basis to advise on and facilitate community engagement, using surveys, public meetings and focus groups. There were over 2,000 organisations on the networks' databases. Service users and the wider public often preferred to talk to network members rather than officials Findings were shared with those who had contributed. Outcomes included:

- Significantly 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.
- Other statutory bodies recognised the value of this approach.

COMMUNITY DEVELOPMENT PERFORMANCE MANAGEMENT FRAMEWORK

5. Outcomes Framework

There is a need to bring about a critical edge to community development activity, emphasising outcomes. The framework is made up of seven outcome areas:

1. **Leadership and corporate commitment;**
2. **User involvement and community engagement in service planning, commissioning and provision;**
3. **Tackling inequalities in health and wellbeing;**
4. **Workforce;**
5. **Partnership;**
6. **Finance and procurement;**
7. **Information communications technology.**

The panel on the following page is a condensed version of the outcomes and stages which builds on earlier work of Community Development and Health Network. (CDHN and Community Development Managers 2007) The outcomes reflect what mainstreaming community development would look like in practice for staff, service users, communities and partners. Specific quantitative outputs under each outcome must be set by agreement within each Trust. The full Performance Management Plan is available at www.hscboard.hscni.net

Each of the seven outcome areas is structured to allow a three-step approach to full achievement. Within each of these steps there are indicators against which to measure progress. A baseline audit against the seven key outcome areas will be completed by the relevant Director, Senior Manager and Community Development personnel within each Trust. From this audit, action plans will be drawn up for each Trust and others to ensure a measurable approach to achieving outcomes in full. Progress will be monitored through annual monitoring meetings with Trusts and others. This process will be managed by HSCB representatives (most likely the Community Development Leads and Director of Social Care and Families).

Monitoring and Evaluation Arrangements

Each outcome area is structured to allow a three-step approach to full achievement. Within each of these 3 steps, a list of indicators against which to measure progress has been listed. A baseline audit against the seven key outcome areas will be completed by the relevant Director, Senior Manager and Community Development personnel within each Trust. From this audit,

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action plans will be drawn up for each Trust to ensure a measurable approach to achieving outcomes in full.

Progress will be monitored through annual monitoring meetings with Trusts. This process will be managed by HSCB representatives (most likely to be the Community Development Leads and Director of Social Care and Families).

Timescales

The following table sets out the initial timescales and responsibilities for the implementation and monitoring of this framework.

Action	Responsibility	Timescale
Baseline Audit within Trusts against seven outcome areas	Trust Staff	End November 2011
Development of Trust Action Plans	Trust Staff	End January 2012
Implementation meetings With Trusts	HSCB CD Lead(s)	End March 2012
Monitoring Meetings	Trust / HSCB Staff	2012 and annually thereafter

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Stages ⇒	1: Slow uptake	2: Solid progress	3: Fully engaged
1. Leadership and corporate commitment	The organisation agrees a community development (CD) strategy	The organisation incorporates CD into each corporate priority	CD is integral to the way the organisation sets priorities, reviews progress and makes decisions
2. User and carer involvement and community engagement in service planning, commission-ing and provision	The organisation has assessed community involvement and identified excluded groups and barriers to involvement. Arrangements with local Voluntary Community Sector organisations are being developed	The organisation sets and pursues objectives ensuring that users, carers and communities are meaningfully engaged in service planning, commissioning and provision, and reviews them regularly	There is full engagement with communities – equal partnerships, fully supported and long-term resourced – where users, carers and communities are integral to planning, commissioning and service provision
3. Tackling inequalities in health and wellbeing	The organisation has published up to date information on the health and wellbeing inequalities experienced by local people and communities	The organisation sets and pursues objectives and targets for health equalities and CD approaches to health and wellbeing equalities, analyses results and reports regularly on progress	The organisation works effectively on the root causes of health and wellbeing inequalities across local areas and partnerships and promotes CD approaches to tacking health inequalities as an integral part of its programmes

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4. Workforce	The organisation arranges for all staff to be trained in CD approaches to health and wellbeing	The organisation ensures that staff have ongoing support on CD in the form of practice-based learning, peer support, coaching etc.	The workforce includes staff highly skilled in CD, and appropriate levels of CD skill are present throughout the workforce
5. Partnership	The organisation seeks out and develops local and/or community based partnerships	Partner organisations incorporate action on community development into their action plans	Locality partnerships flourish. Partner organisations monitor and show their progress in promoting CD.
6. Finance and procurement	Financial plans, including contracts with other bodies, include investment needed to implement community development	Mainstream budgets include costs of supporting CD, VCS partnerships and capacity of the VCS to be service providers	Appropriate funds allocated to achieve user involvement, community engagement, support for community and voluntary sector partnerships and to support capacity of the sector
7. ICT	The organisation arranges to ensure access to data on community develop-ment for use of both staff, users, carers and communities	High quality community development practice data is available and used to identify areas of concern and monitor progress	The organisation demonstrates joined up working between departments on meeting the information needs of staff, users and communities

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