

May 2018

Expansion of Community Development Approaches

Report to Transformation Implementation Group



Health and wellbeing 2026: Delivering Together

Acknowledgments

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Report and Summary document available at :- pha.site/cdreport



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Introduction: The Genesis and Context of this Report

In October 2016, a ten-year approach to transforming health and social care was launched by the Department of Health, in a document entitled “Health and Wellbeing 2026: Delivering Together”.

This ambitious plan, the Health and Social Care Transformation Programme, was the response to a report produced by an expert panel, led by Professor Rafael Bengoa. The panel had been tasked with considering the best configuration of health and social care services in Northern Ireland.

Delivering Together set out a long term roadmap, together with initial priorities, to make an ambitious start towards this reform of our health and social care system.

Two key groups are now in place to provide strategic oversight to this work: the Transformation Advisory Board, which acts in an advisory capacity to oversee the direction of reform, and the Transformation Implementation Group (TIG) leads the design, development and implementation of the Transformation Programme.

As part of the Delivering Together programme, various Work Streams were established. A Community Development Work Stream (which produced this report) was set up in January 2017 to examine how best community development can contribute to the Transformation Process.

The Work Stream is tasked to set a clear direction and expand community development approaches to reducing health inequalities in Northern Ireland. Our remit was to assess current progress and make recommendations for how community development practice could be strengthened in the future. The workstream developed a draft Framework, tested concepts, principles and practice at an early symposium in June 2017. These ideas were then further developed through an extensive engagement process August-November 2017 and further refined at a second symposium in February 2018. The workstream also sought to develop links with other relevant areas of the HSC Transformation process, notably, Collective Leadership, Multi-Disciplinary Team in Primary Care, Co-Production and Co-Design and Workforce Strategy. Links were also explored with related areas of the Programme for Government Delivery Plans and opportunities for alignment with other Government strategies and their implementation.

This report charts the progress of this initiative and presents a draft implementation plan for how this work should be taken forward. The purpose of this document is to outline a clear rationale for community development and its contribution to improving health and wellbeing.

A key driver is the need to reduce health inequalities and improve population health and wellbeing. Whilst there have been significant improvements in the health for the whole population over the decades, these benefits are not evenly distributed: the gap between the most and least affluent parts of our society persists, and in some instances is widening.

Community Development has a strong contribution to make to achieving health and wellbeing outcomes. The health and social care system, irrespective of how effective and efficient it is, can only ever address a limited dimension of health. The ‘system’

needs to have communities at the heart of processes in order to address need, whilst at the same time strengthening cross-government efforts to address the determinants of health. It is the intrinsic resources of communities - their strengths, skills, knowledge, experience and networks that this work stream seeks to expand. It is important also to note that the process of community development has in itself a health giving value: it builds social capital and enables communities to influence and work with public agencies to improve wellbeing.

The Approach

The Community Development Work Stream Team identified seven elements to fulfilling its remit. This report presents their findings on each:

1. Set out the nature of health inequalities and of community development (Section 1)
2. Review policies and strategies of relevance to health inequalities and community development (Section 2)
3. Scope existing community development practice by reviewing current provision and illustrating with case studies (Section 3)
4. Consider how the outcomes of community development might be demonstrated and measured by developing a draft outcomes framework for community development (Section 4)
5. Identify the critical success factors, or enablers, needed to support the effective application of community development in addressing health inequalities (Section 5)
6. Develop a Framework for the Expansion of Community Development Approaches with a clear implementation plan and governance structure (Sections 6 and 7)
7. Shape, test and refine the Framework through consultation with the community development and health sectors (Appendices 1 and 2)

Regional Report 2016 - Infographics

719 alcohol related admissions per 100,000 population in 2012/13-14/15



Rate in the **most deprived** areas was over **five times** the rate in the **least deprived**

Mood & Anxiety Disorders 2014

One in five people in NI suffer from a **mood & anxiety** disorder



Rate among **Most Deprived** more than **two-thirds higher** than **least deprived**

Alcohol related mortality in the **most deprived** areas was **four times** the rate in the **least deprived** areas in 2010-14

Life Expectancy at Birth 2012-14

- Male** Life expectancy was **7.0 years lower** in the **most than least** deprived areas
- Female** Life expectancy was **4.4 years lower** in the **most than least** deprived areas
- Male** 78.3 years
- Female** 82.3 years
- The **Male Life expectancy Deprivation Gap** narrowed over the last 5 years
- The **Female Life expectancy Deprivation Gap** remained similar over the last 5 years

Smoking in Pregnancy in the **most deprived** areas was over **four times** the rate in the **least deprived** areas in 2015

The 2014 **teenage birth rate** in the **most deprived** areas was **5 times** the rate in the **least deprived** areas

Avoidable Mortality 2010-14

The **children and young people avoidable mortality** rate was **77% higher** in the **most deprived** than **least deprived** areas

409 Per 100,000 population

Most Deprived

Gap: 141%

170 Per 100,000 population

Least Deprived

1 Health Inequalities and Community Development

1.1 The Nature of a Fundamental Problem

Health inequalities are the unfair and avoidable differences in the health of people in our society. They are the result of imbalances of power, wealth and resources and are produced and shaped by factors such as quality of housing, educational attainment, employment opportunities, physical environment, access to services and level of social connections known as the social determinants. These imbalances mean that no one's health is as good as it could be in Northern Ireland.

As the infographic (over) starkly demonstrates, there is a social gradient in health – the lower a person's social position, the worse his or her health is likely to be. Those who live in areas of disadvantage are most likely to experience the worst health outcomes, with shorter life expectancy and more years with chronic illness and/or disability. Whilst we have seen improvements in the overall health of the population, the gap between the most affluent and least affluent persists and in some instances is widening. Poverty is a significant determinant of health and a challenge given that an estimated 23% of children in Northern Ireland are reported to live in poverty.¹

In Northern Ireland many people die prematurely. In 2013-15 the life expectancy for men living in the most deprived areas was 74.1 years, seven years less than those in the least deprived areas (81.1 years). Inequalities are also evident in a range of groups such as young men, ethnic minorities, migrants, carers, lesbian, gay, bisexual and transgender people, people experiencing homelessness, and people with a disability. For example, male Traveller's life expectancy is 61.7 years – fifteen years less than the general population.

Focusing solely on the most disadvantaged groups will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal (across all of society), but with recognition that people in areas of disadvantage may need more intense support, or support of a different kind.

Tackling inequality is a matter of fairness and social justice which requires action across the social determinants, between government departments and within communities across the whole of Northern Ireland. Improving health and reducing health inequalities requires co-ordinated action across government, health and social care, and a range of partners across community, voluntary and independent sectors.

1.2 Reducing Health Inequalities

The World Health Organisation (WHO) Commission on the Social Determinants of Health (CSDH)² recommends three principles for tackling health inequalities. These have been adopted by the Work Stream to underpin its work:

¹ Poverty in Northern Ireland, Joseph Rowntree 2018 <https://www.jrf.org.uk/report/poverty-northern-ireland-2018>
This section has been influenced by the work of Sir Michael Marmot, specifically the review of health inequalities in England published in 2010 <http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf>
² http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf

1. Improve daily living conditions – the conditions in which people are born, grow, live and work.
2. Tackle the inequitable distribution of power, money and resources – the structural drivers of these conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise awareness of those determinants.

Action on the social determinants of health must involve the whole of government, civil society, local communities and the business community. Policies and programmes need to embrace all the key sectors of society not only the health sector. Commitment to tackling health inequalities through action on the social determinants is nuanced and sometimes complex. People, communities and populations are affected by different determinants at different times and to varying degrees; for example, taking action to increase housing stock across a region may improve health outcomes for some, but not all. It is essential that we understand what approach works, for whom and in what context.

Margaret Whitehead³ outlines four broad categories where action to tackle social inequalities tends to be positioned:

1. Strengthening individuals
2. Strengthening communities
3. Improving material and living conditions
4. Promoting healthy macro policies

Community development processes tend to be categorised in a similar way (as evidenced in the Draft Outcomes Framework attached), which strengthens the case for community development as an effective approach to tackling inequality.

1.3 Defining Community Development

Community Development is a distinct approach but can often be misunderstood or subsumed within other approaches e.g. community participation, community engagement, community consultation, community based services or organisations. The Work Stream reviewed a range of definitions of community development and associated principles and values, including the UK National Occupational Standards for Community Development⁴ (UK NOSCD), the All Ireland Standards for Community Work⁵ and the European Network for Community Development Framework.⁶ The Work Stream identified that the UK NOSCD provided the most appropriate definition, principles and values for community development in the context of tackling health inequalities and improving health, as set out below.

³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2465710/>

⁴ <https://www.cdh.org/sites/default/files/FACTSHEETS%20.pdf>

⁵ <http://communityworkireland.ie/wp-content/uploads/2015/12/All-Ireland-Standards-for-Community-Work.pdf>

⁶ <http://eucdn.net/wp-content/uploads/2014/10/2014-24-09-EuCDN-Publication-FINAL.pdf>

Definition

Community development enables people to work collectively to bring about positive social change. It is clearly not only about community engagement but a longer term process which starts from people's own experience and enables communities to work together to:

- Identify their own needs and actions;
- Take collective action using their strengths and resources;
- Develop their confidence, skills and knowledge;
- Challenge unequal power relationships;
- Promote social justice, equality and inclusion in order to improve the quality of their own lives, the communities in which they live and societies of which they are a part.

There are five key values that underpin all community development practice:

- Social justice and equality
- Anti-discrimination
- Community empowerment
- Collective action
- Working and learning together

Communities can be defined in many ways: in some instances it is geographical, in others it centres on areas of interest, identity, need or relevance. The uniting factor for all, however, regardless of the make up or location of the community, is a shared set of values and vision.

Contemporary approaches within Health and Social Care:

Over the past few decades there have been concerted efforts to integrate and mainstream engagement activities and practice within HSC, especially in the area of tackling health inequalities. Some of these approaches have a specific focus on the individual and their connection to and involvement in the services they receive. Others take a more holistic view, concerned with the social and economic factors that affect people's lives. They tend to focus on engagement, not just at an individual level, but also a community level, as a way to affect change in health outcome.

The three most relevant contemporary approaches are summarised below:

Personal and Public Involvement

The Review of Public Administration made Personal and Public Involvement (PPI) a statutory duty under the Health and Social Services (Reform) Northern Ireland Act 2009. In other words, HSC organisations must actively engage with those who use their services, with carers and the general public. PPI is one of the key strands underpinning the DoH 10-year Quality Strategy, Quality 2020, which was published in November 2011.

It is also seen as one of the key features of effective clinical and social care governance. Implementation of PPI across HSC is currently led by the Public Health Agency and is the only one of the current engagement approaches to be a statutory requirement. This type of engagement, with a specific focus on the involvement of service users, carers and the general public in the development, delivery and evaluation of services, has a long history within HSC having been known as user involvement and stakeholder engagement previously. It has a focus on engagement with service users, carers or other interested individuals in the design, delivery and evaluation of health and social care services. PPI has a set of underpinning values and standards as set out in the “Setting the Standards “ document.⁷

Co-Production

Similar to PPI, Co-Production is not a new concept, however, Delivering Together formally introduced Co production as another important approach within the HSC. Co-production provides an opportunity to co-ordinate and integrate all the engagement work undertaken in Health and Social Care, into an integrated plan of action with the individual at the core. In a HSC context Co production focuses on “citizen powered health”, with an emphasis on individual and community assets and balances of power. Co-Production, unlike PPI, is not just limited to Health and Social Care as it provides a great opportunity to build partnerships with other parts of the public sector and local communities. It works to six principles derived from the NEF / NESTA Co-Production principles.⁸

Community Development

Community development was seen as a key approach during the 1990’s in Northern Ireland. Mainstreaming Community Development, published by DHSSPS in 1999, was one of the most significant commitments made by Health and Social Care to community development. It sought to guide the integration of community development principles and practice within health and social care and still has relevance today. Current relevant strategies all make reference to community development as a key approach within HSC. These include: Making Life Better, Making it better through Community Pharmacy, Delivering Together and the Social Work Strategy 2012-2022. In this context community development is seen as the most appropriate and long term approach to connect with more vulnerable or marginalised communities, who often do not have their voice heard. The emphasis is on the creation of the conditions where they can feel that they have greater control over their lives individually and within their community. As such, Community Development should be seen as the underpinning approach which can support and enhance both PPI and Coproduction. Community Development has a set of underpinning values and principles and a set of standards as set out in the National Occupational Standards (NOSCD).⁹

1.4 Community Development distinguished from Community Work

The Work Stream acknowledges that the terms “Community Development” and “Community Work” are often used interchangeably. The table below was developed by

⁷ http://www.publichealth.hscni.net/sites/default/files/PPI_leaflet.pdf

⁸ https://www.nesta.org.uk/sites/default/files/right_here_right_now.pdf

⁹ <https://www.cdh.ni.org/sites/default/files/FACTSHEETS%202.pdf>

the Australian Institute of Family Studies¹⁰ (based on the work of Ronald Labonte) and provides a useful starting point from which to compare and contrast both approaches

Community-based work	Community development work
Source: Adapted from Labonte (1999)	
An issue or problem is defined by agencies and professionals who develop strategies to solve the problem and then involve community members in these strategies. Ongoing responsibility for the program may be handed over to community members and community groups.	Community groups are supported to identify important concerns and issues, and to plan and implement strategies to mitigate their concerns and solve their issues.
<p>Characteristics:</p> <p>Decision-making power rests with the agency.</p>	<p>Characteristics:</p> <ul style="list-style-type: none"> ▪ Power relations between agency and community members are constantly negotiated.
The problem or issue is defined by the agency.	<ul style="list-style-type: none"> ▪ The problem or issue is first named by the community, then defined in a way that advances the shared interests of the community and the agency.
There are defined timelines.	<ul style="list-style-type: none"> ▪ Work is longer term in duration.
Outcomes are pre-specified, often changes in specific behaviours or knowledge levels.	<ul style="list-style-type: none"> ▪ The desired outcome is an increase in the community members' capacities. ▪ The desired long-term outcomes usually include change at the neighbourhood or community level.

Figure 1 Comparing community-based with community development work

¹⁰ <https://aifs.gov.au/cfca/publications/what-community-development>

1.5 Community Development as an effective way to tackle health inequalities

A community development approach to health adopts an upstream focus, recognising the root causes of inequality which are often complex and encompass many factors which lie outside of health and social care, such as housing, education, jobs, and social supports. Often approaches to improving health for the most vulnerable in our society tend to focus on more conventional methods such as information sharing and education for behaviour change, which while important, will not make significant changes to inequalities, or inequality gaps, in the longer term.

Actions to tackle the social determinants of health and community development practice are driven by similar aims: improving the lived experience, increasing knowledge and skills, rebalancing power, recognising values such as equality, social justice, and empowerment. They espouse the same methods as both require high levels of participation and engagement. We cannot take action to tackle health inequalities without taking action on the areas where community development works: housing, education, jobs and so forth.

This is particularly important in the current climate where evidence suggests that the third sector has lost some of its distinctiveness and the role of the sector as a service provider has overshadowed the key roles of advocate, lobbyist and mediator of the civic voice.

There is a robust and compelling evidence base to support community development as an effective approach in tackling health inequalities.¹¹

The challenge for tackling health inequalities is to ensure that practice extends far beyond consultation and engagement or merely concentrating on individual behaviour change. Instead we must embody community development values and principles to ensure real partnership and co-production with local communities to identify, understand and take action on root causes, retaining a specific and strong focus on redressing imbalances of power, wealth and resources.

¹¹ CDHN Fact sheet on Health Inequalities:

http://www.cdhn.org/sites/default/files/oldwebsite/FACTSHEETS%207_Screen%20View.pdf

Effective Community Development Programmes: a review of the international evidence base:

<http://www.lenus.ie/hse/handle/10147/298996>

Commission on the Social Determinants of Health:

http://www.who.int/social_determinants/thecommission/finalreport/en/

EUCDN Statement on Community Development:

<http://eucdn.net/statement/>

A typology of actions to tackle social inequalities in health (M. Whitehead)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2465710/>

Community Development in health – a literature review (Health Empowerment Leverage Programme)

https://www.thinklocalactpersonal.org.uk/assets/Resources/BCC/Evidence/help_literature_search.pdf

A Charter for Community Development in health (NHS Alliance)

<http://www.nhsalliance.org/wp-content/uploads/2014/08/NHSA-CD-Charter-FINAL.pdf>

Focus on inequalities: a framework for action (Glasgow Centre for Population Health):

http://www.gcph.co.uk/publications/282_findings_series_30-focus_on_inequalities_a_framework_for_action

2 Community Development Policy

2.1 Historical Perspective

Northern Ireland has a long and rich experience of community development in a number of spheres, including health. It is impossible to ignore the links with our troubled past and the role that local community action played in maintaining health, tackling poverty, growing self-help initiatives and resilience, and sustaining basic needs through very difficult times.

The Community Relations Commission, established in 1969, recognised that community tension was a symptom and that there was a need to build confidence and tackle social and economic disadvantage. A first community health profile was undertaken in Moyard (West Belfast) in 1985. The Community Development Review Group in the early 1990s identified the value of the process which embraced community action, community work, community endeavour, whether geographical or issue based, but with an emphasis on working with the disadvantaged, impoverished and powerless to achieve social change.¹²

Various government initiatives over the years, and the Special European Programme for Peace and Reconciliation, fostered growth in programmes at a local level. However, these programmes were often funded on a short-term basis and were focussed on short-term actions, at the expense of sustainable longer term development. This was perhaps understandable, given the uncertain and sporadic nature of political growth and peace building over the years. However, the result is that support for community development has remained fragmented, with funding mechanisms variable and highly uncertain over time.

2.2 Review of Relevant Policy Documents

2.2.1 Health and Wellbeing 2026: Delivering Together

As described in the Introduction above, the mandating report for this Work Stream is Delivering Together, published by the Department of Health in 2016. Delivering Together sets out a vision for transforming health and social care services in response to the Expert Panel Report on Health and Social Services in Northern Ireland – Systems not Structures (the Bengoa report). It also builds on the reports of Sir Liam Donaldson and Transforming Your Care. Delivering Together is now the road map for the reform of health and social care. The goal is the transformation of the whole system of health and social care in order to underpin a more holistic model of person-centred care focussed on prevention of ill health, early intervention, and supporting independence and wellbeing. In other words, a shift towards health promotion and a population health model supporting people to keep well.

Delivering Together places clear emphasis on building capacity in communities in order to reduce health and wellbeing inequalities. Community Development is one of a number of work streams that have been established to commence implementation of the Delivering Together Transformation Programme. In other cases, actions will be taken

¹² Kilmurray, A – Community Action in a Contested Society: The Story of Northern Ireland, Lang 2017.

forward through normal processes for policy development, planning and commissioning. The transformation programme is a key enabler of the draft Programme for Government outcome: long, healthy and active lives for everyone.

Appendix 2 outlines the actions and commitments made under Delivering Together that are particularly relevant to the community development approach to addressing health inequalities and to the development of healthy resilient communities.

2.2.2 Programme for Government (PfG)

The Executive's highest level strategic document, the Programme for Government (PfG), was published in draft in October 2016. This PfG is different from any of its predecessors in that it is constructed around a framework of wellbeing outcomes, expressing the ambitions of the Executive for everyone in society.

There is very substantial focus in the draft PfG on improving health, wellbeing and quality of life, particularly for those who experience economic/social disadvantage and its attendant health inequalities. Health and wellbeing also featured very strongly in public consultation feedback on PfG.

It is proposed that the draft PfG will be taken forward on the basis of twelve high-level population outcomes with progress measured through some 50 indicators of success (see Appendix 3). A large number of these indicators are particularly relevant for community development approaches to health and social care, for example:

- Improved mental health
- Reduced health inequality, increased healthy life expectancy, and fewer preventable deaths
- Better health in pregnancy
- Improved child development
- Reduced educational inequality
- Improved support for adults with care needs
- Reduced crime
- More cultural participation
- Increased confidence and capability of people and communities
- Percentage of the population living in poverty.

The draft PfG has been developed using the Outcomes Based Accountability (OBA) approach whereby progress is measured through numerical indicators of success.

Delivery plans have been drawn up for each of the indicators and continue to be refined. These incorporate programmes relevant to health, such a Healthier Places Programme to work with local communities and develop more effective collaboration across Departments over time to meeting needs. There will also be opportunities to share learning from places where communities have been mobilised to address their own priorities for health and wellbeing and also an important opportunity to align Government Planning at local level.

Some of the actions within these delivery plans that are particularly relevant to improving the resilience of communities are set out at Appendix 4.

2.2.3 Making Life Better (MLB)

The cross-government Public Health Strategic Framework, Making Life Better, sets out an integrated inter-departmental approach to health improvement, the prevention of ill health, and the reduction of inequalities in health. Two of the themes in MLB - “Empowering communities” and “Creating the conditions” are particularly relevant to community resilience building: they are designed to address the wider structural, economic, environmental, and social conditions impacting on local communities. These align with government strategies to develop the economy, tackle poverty, and improve community relations.

A Regional Project Board, led by the PHA, supports implementation at local level and will be informed by, and support, Local Partnerships of statutory, private sector, and community/voluntary bodies. The Partnerships will identify opportunities for partnership working based on local need and will drive services to support those most in need. These arrangements are currently under review.

A new approach will be introduced for wider regional implementation of MLB which will be driven by partners and based on the needs of communities. The aim is to bring about the broadest level of engagement and encourage co-production on issues impacting on health and health inequalities. This involves the establishment of a cross-sectoral MLB Regional Network to:

- encourage local and regional innovation and partnerships;
- share learning and expand good practice;
- and help build capacity and community empowerment.

The Regional Network and local partnerships will link into and align with local government Community Planning arrangements.

2.2.4 Community Planning Processes

Community planning is about wider engagement with communities in the co-design and production of services, and engagement with those sectors that influence the determinants of health and wellbeing, ie education, employment, urban planning and so forth. From a health perspective, it is about working with communities in order to co-create health and wellbeing

Health and wellbeing is now firmly embedded as a theme all of the community plans drawn up for each of the eleven District Councils.

2.2.5 Other strategies and programmes contributing to community development

Enabling individuals, families, and communities to live healthy lives requires action across a wide range and variety of policy areas. This includes policies and programmes for:

- improving health and wellbeing outcomes, addressing harmful behaviour and promoting healthy behaviour;
- addressing the complex inter-relationship between mental and physical health and wellbeing, and inequality and disadvantage;
- improving educational, social, cultural, environmental, and economic outcomes; and
- preventing violence and abuse.

From Social Work to Sure Start, there is a very wide range of strategy and networks across government (and programmes delivered by other sectors) designed to address the issues outlined above and which deliver action that resonates with the community development approach to reducing health inequalities. The task of expanding community development approaches within health and social care also requires action with other Government departments.

Where possible, actions identified within the strategic framework developed by this Work Stream, should be linked to associated actions being taken forward under other relevant strategies. This interconnection will ensure that the potential offered through community development is fully realised and will assist in the achievement of common outcomes. Some exemplars of those strategies offering the greatest potential to contribute to the community development approach to better health and social care are outlined in Appendix 5.

3 Current Practice

3.1 Scoping current practice

A first task of the Work Stream was to briefly scope current community development practice. An overview is set out below.

3.1.1 Health and Social Care

The Social Care department of the Health and Social Care Board, working with Health and Social Care Trusts, identified a number of areas where support is given to community development approaches. This covers all Programmes of Care and includes responses to issues such as self-directed support, learning disability, mental health services, older people's services (including dementia) and physical disability. A key focus of this work is on improving access to services in partnership with community and voluntary organisations, social networking initiatives to support the inclusion of people with a disability, support for outreach and social enterprise.

A wide range of services are also supported for children, including those with disabilities, through voluntary organisations. These services range from family support, music therapy for children and their families, as well as improving access to services. In addition, some 29 family support hubs are now in place across Northern Ireland and 30 locality planning groups have brought focus at a local level. Community, voluntary and statutory organisations have been brought together to plan services and thereby address locally identified needs for children, young people and families. A wide range of community based initiatives are also supported by Health and Social Care Trusts.

3.1.2 Community Pharmacy

The Health and Social Care Board supports the Building the Community Pharmacy Partnership. This is a partnership between the Health and Social Care Board and the Community Development and Health Network, with strategic direction offered by a multi-agency steering group. The programme aims to promote and support local communities to work in partnership with community pharmacists to address local health and wellbeing needs, using a community development approach. The programme works to:

- increase local people's skills;
- encourage community activity and self-help;
- increase local people's understanding of health issues;
- and encourage local people to play a role in health.

The programme financially supports a number of projects across Northern Ireland and addresses a wide range of thematic issues such as sexual health and the needs of carers as well as providing support for neighbourhood based approaches. The programme has demonstrated impact at both the level of community engagement as well as developing practical, tailored support on a one-to-one basis and over a range of specific health initiatives within communities.

3.1.3 Integrated Care Partnerships

Seventeen Integrated Care Partnerships have been established as collaborative networks involving primary, community and secondary care providers working together to address local patient and community needs in a more coherent and effective way. Service users and carers, voluntary and community sectors as well as local councils are all involved in the Integrated Care Partnerships. This work has led to a range of new innovative integrated service models to ensure that people are treated closer to home where possible. For example, integrated acute care at home services has shown a reduction in Emergency Department attendances; a diabetes foot care pathway has significantly reduced diabetes related amputations; more integrated respiratory care in the community and innovative social prescribing schemes have promoted greater holistic care and partnership working between GPs and the community and voluntary sectors. Integrated Care Partnerships are supported through a steering group and infrastructure which includes a dedicated post to support third sector participation in the Partnerships. There has been a growth in the reach and development of programmes as well as better communication on the co-design and co-production of services.

3.1.4 Public Health Agency

The Public Health Agency:

- provides direct financial support for community development support;
- commissions services from community based organisations; and
- develops demonstration models in partnership with a range of community and other organisations.

Typically the Agency provides support for the employment of community development workers and support for enhancing community capacity at local level. In addition, community networks and small grants programmes aim to support the development of capacity at a local level.

Commissioned services include locally based models of good practice such as Healthy Living Centres. These take a neighbourhood-based, community-led approach to health improvement in communities experiencing disadvantage and health inequalities. They identify and define the key health and wellbeing issues and take an holistic approach to addressing needs that recognises the wider determinants of health and seeks to build social capital and participation in the decision making processes that affect health and wellbeing

The PHA also provides specific support for work with more marginalised groups such as Travellers, Black & Minority Ethnic communities and older people, as well as supporting the development of bespoke services to meet the needs of such groups. In addition, a wide range of community based programmes such as those relating to community gardens and allotments, active travel, physical activity and so forth are also supported at local level.

In developing good practice, the Agency seeks to support innovative models of new practice such as the CLARE (Creative Local Response and Engagement) as well as Making Life Better in communities, supporting a locality planning approach to health

improvement at a local level. At the same time the Public Health Agency and the Health and Social Care sector as a whole, contribute to the Community Planning processes of the eleven Councils and this has in turn led to support of local community activity across Northern Ireland.

3.1.5 Health and Social Care Trusts

All Health and Social Care Trusts support community development and community approaches to improving health and wellbeing. The specific role in each Health and Social Care Trust may vary; however, there is a commitment to going beyond the statutory responsibility of Personal and Public Involvement (PPI) to engage more actively with local communities. Examples of this type of engagement include: supporting community organisations to promote and run health improvement programmes at local level; neighbourhood development work which seeks to identify needs at local level, build capacity and develop local action plans; specific programmes such as Arts and Health, Men's Sheds, Mental Health and Wellbeing; co-ordinated approaches in thematic areas such as older people and the promotion of Age Friendly and Dementia Friendly communities.

Particular communities of need are also supported such Travellers, Black & Minority Ethnic groups, women's groups, refugees, carers and so forth. Many Trusts also directly support services that are based in local communities, such as Sure Start and children's services including Mother and Toddler groups, Child Protection training, parents' support programmes and specific work for parents of disabled children. In addition, the Trusts have a commitment to engage and develop the role of volunteers in a range of programme areas.

The Trusts are also involved in working in partnerships at a local level such as Community Planning processes and Neighbourhood Renewal Partnerships. These programmes cover a wide range of health issues and are guided by local needs. Training and capacity building is also an important function that some Trusts provide for community and voluntary organisations. In one Trust, (Southern) work has been undertaken to develop a post-qualifying Certificate in Community Development, initially for social workers, and eventually for other professions.

3.1.6 Community and Voluntary Sector

NICVA's State of the Sector Report for 2017 identified a work force of some 44,703 and an approximate funding of £587 million. In addition, an estimated 241,264 volunteers and some 6,127 organisations are identified as participating in the sector. Of these organisations 70% identify themselves as being voluntary, 25% as community groups and some 5% as social enterprises. Almost one third of organisations reported that they had an income of less than £10,000.

The top five most common themes of work which these organisations undertake include community development and health and wellbeing. The health and social care sector is the second largest funder of activity in the sector.

Research commissioned by Building Change Trust and published in 2016¹³ into the independence of the VCSE sector explored a long-term trend within the sector, driven by funding patterns, towards a greater focus on service delivery on behalf of the public sector. The research found that this has been perceived by many within the sector as detrimental to the sector's community development function, whereby it acts as a facilitator of citizen and community activism and voice.

This 'democratic' role of the sector is recognised within the 2011 Concordat between the NI Executive and the VCSE sector, for example in the following extract:

"Signatories to this Concordat share the belief that these partnership arrangements will assist citizens and communities to empower themselves, make a significant contribution to democratic governance, bring people and politicians closer together, provide a better understanding and opportunities to influence decision making and resource allocation" ¹⁴

3.1.7 Department of Agriculture, Environment and Rural Affairs (DAERA)

The Rural Community Development Support Service Programme (RCDSSP) has been in place since 2012 and delivers community development support funded by DAERA through the Tackling Rural Poverty and Social Inclusion (TRPSI) programme across Northern Ireland and in four border areas. In addition, the regional infrastructure support programme, which is a regional programme for voluntary and community sector, is managed by the Department for Communities and funded by DAERA through the Rural Community Network and the Northern Ireland Rural Women's Network.

The RCDSSP contributes to 3 priority areas for intervention:

- Access poverty - focuses on access to statutory services such as advice on welfare benefits, health and social care advice and support, education and training, and public transport;
- Financial poverty - focuses on measures which ensure that vulnerable rural dwellers can maximise their income;
- Social isolation - focuses on measure which identify and address different types of isolation experienced by vulnerable groups, providing support for those deemed to be at risk of social isolation.

The programme is operated by community development support service contracts aligned to the new council areas. Contracts are awarded to one lead network in each district, with consortium partners in some areas. These lead network organisations provide support for individuals and communities in rural areas and support rural community development.

¹³ Independence of the Voluntary, Community and Social Enterprise Sector in Northern Ireland. Changing Narratives, Changing Relationships: A New Environment for VCSE Action?, 2016, accessible at: http://www.buildingchangetrust.org/download/files/BCTUU_IndependenceReport_Final.pdf

¹⁴ <https://www.communities-ni.gov.uk/publications/concordat-between-voluntary-and-community-sector-and-ni-government>

3.1.8 Department for Communities

The Department for Communities supports community development across Northern Ireland through a range of programme areas. In particular, the Neighbourhood Renewal Programme supports 34 voluntary renewal neighbourhood partnerships which comprise key community, political, statutory and private sectors and take the lead on local planning, identification and implementation of agreed priorities and actions as set out in the agreed action plans. The partnerships aim to

- manage, develop and oversee regeneration in their areas and seek to create an environment where there is a better quality of life, better prospects and the creation of a safer environment;
- develop economic activity;
- develop confident communities; and
- improve the environment and image of the area.

Community development is identified as an underlying theme of the programme. In addition, capacity building and health is identified as a key theme in its own right.

The Neighbourhood Renewal programme is currently being reviewed in order to inform the future development of, and the relationship with, the Programme for Government outcomes.

Related programme areas include urban regeneration; a wide range of specific initiatives such as Together: Building a United Community; arts and culture; historic environments; in addition to specific community services such as libraries and museums. The Executive Office has also driven a number of specific initiatives which have sought to actively engage communities.

3.1.9 Local Government

A wide array of programmes are supported wholly or in part by local councils. There is a strong emphasis on services as well as supporting community development processes and specific neighbourhood/communities of identity. Economic development, urban regeneration, and wellbeing are major themes which councils support, as well as community safety and good relations.

Councils also provide grants to local communities for a wide range of activities, such as festivals, training and education, social and cultural events, arts programmes and tackling disadvantage. The community planning process aims to develop a more coherent and co-ordinated approach to improving the lives of residents and will be a critical feature of development in the future.

3.2 Case Studies of Community Development in Practice

The following is a series of case studies drawn from real examples of practice across Northern Ireland. They document change within a community, the timescale within which the change happened and the community development principles which are most apparent within them. They are not intended to be comprehensive, rather they are illustrative of the benefits of community development to health and wellbeing.

Case study 1:

Type: Health Promoting Home's Traveller Engagement

Duration: 6 months – 1 Year (on going)

Community Development Principles: Identify their own needs and actions; Take collective action using their strengths and resources; develop their confidence, skills and knowledge

Members of the Traveller community still face some of the biggest health inequalities in comparison to other BME and non-minority groups. The life expectancy of this community can be between 10-15 years less than that of the life expectancy of NI average.

An opportunity arose in 2017 to allow a community-based project in a large city to engage Traveller families in a programme involving personal development, physical activity and nutrition.

The project already employed a worker to provide support and build capacity within the Trust area to ensure co-ordination of programmes with and within the Traveller community. The Traveller Intervention Coordinator also ensures connections between other local projects, family support services and early year's programmes to address the needs of Traveller children and families.

Keeping all of the above in mind it was agreed that the already established Health Promoting Homes programme could be useful means to engage the Traveller community in improving their health. The aim is to introduce Travellers to this programme enabling them to access a greater range of services, but also empower them to take greater ownership of their health.

The project initially met with a number of other groups who worked with the Traveller community to ensure complementarity and non-duplication where concerns were raised and assuaged.

It took approximately four weeks of meetings and discussions to establish the Traveller-based Health Promoting Homes group, given that members of the Traveller community would often be reluctant to get involved in wider community activities for many reasons. While the Traveller group is quite diverse, many had similar experiences. Several were currently engaged with social services and their aim was to re-gain access to their children. Many had experienced racially motivated intimidation in their neighbourhoods and many had experienced loss of infant family members.

After the nature of the engagement had been properly explained and accepted, project staff began to use their bespoke personal development Tool Kit, using a CBT approach, to work towards self-awareness and self-improvement. As the group developed over a short period of six weeks it was very evident that people were becoming more aware of themselves and how they were becoming empowered to make the desired changes.

The group were introduced to the gym in the community project. This gym is strictly by referral and designed to overcome issues in relation to self doubt and both external and internal stressors. The group attended the gym with other users of the centre who would not be from the Traveller community and soon developed a confidence in attending the gym outside of the group setting.

Through the COOK IT programme not only were young Travellers encouraged to learn how to cook fresh and healthy meals, but older members of the group also taught younger members traditional Traveller meals.

The outcomes of this engagement programme have been exceptional. There have been many developments that were expected but there have also been many that were not.

- Previous to this engagement the community project had viewed the Traveller Community as extremely hard to reach in that they found great difficulty in securing a commitment from individual members. However, after a few weeks if a participant was unable to make the group on a particular day they would not only inform the worker, but also often express concern about missing the group and would be keen to catch up on lost work.
- Members of the group and their families have since begun to use other services in the centre, separate from the HPH engagement, including the gym, group exercise classes, counselling services and complementary therapies.
- Local Social Services have engaged with the worker to discuss the progress of those currently both engaged with their service and part taking in the programme but also look at referring others to future programmes and opportunities.
- Group members have reported a greater sense of safety in their communities. Many have started to access numeracy and literacy programmes with the ultimate goal of gaining employment. This has been achieved through the development of their own personal programmes which has supported them to set goals.
- Other community groups who had expressed concern at the beginning of the programme have also seen the impact and support for their own programmes and have fully engaged in the work.

Case study 2:

Type: Estate based work

Duration: 1 year to 18 months

Community Development Principles: Identify their own needs and actions; Take collective action using their strengths and resources; develop their confidence, skills and knowledge

An estate based community organisation in a large town became aware of an anti-social driving issue with the young people in and around their estate. The population of the estate was quite mixed in terms of age range, with a number of resident teenagers, families with young children and a sizeable population of older people.

No one fully understood the reasons why the young people were engaged in anti-social driving, although many people made assumptions about it, ranging from “making trouble”, to “nothing for them to do”. In their day to day engagement with the residents of the estate, it became apparent that the older people in particular were feeling fearful about going out in the evening because of the issue. There was also a reluctance to involve the police as it was felt this may increase tensions between residents and the young people.

The community organisation had a community development worker in their employment. He decided to spend some time observing the young people in the evenings and over a period of weeks he began to build up a rapport with them. Other members of the estate began to join him in the evenings and they used the opportunity to get to know the young people and connect with them. This evolved in a non-confrontational and non-judgemental way and the worker and other residents were able to share some insights with the young people regarding the effect that the anti-social driving was having, especially on the older people in the community.

Eventually, they collectively reached a solution that took insights from all perspectives into account, and meant the community could retain control over how the issue was dealt with, rather than depending on external service provider to provide a solution. The anti-social driving ceased and a number of the young people mobilised and began to volunteer their time for environmental work around the estate.

Case study 3:

Type: Men experiencing homelessness with addictions

Duration: 1 year

Community Development Principles: Identify their own needs and actions; Take collective action using their strengths and resources; Develop their confidence, skills and knowledge; Challenge unequal power relationships; Promote social justice, equality and inclusion in order to improve the quality of their own lives, the communities in which they live and societies of which they are a part.

An organisation providing support for people experiencing substance abuse and housing issues identified a range of issues affecting the men and women availing of their support. These issues were uncovered over a prolonged period of time, through informal conversation. The issues included reliance on daily medications and the need for regular medical assistance. However, due to their complex personal circumstances, low levels of self-esteem and lack of confidence, they were finding it very difficult to engage with medical professionals. As a result, relatively minor issues were going untreated and in some instances became a major problem.

Their key worker continued to facilitate conversation with the men and women about the issues they were experiencing, and whether they could identify any solutions. The group suggested that the pharmacist may be a good source of information, and was someone that they would like to have a better relationship with, as there were tensions between the pharmacy staff and the people using the recovery service regarding perceived “anti-social behaviour”.

The worker approached the pharmacist and invited her to meet with a small group of men from the service, who had specifically expressed an interest in being involved in “something”. She also secured some resource to cover the costs of the pharmacist being away from her place of work.

Over the period of a year the pharmacist and the group of men developed a deep and lasting relationship. The pharmacist was able to get to know the men as people, not addicts, and gained insights about their life and journey through addiction. The men were able to understand the job of a pharmacist and gained insights about her fears and lack of knowledge about how best to support them when they presented at her place of work.

Collectively they were able to identify some very practical ways in which the men could manage their medication themselves, and see the pharmacist as a first point of contact if something went wrong, rather than presenting at the GP, Out of Hours or the Emergency Department.

The pharmacist felt she was able to use her skills to their maximum effect and successfully supported her team to understand the lived experience of a vulnerable community within their town. The pharmacy is seen by the men as a place of welcome and support, a key asset for them in their recovery.

Case study 4:

Type: Women in a rural area

Duration: 10 + years

Community Development Principles: Identify their own needs and actions; Take collective action using their strengths and resources; Develop their confidence, skills and knowledge

A group of women in a very small rural, border area met on an ad hoc basis in their local community hall. This community had many legacy issues to deal with including underinvestment in education for children and adults alike, a lack of job opportunities, and weak transport infrastructure. Many people within the community were experiencing physical symptoms relating to these issues such as anxiety, depression and a feeling of isolation, but were remaining undetected as they had no trusted person or mechanism to share that information and receive support.

Over time the group of women began to identify these issues for themselves and supported each other, peer to peer, specifically around their mental health and family issues. They invested time in building connections with people, organisations and agencies that could support them. Within two years they had persuaded a range of health and education providers to offer a series of information sessions, clinics and learning opportunities for the local community. They were situated in the local community centre at a time that suited those who were in most need of the support. This led to the group recruiting new members and developed a sense of trust in the group that they had the best interests of the community as their priority. They were beginning to be recognised as credible representatives of the local community and people were beginning to link to those providers who were reaching out to them with support. The mental health issues which for so long had gone undetected, were beginning to be more opening discussed and help sought.

From then until the present, the group has continued to maintain those relations with outreach providers. Membership has changed as people's circumstance and the demographic make-up of the area has changed. However the ethos driving the group has remained consistent –community based, community owned and relevant.

In recent years they have developed a great working relationship with their local pharmacist as well as the Regional College in the closest town (18 miles away). Both now recognise this small rural community as a key outreach location. They, along with a high number of other individuals, organisations and agencies provide support, advice, training, and education opportunities on issues such as housing, advice, debt, mental health, family support and skilling / re-skilling for employment.

Key to their success has been their ability to remain rooted in the community, driven by the issues most relevant to them, with support from outside bodies when needed, based on relationships of mutual trust and respect, built up over several years.

Case study 5:

Type: Transformation of a community

Duration: 20+ years

Community Development Principles: Identify their own needs and actions; Take collective action using their strengths and resources; Develop their confidence, skills and knowledge; Challenge unequal power relationships; Promote social justice, equality and inclusion in order to improve the quality of their own lives, the communities in which they live and societies of which they are a part.

A sprawling housing estate in large busy Northern Ireland town had gained a reputation as being one of the least desired estates to be housed in within the region. Many houses and businesses in the estate were empty and boarded up, there were no facilities for the community to meet and connect, public sector services had no positive linkages to the area and were unsure what, if anything, could be done. Unemployment levels were at an all-time high and the estate, and those residing within it were in real danger of becoming irreparably damaged.

A small group of residents and other people who had a genuine interest in regenerating the area began to mobilise and organised activities and events with families, providing a much needed opportunity to connect and socialise. Over a period of a few years an organisation emerged made up of local residents volunteering their time. They had a clear focus on a small number of core issues that they knew through their connection with local people were the most relevant to them. Their focus was physical regeneration, health in its widest sense, employment and social connections.

The organisation invested a huge amount of time and effort in developing solid relationships with the local community, gaining their trust and taking a lead from them. They also invested in the development of skills within the community and recognised and engaged emerging community leaders. They made full use of the business skills that key community leaders possessed and were able to reduce their reliance on government grant aid and funding over their first ten years, with investments made in social housing and other small businesses that were community owned and managed. This was only possible due to the high levels of trust and connection within the community and by coupling that business sense with a social focus.

Building relationships and seeking support and expertise from other bodies and organisations was another key element of success. Working partnerships were established with health, education, private business, faith and youth organisations, amongst others. Lasting relationships of trust were built with politicians regardless of their political affiliation, in recognition of the importance of local people having a voice, and politicians having a mandate to listen to the voice and act accordingly. Six years ago partnerships which had operated informally for many years were formalised and a community “umbrella” has been established which provides a united and strong local voice.

The community has been and remains at the heart of this example - the organisation always has the issues most relevant to local people as its starting point. It has recognised from the outset that the health and wellbeing of the local community is dependent on many factors outside of people’s control. It takes action and provides support across the spectrum of factors that influence health and wellbeing: good housing, quality education, employment opportunities, skills development, debt

management, environmental improvements as well as access to good quality health services.

The membership of the organisation has grown to upwards of 1000 people and is diverse and dynamic, in line with the changing context and circumstances of the community. It is a learning organisations – many mistakes have been made along the way, but they have been analysed, learned from and used to inform future plans, over the 20 years of its existence.

Case Study 6

Type: Volunteer Based Community Support Project for Older People

Duration: 5 years+

Community Development Principles: Identify their own needs and actions; Take collective action using their strengths and resources; Develop their confidence, skills and knowledge

Vision - "To create communities where all people feel supported and engaged, where people look out for each other and where everyone has the opportunity to reach their full potential"

The concept grew from an integrated planning initiative in a small urban housing estate. Local community representatives worked alongside statutory agencies initially to explore ways in which local communities could support more vulnerable members of their own community and deliver services effectively and efficiently in order to achieve better outcomes for individuals, communities and the wider society impacting at a local and strategic level.

The project was developed using a co-production approach where older residents within the estate were initially supported to identify the services, resources and practical supports they required to enable them to maintain independent living, and to identify potential barriers to engagement in services such as lack of confidence, poor mobility and transport, which could be addressed by local community support.

The project also supports local people to volunteer and become 'Community Champions' carrying out meaningful volunteering activities that enable those most vulnerable to maintain their independence and feel connected and supported within their communities. A robust volunteer recruitment, engagement and management process is currently in place offering opportunities for local people to gain a valuable volunteering experience, enhance personal development, achieve accredited qualifications, increase social networks and improve employability prospects.

The Community Champions are engaged in a wide range of roles such as facilitating weekly older persons group, one to one support to attend medical/advice appointments, help with personal shopping, light housework, support to care for a pet, support to return home when discharged from hospital, support to engage with external services addressing social, educational and physical needs and general befriending to tackle isolation and loneliness. To date the project has supported over 200 vulnerable older people remain independent and connected. In addition a number of Community Champions have gained employment following their volunteering experience.

The project is successful as it recognises the value of volunteer support in communities and the potential of people within their own communities to help each other and improve lives. Feedback from people who use the services shows that the approach has made a real difference as they are encouraged to overcome isolation, make meaningful social

contact and have support to take better care of their health and wellbeing. Formal evaluation confirms improved outcomes for residents. The model connects people to the wide and diverse range of community and voluntary supports that exist locally and ensures that the assets of communities are valued, resourced and re-invested back into making real difference to everyone in the community.

The project recognises the uniqueness of each community and that an asset based model cannot be imposed from above, rather, that such work needs to begin with the individuals living in the community themselves, designing services through imaginative and focused engagement.

Case study 7:

Type: Supporting children with an additional need

Duration: 3+ years

Community Development Principles: Identify their own needs and actions; Take collective action using their strengths and resources; Develop their confidence, skills and knowledge;

The Children and Young People's Strategic Partnership (CYPSP), led by the Health and Social Care Board, is a multi-agency partnership that includes the leadership of key statutory agencies and community and voluntary organisations that have a responsibility for improving the lives of children and young people in Northern Ireland.

In 2014, the CYPSP Locality Planning Officer in partnership with the NHSCT Autism Team and EA Youth Service established a small working group consisting of young people from Millgreen Youth Club in Newtownabbey, Carrickfergus College and the Inclusion Youth Project in Whitehead (who have been working with the Education Authority Youth Inclusion Project).

The project began in July 2014 in response to young people with ASD expressing concerns about the lack of secure spaces in the community for them to engage with peers socially. Feedback from parents, teachers and young people confirmed that a vast majority of young people with ASD in mainstream school did not engage in any social activity outside of school.

During the initial stages of this project, time was taken to build relationships between the young people with ASD and professionals from a range of sectors including health, the youth sector and education. A series of team building activities such as a puppet show, a short DVD production and a summer residential were facilitated to identify the needs of the young people engaged on the project.

Over the course of 2015 - 2016, young people led the development of the online ASD and Me App through the support and guidance of Digital Media Choices to develop the online ASD and Me App.

Through ongoing training and support of Digital Media Choices, young people of the project were able to demonstrate their confidence and skills in using digital technology including a short DVD production and the co-design and development of an app that included personal requirements from the service users themselves.

In early June 2016 the ASD and Me Project Group collectively launched the ASD and Me App that is now available to support young people with ASD across Northern Ireland.

The App was co-designed between young people and partnering organisations to:

- Enable young people to communication with teachers, parents and youth workers
- Provide a safe and confidential space to express feelings and request space if required
- Provide a space for young people to share experiences
- Provide a go to guide on difficult situations based on personal and individual coping strategies for peers to share and update.

The success of this project was inevitably driven by the engagement of the young people with ASD from local communities who were involved in the project to ensure the issues affecting them were understood by the partnering organisations. Over the course of the three years a support structure was developed through relationship building, trust and respect to assist young people with ASD in the community. The working group extended its thanks to Fiona Nelson the EA Inclusion worker who supported the young people through this initiative.

Case Study 8

Type: Supporting Addiction recovery

Duration: 10 – 20 years

Community Development Principles: Identify their own needs and actions; Take collective action using their strengths and resources; Develop their confidence, skills and knowledge; Promote social justice, equality and inclusion in order to improve the quality of their own lives, the communities in which they live and societies of which they are a part.

A mid-sized rural town during the mid-1990's had a growing addictions issue, specifically alcohol and solvents, which was a problem for their young people. This had been identified by members of the local Community Development Association who taught in the local secondary school. The Association felt they should try to address the issue in some way and so began linking more closely with the schools and youth provision in the town in an attempt to understand the problem better. It became apparent that not only was addiction an issue, but that there was also no local support mechanism for young people to access advice or practical support to understand why an addiction had developed, or how to manage it. The issue was heavily stigmatised resulting in further isolation and withdrawal by the young people affected.

The Association decided to set up an organisation to provide support to those affected by addictions. They employed people with expertise in the area, sought out examples of good practice to learn from, and established a strong relationship with professionals within the local Health and Social Care Trust who could provide professional oversight and guidance on specific policy and procedural issues. In more recent years their work has become more focused on community based support in addition to specific support for young people. This is in recognition of the fact that addiction is an issue across the life span and social gradient.

The organisation has two core elements: prevention and supported intervention.

The prevention work includes facilitating conversations around addiction to remove stigma and promote awareness; building community cohesion and connectedness, networking into other organisations that can add value to their work and provide additional support; helping to create the condition where families feel better able to

identify the signs of addiction and know where to get support; provision of “detached” street based work with adults and young people to connect them to each other and into services. This community led approach is seen as key in removing the stigma of addiction and creating a range of opportunities to share important messages and learning.

The supportive interventions include programmes to build confidence and resilience; motivational interviewing to identify triggers and coping mechanisms, and counselling services for adults. They also link to a range of other service providers within the community and voluntary and public sector for additional support.

There are a number of key strengths to the approach that this organisation has taken in supporting people who are dealing with addiction. Firstly, they are rooted in their local community and as such are seen as a trusted and respected source of support. Linked to this, they are also known for their professionalism, confidentiality and dependability. This is crucial when dealing with a sensitive topic such as addiction, as high levels of trust will result in a higher level of engagement from those most in need of support. Because they know their community well and have a position of credibility and trust, they can be responsive as needs arise.

They take an assets approach – they understand their own strengths and abilities and the strengths and abilities of others, this results in long term and sustained partnerships with real added value for those who avail of support. For example, the organisation makes their premises available to other organisations that have specific relevant expertise, but no local base, to enable them to provide their services in the local community.

In the same way they value the concept of creating networks and connections with and between the people they support and other organisations, for added value and sustainability.

4 Creating a Community Development Outcomes Framework

4.1 Introduction

The Work Stream developed a draft outcomes framework to explain how community development outcomes contribute to the pre-conditions for reducing health inequalities and to the Programme for Government.

This type of framework can improve the effectiveness of policies, services, programmes and projects by ensuring that they are centred on outcomes from conception through to evaluation.

4.2 Creating an Outcomes Framework: Methodology

Removing health inequalities is a long term goal. Mapping out the logical connections between a long term goal and the short term actions aimed towards achieving it provides a means of monitoring progress toward the ultimate goal. This is primarily achieved by monitoring the effects of the intermediate actions.

An outcomes framework is simply a way of organising thinking about how to reach a goal. It starts at the end of the process, by defining the goal and then works backwards, asking what long, medium and short term changes are needed to create the conditions necessary to achieve it. This documents a causal chain, the outputs and outcomes from one action feeding into the next until the ultimate goal is reached.

As the goal currently under consideration is to reduce health inequalities, a fundamental question is the root causes of those inequalities and the identification of the type of actions and intermediate outcomes that will address them. Thereafter, we will consider how these actions and outcomes might link to community development.

4.3 The root causes of health inequalities

In the Health Scotland publication, “Power - a health and social justice issue”¹⁵ the authors identify power as a root cause of health inequalities.

“Power is regarded as one of the three fundamental determinants of health, together with income and wealth. These are the ‘causes of the causes’ that underpin inequalities in disease and life expectancy or, alternatively, create the potential for equity in health across the population.” p3

Addressing the inequitable distribution of power, money and resources is one of the three principles of action set out by the World Health Organisation Commission on the Social Determinants of Health¹⁶:

¹⁵ Dickie E, Hearty W, Fraser A, McCartney G, Doyle E, Myers F. (2015) *Power – a health and social justice issue*. Edinburgh: NHS Health Scotland

¹⁶ WHO (2008) *Closing the gap in a generation: health equity through action on the social determinants of health: Commission on Social Determinants of Health final report*. Geneva, Switzerland : World Health Organization, Commission on Social Determinants of Health

1. **Improve daily living conditions:** These are the circumstances in which people are born, grow, live, work and age. Actions include supporting early child development, creating healthy places and people, providing access to fair employment and decent work and to developing social protection and health care.
2. **Tackle the inequitable distribution of power, money and resources:** This means addressing the structural drivers of the conditions of daily life. Actions relate to making health equity part of all policies, systems and programmes. Others are about changing how society operates to empower all groups through fair representation and enabling civil society to organise and act.
3. **Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health:** Key actions are around monitoring, investing in evidence, sharing learning and providing training, and raising awareness about the social determinants of health.

The table below gives some examples of the actions prioritised by the WHO in pursuing the goals of reducing health inequalities whilst improving health for all.

Improve daily living conditions	Early child development Fair employment and decent work Create healthy places and people	Reduced health inequalities
Tackle the inequitable distribution of power, money and resources	Enable civil society to organise and act to promote health rights Empower all through fair representation in decision-making	
Measure, evaluate, learn, train and raise awareness of social determinants	Maintain a socially inclusive framework for policy-making Monitor, train, make aware of social determinants and health inequalities Reduce gender inequality	Improved health

Figure 2 WHO Actions and potential impacts for reduced health inequalities

In Northern Ireland, Making Life Better also identifies equity as a value underpinning all action towards reducing health inequalities as shown in Figure 3.

Values		Aims
Social justice, equity and inclusion	All citizens should have the right to the highest attainable standard of health.	Better health and wellbeing for everyone
Engagement and empowerment	Individuals and communities should be fully involved in decision making on matters relating to health, and empowered to protect and improve their own health, making best use of assets.	
Collaboration	Public policies should contribute to protecting and improving health and wellbeing, and public bodies should work in partnership with local and interest group communities.	
Evidence - Informed	Actions should be informed by the best available evidence and should be subject to evaluation.	
Addressing Local Need	Action should be focused on individuals, families and communities in their social and economic context	
		Reduced inequalities in health

Figure 3 Values underpinning actions in Making Life Better

Making Life Better then sets out its outcomes under 6 themes as summarised below.

- Theme 1. Giving Every Child the Best Start and Theme 2. Equipped Throughout Life
These take account of particular needs across the life course and cover childhood and adulthood
- Theme 3. Empowering Healthy Living
This addresses support for individual behaviours and choices
- Theme 4. Creating the Conditions and Theme 5. Empowering Communities
These address the wider structural, economic, environmental and social conditions impacting on health at population level, and within local communities
- Theme 6. Developing Collaboration
This identifies three areas in relation to food, environments and places, and social inclusion with potential to bring together communities and relevant organisations

As themes 4 and 5 indicate, reducing health inequalities means taking actions that redistribute power so that communities are empowered to “address the wider structural, economic, environmental and social conditions impacting on health at population level, and within local communities.’

4.4 The role of community development in addressing inequalities

Challenging unequal power relationships and promoting equality are central tenets of community development, as defined by the National Occupational Standards. The key outcomes created by implementing community development values and principles have been identified as co-operation, organisation, confidence, inclusivity and influence.¹⁷

By developing individual confidence and co-operation, community development has the potential to enable people to make changes that support their health. More significantly, by enabling communities to address their own needs, community development has the potential to empower people to improve their local services, environment and life conditions. Most importantly, by transferring power to communities, and their constituent groups, community development addresses the inequitable distribution of power, a root cause of health inequalities.

Values	Principles	Outcomes	Long term impact	Health Goals
Working & learning together	Identify their own needs and actions	Co-operation	Improved individual capacity to make positive change	Reduced health inequalities
Community empowerment	Develop their confidence, skills and knowledge	Organisation		
Collective action	Take collective action using their strengths and resources	Confidence	Improved quality accessible services	Improved health
Anti-discrimination	Challenge unequal power relationships	Inclusivity	Fairer distribution of power, wealth and resources	
Social justice and equality	Promote social justice, equality and inclusion	Influence		

Figure 4 Outcomes arising from community development principles

¹⁷ Cdx, changes (2008) *What is community empowerment?* Cdx, changes, National Empowerment Network

By identifying indicators which show when community development outcomes are being delivered in the medium and long term, we can map progress towards the ultimate impact of re-distributed power and reduced health inequalities.

As a starting point the next section suggests potential outcomes that may arise from community development in the medium term, and some possible indicators for each. The outcomes are presented at the different levels at which they occur.

Changes in individuals are more likely to be seen in the medium term than are effects on policy and practice. Social change takes such a considerable time; consequently, we have not included such indicators here since few projects are of sufficient length to be expected to deliver them. Likewise, no short term outcomes are included because community development takes time to produce significant change.

Levels	Outcomes most relevant
Individuals	Co-operation. Confidence
Communities	Organisation. Inclusivity. Confidence. Co-operation
Policy, practice, services	Inclusivity. Influence
Society	Social Justice

Figure 5 Levels at which different outcomes are relevant

This is a draft and generic outcomes framework. It is neither comprehensive nor definitive. Rather, it is a starting point for iterative development through consultation about meaningful indicators, and existing or new measures which will complement the indicators in *Making Life Better*.

Making the outcomes framework useful will require:

- a. Development work – the different outcomes of specific community development projects are so various that it is impossible to add them all to this draft framework. However, there is great scope to develop it into a wider and deeper lexicon of outcomes and shared measures through focused, consultative working parties.
- b. Understanding outcomes - to select the most appropriate outcomes and measures for their own work people will need to develop skills in good impact practice and outcome-centred design. Selecting outcomes and measures requires an assessment of the level of accountability for change, the level at which change will be evident, the timing at which different effects will emerge and their likely duration.

4.5 A draft outcomes framework for community development

Most of the indicators in the framework below can be assessed through either direct counting – of the number of people, incidents or locations etc - or by asking for information from people using existing, shared or specially designed questionnaires or surveys.

* Some of the existing measures that may be useful are noted at the end of the section. There are many more which could be added in the future. This is work which will be continued as part of the implementation of the Community Development Framework.

INDIVIDUALS CD outcomes	Medium-term outcomes	Indicators that outcomes are occurring
<p>Co-operation</p> <p>Confidence</p>	<p>Individual members of the community:</p> <p>have accessible opportunities to meet others in the community</p> <p>have the skills, information and knowledge needed to understand personal and community health issues</p> <p>have confidence that positive change can happen at a personal and community level</p> <p>have the capacity to engage with others to identify and address common issues</p> <p>engage with and tackle local issues with skills</p> <p>take up leadership roles in their community</p> <p>have the space to reflect on their learning together</p> <p>gain transferable skills or qualifications</p>	<p>Extent of:</p> <p>Opportunities to meet and interact</p> <p>Individuals meeting with and feeling connected to others around issues *</p> <p>Accessibility for people with disabilities (language, information, timing, media, physical access and geographical location)</p> <p>Information about health determinants</p> <p>Health Literacy</p> <p>Information about community needs and assets</p> <p>Confidence in ability to make changes in own, family or community conditions *</p> <p>Skills: Data collection and analysis; Negotiation and communication; Organising and leading; Planning and reviewing skills; Funding and budgets</p> <p>Knowledge of how policies are shaped, decisions taken and how to influence</p> <p>Engagement with others to tackle issues, both informally and through community groups and organisations *</p> <p>Leadership roles in a community held by members of that community</p> <p>Opportunities for community members to learn from their experience</p> <p>Range of skills and qualifications gained by members of the community</p>

SAMPLE OF SOME EXISITING MEASURES

Reduction in social isolation or increased social support

This question is used by the Organisation for Economic Cooperation and Development (OECD). It is taken from [Gallup World Poll](#) and is accepted as being reliable and tested worldwide for people aged 15 and over.

If you were in trouble, do you have relatives or friends you can count on to help you whenever you need them, or not? Yes No

NI and UK surveys also use questions such as these from the [ONS Social Capital Question Bank](#)

There are people among my family or friends who can be relied on no matter what Not true Partly true Certainly true

There are people among my family or friends who would see that I was taken care of, if I needed to be Not true Partly true Certainly true

There are people among my family or friends who give me support and encouragement Not true Partly true Certainly true

Confidence to make change

Confidence to make change is being measured by NISRA and as part of the Programme for Government using Self-Efficacy on a five question survey.

<i>I can always manage to solve difficult problems if I try hard enough</i>	<i>Strongly disagree Disagree Neither agree or disagree</i>	<i>Agree Strongly agree</i>
<i>I am confident that I could deal efficiently with unexpected events</i>	<i>Strongly disagree Disagree Neither agree or disagree</i>	<i>Agree Strongly agree</i>
<i>I can remain calm when facing difficulties because I can rely on my coping abilities</i>	<i>Strongly disagree Disagree Neither agree or disagree</i>	<i>Agree Strongly agree</i>
<i>When I am confronted with a problem, I can usually find several solutions</i>	<i>Strongly disagree Disagree Neither agree or disagree</i>	<i>Agree Strongly agree</i>
<i>No matter what comes my way, I'm usually able to handle it</i>	<i>Strongly disagree Disagree Neither agree or disagree</i>	<i>Agree Strongly agree</i>

Community or civic engagement

As well as making a direct count of volunteers or other forms of participation, this is a survey used by ONS and the General Household Survey

In the last four weeks have you helped or provided a service or lent a hand to someone who is not a member of your household or a relative? Yes / No

In the past four weeks have you given your time to help out at an organisation such as a school, a hospital, a prison, a probation office, a charity, a church, a voluntary organisation or a community group? Yes / No

In the past three years have you had any responsibilities in such organisations, e.g. being a committee member, raising funds, organising events or doing administrative or clerical work? Yes / No

And NISRA use a version of this in the Continuous Household Survey:

In the last twelve months, have you done any of these things to try to get a local issue addressed?

Written to a local newspaper

Contacted appropriate organisation to deal with problem

Contacted local councillor MLA or MP

Attended public meeting or forum to discuss local issues

Attended tenants or local residents meeting

Attended a protest meeting or joined an action group

Helped organise a petition on a local issue

COMMUNITIES CD outcomes	Medium to longer-term outcomes	Indicators that outcomes are occurring
Organisation Inclusivity	<ul style="list-style-type: none"> • Members of the community are able to come together and organise into informal or formal groups to address common needs <p>Community groups:</p> <ul style="list-style-type: none"> • are strong and well led and governed • are open, democratic and represent community interests • remove barriers to participation • are able to source resources for sustainability • are able to end well if their work is complete 	Extent of <ul style="list-style-type: none"> • Community groups, numbers involved and range of issues addressed • Disability and cultural accessibility of community groups • Diversity of people engaged in community groups. • Minority group members feeling safe, valued and free to express their culture as members of community groups • Time and skills given by members to community groups • Good governance in groups to promote access, equal opportunities and record and act on discrimination • Community ownership and governance of its own organisations

<p>Confidence Co-operation</p>	<p>Community groups:</p> <ul style="list-style-type: none"> • have knowledge and skills to address community needs • are aware of their own community assets • have confidence that they can bring about positive change • have skills and knowledge, confidence to make change • are well connected • have the capacity to exert influence 	<p>Extent of</p> <ul style="list-style-type: none"> • Community group awareness of common needs amongst its members • Community group awareness of the community's current assets • Confident and competent leadership within community groups • Networks and alliances with other groups in the same community • Networking with groups in other communities working on similar issues • Community group delivery of activities to its own members (not public services) • Community use of and satisfaction with community group service • Community group engagement with local services • Commonwealth, or community ownership of assets • Other groups and agencies' awareness and use of community groups' services • Community groups influencing skills • Positive community identity, cohesion, shared vision and social capital
<p>POLICY, PRACTICE, SERVICES CD outcomes</p>	<p>Medium to longer-term outcomes</p>	<p>Indicators that outcomes are occurring</p>

<p>Inclusivity</p> <p>Influence</p>	<p>Local or regional agencies</p> <ul style="list-style-type: none"> • understand the values and value of community development • support the development of strong communities • actively listen and respond to community representation • encourage participation across all communities • engage in co-design with communities • have policies to share influence over planning, decision making, evaluation and improvement with the community • are transparent in their decision making and resource allocations <p>Multi-agency responses are developed</p> <p>Community groups and organisations control assets and services</p>	<p>Extent to which agencies:</p> <ul style="list-style-type: none"> • Support diversity and inclusion • Take affirmative action to engage diverse communities • Understand and utilize community development methods • Encourage community development approaches • Invest in community development practice • Change policy or strategy in response to community development needs • Resource community development activities • Create opportunities to listen to the views of community groups • Make changes in response to representation from the community • Make agency resources available to the community • Engage the community in decision making at all levels • Work together with others and the community sector to address need • Transfer of assets or services to the community to run for community use
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SOCIETY	Long term outcomes	Indicators
	<p>Greater social justice, equality and inclusion</p>	<ul style="list-style-type: none"> • Indicators of Pfg Outcomes as set out in the section below – these encompass elements of individual wellbeing, community efficacy and economic conditions

4.6 The outcomes framework and the Programme for Government

The revised Draft Programme for Government (PfG) 2016/21 for Northern Ireland is constructed around a specific methodology called Outcomes Based Accountability™. It sets out twelve desired conditions of wellbeing for the population called PfG Outcomes. (Appendix 3)

The extent to which the PfG Outcomes are being delivered is shown through 48 Indicators, or proxies. These are all numerical and are presented as curves on a graph showing change over time. The extent to which each indicator curve turns in the desired direction is the measure of how well an outcome is being created. OBA™ uses its own specific terminology as is explained in the endnote.

The application of community development principles to addressing health inequalities contributes to several of the outcomes in the PfG, affecting their ‘curves’ or Indicators. Some of the PfG indicators, such as confidence and satisfaction with services echo those in the core community development and health inequalities framework, above.

The figure below shows the link between community development and the most relevant PfG outcomes and their indicators. In effect, this table is the very top of our outcomes framework, presenting the population wide measures that will show when community development is having an impact on our ultimate goals of improved health and reduced health inequalities.

Contribution of community development		Draft PfG Indicators	Draft PfG Outcomes
Improved individual capacity to make positive change	Improved health	28 Confidence of the population aged 60 years or older (as measured by self-efficacy)	Outcome 4. We enjoy long, healthy, active lives (Indic 2,3,4,5,6,28)
Improved social and physical health determinants		7 The proportion of babies born at a low birth weight	Outcome 12. We give our children and young people the best start in life (Indic 7)
Improved quality accessible services	Reduced health inequalities	6 % population with GHQ12 scores ≥ 4 (signifying possible mental health problem)	Outcome 8. We care for others and we help those in need (Indic 6, 28)
Fairer distribution of power, wealth and resources		5 % people who are satisfied with health and social care	Outcome 5. We are an innovative, creative society where people can fulfil their potential (Indic 28 all ages)
		4 Preventable mortality	Outcome 3. We have a more equal society (Indic 2)
		3 Healthy life expectancy at birth	
		2 Gap between highest and lowest deprivation quintile in healthy life expectancy at birth	

Figure 6 Community development for health and the Programme for Government

5 Enablers for the delivery of community development outcomes

The circumstances necessary for success in creating medium-term outcomes vary with the nature and context of each initiative or project. However, our reading and consultation has identified core enablers for community development that apply across all such work.

It is clear from the work so far that there is a need to support the development of skills and good practice in Northern Ireland. The engagement events highlighted overall support for a phased approach, clarity around definition and principles, as well as fundamentally adopting an asset based approach. A key area of concern remains the fragmentation and short term funding of such work and the need to support skills development along with evaluation of the impact of community development.

5.1 Suitable Funding and Programming

5.1.1 Longer term funding

Community development requires flexible, longer term funding to match the nature of the process of working from individual engagement through to the ability to take part in policy making. This means:

- Sufficient funding to manage through the unexpected and to meet the needs of individuals and communities which emerge through the community development process.
- Long term funding when seeking to engage communities where very little infrastructure exists, providing for time to listen and build trust as a precursor to fuller engagement.
- Time to engage groups unused to engaging.
- Funds and time to map local assets and find partners before beginning a project.
- A move away from individual pilot projects in order to develop a clear stream of quality community development work, informed by shared definitions and standards.
- Moving away from deficit based to asset based funding
- Providing funding that allows for risk and failure.

5.1.2 Co-design of interventions and funding programmes

Co-design is a cyclical enabler: it helps to design effective community development and, in turn, community development supports effective co-design by creating in communities the capacity to take an equal part. It provides a way to identify appropriate outcomes, processes, enablers and time lines for new projects. Additionally, it is a means to express and develop respect and understanding for all parties and for all stages of the community development process.

In order for communities to be involved in designing their own programmes to enhance their own assets, there needs to be investment in building the co-design capacity of funders, community development organisations, practitioners and community representatives.

5.1.3 Reduced insularity

Health inequalities are recognised as stemming from a range of social and economic factors and this must be reflected in programme design and delivery. The ‘stop working in silos’ is considered to be an enabling principle, applicable from the ground up. In the same vein, a further enabler is to facilitate better connections between practitioners across the public and voluntary-community sector, in order to share skills and good practice.

5.2 Skills and Personnel

5.2.1 Skills

Skilled personnel are a key enabler of effective community development. The skills and supports needed include:

- Knowledge of the principles of community development
- Skills for getting people involved; knowing when to concentrate on individuals and when to start working as a community
- The ability to listen to what communities see as their key shared issues
- Access to information support and examples of best practice
- Strong leadership of the highest quality
- Strong, carefully constructed teams of paid and volunteer workers
- Support and supervision for all key staff
- Passion, compassion and support to meet the challenge
- Knowledge of resources and plans relevant to the community
- Influencing skills
- Knowledge of how to manage expectations within short-life programmes
- Life experience and the support of colleagues with wider experience
- Ability to call on and have access to experts and good practice
- Access to data, evidence and information to understand complex issues
- Access to information about successful pilots and the reasons for their success

5.2.2 Volunteers

Using local personnel, either by employing members of the community in community development work or by engaging volunteers, is a key enabler to community development. There is a need for a clear policy around the role of volunteers in order to recognise their unique contribution, whilst clearly avoiding job substitution. Resourcing the development of volunteer skills is an enabler of effective and sustainable asset development.

5.2.3 Representativeness

Identifying and engaging people who are representative of a community is an essential enabler of community development. Avoiding 'gatekeepers' and recruiting people on an ongoing basis helps to give a wider range of engaged people which helps enables smooth succession when existing leaders or champions stand down.

5.3 Infrastructure

A strong infrastructure to support skills and the people who deliver community development is a crucial enabler of outcome delivery. There is a sense that changes in investment and policy emphasis, along with an ill-defined practice infra-structure, has meant that community development skills have been lost over the years. Trained practitioners have retired or moved to other positions whilst new community workers, and volunteers, have not had the same access to support in community development practice with clear, professional standards.

6 Conclusion: Community Development in Health Transformation

Clearly the process of community development has the potential to improve health outcomes and reduce health inequalities.

The process itself builds on the strengths or assets of the community, creates social capital, and enables participation, empowerment and the growth of self-efficacy. All of these features build strength and resilience in communities which can help reduce the negative impact of conditions on health, greater ability to deal with adversity and greater confidence to address needs holistically and in partnership with others. Further, a healthy community is one which is more self-reliant and is less likely to place increased demands on the health and social care system.



In conclusion, community development has much to contribute to improving health as well as improving the reach and effectiveness of health and social care services. There is a need to grow the asset of the inherent strengths and skills of communities by supporting community development.

Currently, there is a disjointed approach to community development in Northern Ireland.

There is a need for greater transparency and security of funding; for consistency of policy and understanding about the practice of community development; and a need for support for practitioners to address the current fragmentation and fracturing of provision.

Following the process of development and engagement in shaping this Framework, key areas emerge which have led to our conclusions and recommended actions: a need to strengthen alignment and influence relevant areas of Government policy; providing

accessible 'tools' to support practice; opportunities for sharing and growing good practice; enabling and shaping the delivery of training in a range of formats (two models have been piloted to date); developing an outcomes framework that will assist with evaluation; and working toward the development of standards in community development practice. A critical area, which falls outside the immediate remit of this group, is funding – greater coherency and longer term sustainable funding. This remains a key challenge and one which the Implementation Board will continue to address with Government.

The Work Stream found great commitment to, and enthusiasm for, community development and its role in transforming health and reducing health inequalities. There is a real welcome for the clarity and profile being given to community development and the contribution that this process can make to wellbeing. The following implementation plan is outlined as a means to stimulate conditions in which community development can best succeed.

7 Implementation

7.1 Stages of Implementation

This section sets out the proposed implementation plan for the Community Development Work stream. There are four recognised stages¹⁸ in the implementation of any initiative:

- a. Preparing and Exploring - which involves carrying out a situational analysis, clarifying definitions and best practice, consultation with key stakeholders and goal setting
- b. Planning and Resourcing - developing a clear implementation plan, identifying roles, responsibilities and governance; estimating resources, time, facilities and supports necessary; preparing a communication strategy, assigning tasks and putting in place the structures and relationships to support implementation
- c. Initial Implementation and Operationalisation - mentoring and support to the implementation leads; setting up accountability, evaluation and monitoring systems; capacity building; integration with mainstream activity and other initiatives; communication and review points to inform future action
- d. Business as Usual - at this point the programme is fully operational. For the Community Development Work Stream this is envisaged as years 4 - 5. At this point, the core components of the implementation plan should be in place and the necessary resources invested. Evaluation and monitoring systems should demonstrate impact, benefits and areas for improvement or innovation for greater efficiency and effectiveness. This will inform future policy development and strategic goal setting for the next phase.

¹⁸ Adapted from NIRN - National Implementation Research Network <http://nirn.fpg.unc.edu/>

The Community Development Framework developed during 2017 and detailed in this report completed the first of these stages and started work on the second.

Moving forward, the Work Stream proposes a three phased approach across ten years:

- **Phase 1 – (2017 – 2020):** develop the framework presented on February 21, 2018, at a second symposium; establish a website portal to share tools, resources and materials; begin system mapping; identify and enable training and capacity building with academic and other providers; develop an on-line Academy with resources and training opportunities; refine outcomes framework.
- **Phase 2 – (2020 – 2025):** embed good practice; initiate systematic change; build on existing procurement and measurement systems.
- **Phase 3 – (2025 – 2027):** Capture the learning, facilitate positive practices and modules; validate an established community development register of approaches and their application; apply quality standards.

7.1.1 Recommendations for Year One

The implementation plan for the Community Development Framework has been created in detail for Year One: 2018 – 2019. The focus is on establishing a foundation infrastructure. The priorities, based on the consultation and research which the sector, are to embed the outcomes framework, build capacity and establish governance arrangements. This will enable more detailed plans for years 2019 - 2021 to be developed.

The stages and activities for Year One implementation include the following:

- a) Produce the Community Development Framework, report back to the contributors who were consulted with regionally and at local council levels and align with parallel TIG work streams
- b) Where possible, align with other relevant process such as PHA's procurement of Community Development, review of Neighbourhood Renewal, relevant plans of the Department of Communities, the development of Healthy Places, and the Community Plans of local councils
- c) Collate and share community development tools and resources and make available through a Community Development online "portal" which is fundamental to capacity building capacity and skills, and the dissemination of good practice
- d) Develop a Capacity Building curriculum with providers and community organisations which is relevant, accessible and evidence based

- e) Map the overall system of Community Development activity in Northern Ireland to provide a baseline against which future progress and impact can be assessed
- f) Secure resource and funding on a multi annual basis to rebuild community development practice and infrastructure in conjunction with other government departments
- g) Design and implement an evaluation framework to measure and assess the impact of the Community Development Framework and create a Northern Ireland evidence base which will inform future development in 2019-2021.

Indicative Work Plan for Phase 1 of Community Development for Health Improvement				
ACTIVITIES	Who	2017 - 2018	2019	2020
Produce the CD Outcomes Framework				
Complete the Engagement Events and summarise and set up a contact database	PHA	Dec-17		
Distill Learning and Lessons from events	CENI	Nov-17		
Shape an draft Outcomes framework that speaks to FIG, MLB, Community Planning and Com Dev. process; quality assure	CENI/ PHA	Nov-17		
Reconvene Regional Symposium to report on progress and plans for Phase 1; secure commitment and contributions	PHA	Feb-18		
Align the developing CD Outcomes with Community Planning activity with Local Government and establish a CD forum with Comm Planning Leads	PHA/ SOLACE	q1-q2 2018		
Align the developing CD Outcomes with ASCOF with HSCTs and Vol Sector	Steering Group	Q1-3 2018		
Align with other relevant TIG work streams	PHA	Q1-3 2018		
Collate and Share Tools, Resources				
Collate current provision in NI from providers	PHA	Q1-Q2 2018		
Design a Comm Dev Toolkit architecture and content; commission development	Steering Group	Q1-4 2018	launch	monitor
Establish a Community Development Portal website which would include the online Academy and resources	PHA Consortium	Q1		
Set up a steering group to oversee and monitor quality	Sub group	Q1-4 2018	launch	monitor
Create a network whereby community organisations are able to share experiences, case studies good practice.	Sub group	Q1-4 2018	launch	monitor
Capacity Building				
Meet with providers to collate current provision, demand, uptake and funding.	PHA	Q1-2 2018		
Encourage providers to integrate the CD Framework into the design of their curricula	PHA	Q1-2 2018		
Link with HSCTs and Councils to adapt this approach into their development activities	PHA	Q1-2 2018		
Populate the Online Academy with up to date resources and capacity building opportunities	PHA Consortium	Q2 - Q4 2018		
Develop a Community Development Curriculum and target specific skills and knowledge areas such as outcome based approaches, measurement and evaluation	Steering Group	Q1-4 2018		
System Mapping				
Map all relevant stakeholders including Comm Dev providers and agree how they incorporate CD Framework into their operations	CFNI	Q3- Q 4 2018		
Meet relevant government departments and secure their support and integration into their relevant areas of work	PHA	From Q1 2018		
Resources and Funding				
Ensure procurement Of Comm Dev. is incorporated into PHA procurement Workstream for review	PHA	Jan-18		
Scope other models including POBAL to design a method for ensuring that Comm Development investment across departments is deployed and realigned with the CD Framework and capacity being tools and resources.	PHA	Q1 2018		
Attract new resources to support community development from TIG and elsewhere				
Evaluation and Evidence				
Create a system to capture the evidence base for community development in NI to demonstrate and capture impact	PHA	Q1 - Q2 2018		
Produce an evaluation framework relevant to different types of community development integrated with existing mechanisms and support	To be procured	Q2 2018		
Review Phase 1 of CD Workstream implementation and plan Phase 2 and 3	CD Steering group	Q3 - Q4 2018		

8 Governance

8.1 The Governance structure

The diagram below sets out the proposed governance arrangements to oversee the implementation of the Community Development Framework.

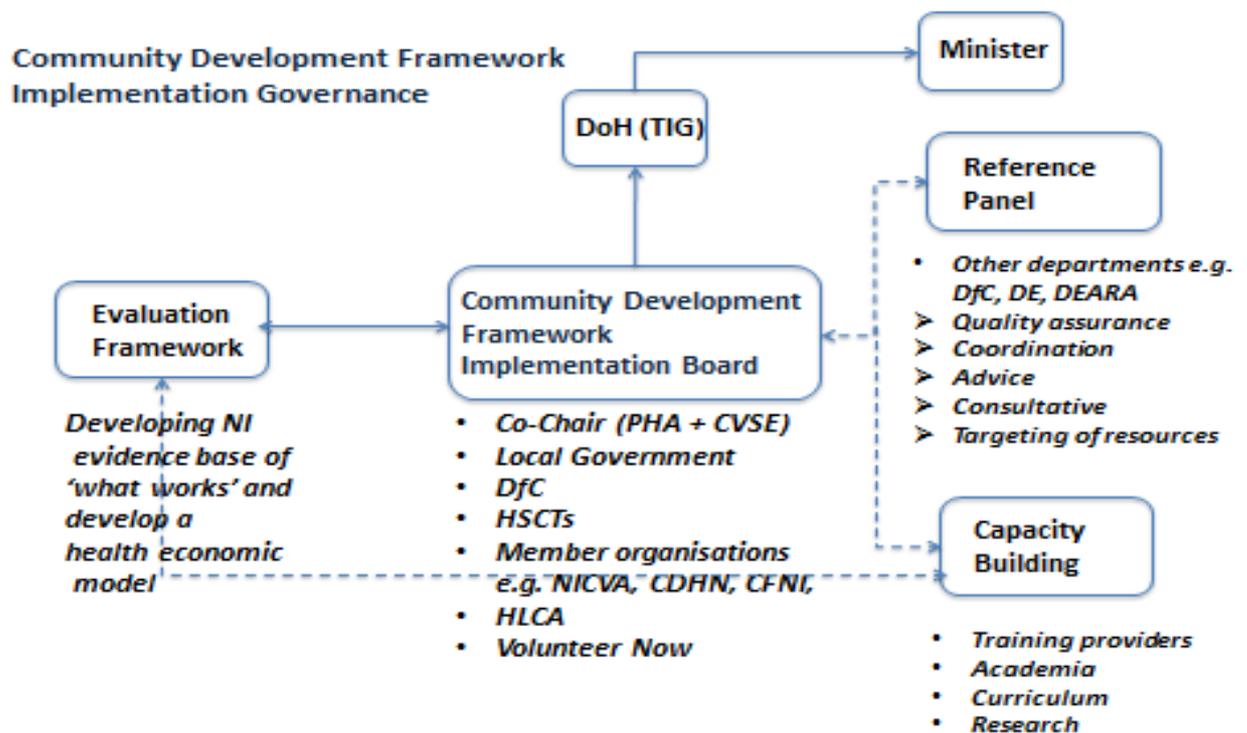


Figure 7 proposed governance arrangements to oversee the implementation of the Community Development Framework.

8.2 Overall accountability

Overall accountability for the implementation of the Community Development Framework is through the TIG to the Minister as part of Delivering Together policy implementation. Reporting arrangements in terms of frequency, performance indicators and measures will be agreed with TIG (DoH).

8.3 The Community Development Framework Implementation Board

The Community Development Framework Implementation Board will be co-chaired by the PHA and a nominated community development representative. Membership will be drawn from those sectors or organisations that have a direct impact on implementation, i.e. HSCTs, local government (SOLACE representative, Community Planning) and member organisations such as CDHN, NICVA, HCLA, Volunteer Now and CFNI.

The rationale for membership is:

- a) Have a direct role in implementing the framework (commissioning or delivery);
- b) Are a membership organisation with outreach capacity to link to community networks and community development groups.

The Implementation Board will meet five times a year. There is a need for a Programme Management Officer role to help drive implementation activities and oversee particular Task and Finish groups or the initiation of new arrangements, as well as alignment with other TIG Work streams.

8.4 Sub groups

Two associated sub groups will link with the Implementation Board:

8.4.1 A Stakeholder Group

A Stakeholder Group which will consist of members from other government or Arms Length Bodies whose strategies will converge or have synergies with the Community Development Implementation Board. This group will meet quarterly to update and share information, plan how to support and promote areas of common interest; target resources to avoid duplications or gaps in provision.

8.4.2 A Capacity Building sub-group

A Capacity Building sub-group consisting of representatives of the “provider system”, including communities of interest, academic and research, who would assist in developing and delivering the Community Development curriculum and populating the online Community Development Academy website.

8.4.3 Local Fora

Consideration will also be given to mechanisms for ensuring local participation in the governance arrangements.

8.5 Independent Evaluation of Implementation

An independent evaluation of the implementation process is recommended to design an outcomes based approach to evaluating impact and collating Northern Ireland best practice. The evaluation team would report to the Community Development Implementation Board in a formative manner, i.e. reporting on impact and facilitating the application of lessons learned to the next phase of activity; as well as providing a summative evaluation report at the end of Phase I to inform Phase II and demonstrate the benefits from the investment.

9 Appendices

9.1 Appendix 1 Summary report of Engagement Events

Community Development and Health and Wellbeing Engagement Events

Summary Report from the Local Workshops December 2017

1. Introduction

In October 2016, a 10 year approach to transforming health and social care was launched, “Health and Wellbeing 2026: Delivering Together”. This ambitious plan was the response to the report produced by an Expert Panel led by Professor Bengoa tasked with considering the best configuration of Health and Social Care Services in Northern Ireland.

A programme of work is underway to deliver the ambition set out in Delivering Together. This work places a strong emphasis on ensuring that the user’s voice is heard, as they will play a key role in developing and implementing new services and care pathways. A number of Transformational Implementation Group (TIG) work streams have been established including a Community Development (CD) Work Stream, which has been tasked to share the learning from effective community development practice and grow this practice over time in order to improve health and wellbeing and reduce inequalities.

The CD work stream team, chaired by Mary Black, Public Health Agency (PHA) includes representation from across the statutory, community and voluntary sectors. Membership of the work stream is provided in Appendix 1. There is a rich history of Community Development practice in Northern Ireland and the team sought to build on this experience. The team has worked together over the past number of months to examine how best community development approaches can contribute to the overall Health and Social Care Transformation process. Having drafted statements of the purpose, principles and outcomes of community development and health, a series of local community engagement workshops were delivered during August – November 2017, in partnership with local government, and together with health and social care trusts, in order to share expertise, and explore critical success factors needed to nurture the growth of community development practice, as a means to tackle health inequalities and improve health and wellbeing.

The purpose of this report is to provide a brief summary of the workshops and outline how the findings will be used to shape and inform the next stage of the developing framework to support community development in the future.

2.0 Aim and Objectives

The overall aim of the workshops was to engage with a wide range of key stakeholders and Community Development and Health and Wellbeing practitioners in

order to inform the development of a Community Development Strategic Framework for the future.

2.1 Objectives

- Consider the policy context for community development
- Share experience of community development at a local level
- Examine outcomes and the rationale for the vital role that community development can play in reducing health inequalities and the link with the draft Programme for Government.
- Consider critical success factors, enablers and barriers to creating effective community development outcomes in Northern Ireland.



3.0 Workshop Structure

The workshops were co-hosted with local councils which provided an opportunity to highlight the strong link between the Health and Social Care Transformation Implementation and local community planning processes, see Appendix II. The agenda was formatted to include a number of presentations with opportunities for facilitated discussion.

Session 1: Setting the NI policy context for Community Development in Health and Social Care

- Who we are, Policy context, what we are doing
Mary Black, Public Health Agency
- The purpose and principles of community development
Joanne Morgan, Community Development and Health Network (CDHN)

Facilitated table conversation A

Session 2: The process by which community development creates health

- Outcomes, rationale and enablers theory of change
Brenda Kent, Community Evaluation NI (CENI)

Session 3: How does the theory measure against practice?

- Local practice example

Facilitated table conversation B followed by feedback

Session 4: What next to enhance readiness - things for the Framework.

- Questions and comments about the readiness of the health sector to use community development approaches to transform health. (*Plenary*)

(A) Workshop participants were asked to briefly reflect on the purpose and principles of community development and why it is important to have a clear definition.

(B) The second discussion focused on the learning that could be distilled from a local case study and participants' own experience. Participants were asked to reflect on their own knowledge of Community Development practice and the discussion was focused on:

If Community development is going to deliver the health outcomes as suggested

- a) What are the enablers and critical success factors to make it happen and
- b) How can we show that change is happening –proof via indicators.

4.0 Summary of Workshop Discussions

The 12 engagement workshops were promoted through a range of networks including the PHA, local Councils, Community Development and Health Network (CHDN) and Northern Ireland Council for Voluntary Action (NICVA). A total of 391 participants attended from across the community and voluntary sectors, Government Departments, statutory agencies, Health and Social Care Trusts and Councils.

Key points from the table discussions were recorded and reviewed for recurring themes and comments.

4.1 Discussion A

Reflection on the principles and definitions of community development

There was a general welcome for the attention being placed on health inequalities.

The comments indicate different levels of understanding, and perhaps some confusion, between the effect of socioeconomic inequalities on population health and the experience of inequity on individual health. This conflation of the societal and individual also appeared in discussions about the outcomes framework.

The main comments on the definition presented are summarised as:

- The language is more suited to policy makers but not to public audiences
- It would be better to reference all groups that experience inequality rather than just one
- There could be better clarity in explaining that both those in poorer communities experience worse health and that specific groups (older, disabled inter alia) also experience health inequalities irrespective of income

Community development and its principles

The majority felt the definition was:

- Relevant and useful
- Aligned with experience
- Something that all could get aboard with.

The link to the UK National Occupational Standards, and the very similar All Island Standards for Community Work, was welcome. This was in part because it drew on the wealth of time and experience already invested and in part because some participants felt that the focus on community development as a particular and skilled practice had been lost over the last 15 or so years in Northern Ireland.

“Community development policy and practice exists and it is not about re-inventing the wheel but about consolidation through improved quality assurance, standards and sustainability”

“A clear definition is vital for a shared and clear understanding of what is and is not community development. It has evolved and useful to refresh our understanding in today’s context.”

The participants suggested that an agreed definition would have great utility in:

- Clarifying what is and is not community development.
- Creating a common base of expectations for the process.
- Informing and influencing the design of funding streams.
- Establishing reasonable and shared measures of progress.

A number of comments called for efforts to ensure an ‘across the board’ understanding so that policy makers and funders distinguished between the effects of community development and that of particular community projects. As one commentator noted:

"Community development is not a package; it is a process and ethos. There are differences between community development projects but not in community development practice, that is, the different needs of communities are central but same principles apply across all contexts."

The outline outcomes framework for community development and health inequalities

Elements of change

There was a general welcome for the distinction between benefits accruing to individuals, communities and society. The majority of comments were that the framework covered the key effects of community development but that a short presentation was insufficient time to consider it thoroughly.

There were calls for the work to be developed with community development practitioners and, from some, with members of communities being supported. In this regard, commentators suggested a ‘lay’ or easy read version of the framework.

Social justice as the ultimate outcome

There was a welcome for the inclusion of inequalities and social justice in the framework. However, most noted that short term projects could only make small contributions in this direction rather than deliver major change, especially those that needed to ‘fire-fight’ day to day issues before they could start to address the bigger picture.

A few voices called for an emphasis on the individual:

"People are the primary asset, you need to get the motivated people involved."

"...it is not all the government's fault, individuals have to take responsibility."

Given that community development, as defined, is about collective action, often through groups, as a means to community and ultimately, social change, it would seem that there is not a shared understanding of the process. Likewise, there is not

yet universal understanding of the distinction between the social and individual determinants of health, their relative importance and susceptibility to change through community based work. Addressing these gaps will be key to devising an outcomes framework that all find meaningful to their purpose.

Outcomes for individuals and communities

People suggested that the outcomes for individuals were useful, but at a very high level. The outcomes for each person in each project would need to be varied and depend on where people were at in their journey. Similar comments attached to the outcomes for communities.

The level and nature of the comments about outcomes suggests that community based workers have had varying exposure to, or time to explore, outcome frameworks showing how short term changes feed into longer term effects. Given the current emphasis of the Programme for Government on outcomes and Outcomes Based Accountability, this may indicate an important gap in the community development sector's preparedness for transformation.

4.2 Discussion B

Enablers essential for actions to lead toward outcomes

Suitable funding and programming

The most consistent comments were for more flexible and longer term funding to match the nature of community development. Within this were calls for:

- Sufficient funding to manage through the unexpected and to meet the needs of individuals and communities surfaced by the community development process.
- Long term funding when seeking to engage communities where very little infrastructure exists, providing for time to listen and build trust as a precursor to fuller engagement.
- Time to engage groups not used to engaging.
- Funds and time to map local assets and find partners before 'diving in'.

"Community development needs to be bottom up and reflective of local needs. How can you deliver a smoking cessation programme without building trust, confidence and relationships first? Who funds us to do that?"

"Funding should recognise that many groups have a high tolerance of living with discrimination and so will not simply rush into a project and work for equality and social justice. Very often they just want help with day to day things."

Many comments about resources underscored an impression that community development is stop start because funding is short term and therefore workers need repeatedly to learn about and build links with communities.

There was a loud call for a move away from individual pilot projects to develop a clear stream of quality community development work informed by shared definitions and standards.

Asset based co-design

Moving away from deficit based to asset based funding and providing funding that allowed for risk and failure were also seen as essential steps to enabling community development to impact on communities and the determinants of health.

Underpinning this issue was a desire to see communities involved in designing their own programmes for building the assets in their community. This requires an investment in the co-design capacity of funders, community development organisations, practitioners and community representative.

Co-design

Co-design was seen by some participants as a way to identify appropriate outcomes, processes, enablers and time lines for new project and as a means to express and develop respect and understanding for all parties and for all stages of the community development.

Overall, co-design was considered a cyclical enabler; it helps to design effective community development and community development supports effective co-design by creating in communities the capacity to take an equal part.

Silos

As a natural extension from co-design, participants called for funders and programmers to break out of their administrative 'silos'. Health inequalities are recognised as stemming from a range of social and economic factors and participants felt that this must be reflected in programme design and delivery. The 'stop working in silos' was seen as a principle seen as applicable from the ground up. In the same vein, people noted that community development occurred in both the public and voluntary-community sector and that practitioners in both might benefit from being better connected.

Skills and personnel

Participants identified access to skilled personnel as a key success factor. The skills and supports most often cited were:

- Knowledge of community development as defined by the principles

- Skills for getting people involved and knowing when to build up individuals and when to start working as a ‘community’
- The ability to listen to what communities see as their key shared issues
- Access to info support and best practice examples
- Strong leadership of the top order
- Strong, carefully constructed teams of paid and volunteer workers. These take time to build delivery teams
- Support and supervision for all key staff
- Passion, compassion and support to challenge
- Knowledge of resources and plans relevant to the community and
- Influencing skills
- Knowledge of how to manage expectations within short-life programmes
- Life experience and the support of colleagues with wider experience
- Ability to call on and have access to experts and good practice
- Access to data, evidence and information to understand complex issues
- Access to information about successful pilots and their success factors

Infrastructure

Participants felt that a strong infrastructure to support the above skills and the people who deliver community development was a crucial enabler of outcome delivery. There was a sense that changes in investment and policy emphasis, along with an ill-defined practice infra-structure has meant that community development skills have been lost over the years. Trained practitioners have retired or moved to other positions and new community workers, and volunteers, have not had the same access to support in community development as a practice with clear, professional standards.

“Current community development support structure as fragmented”

“There is no means to share or replicate good practice or set standards”

“Need to resource the infrastructure and do this before any other components”

Volunteers

Participants highlighted the importance of local personnel, either in terms of employing members of the community to deliver community development or by engaging volunteers.

There were calls for a clear policy around the role of volunteers in delivery so as to recognise their unique contribution while also being clear about avoiding job substitution; and for resourcing the development of volunteer skills as an enabler of effective and sustainable asset development.

Representativeness

Identifying and engaging representative people in the community was identified as an essential enabler of community development. Avoiding 'gatekeepers' was highlighted as was the need to find new people to engage and develop so there was a spread of people engaged and increased likelihood of smooth succession when existing leaders or champions stand down.

Indicators and measures

Participants recognised the framework as operating at the high level of outcomes. This was seen as positive at this early stage because it meant that all contributors' work could be located within it.

Many suggested that measures ought to be agreed Programme by programme, and with beneficiaries as part of the process of building skills and transferring power to the community.

"You can't have outcomes without process; it won't work, particularly if outcomes are about how communities need to be involved."

There was a very strong message that narrative evidence is important to demonstrate impact. Qualitative information, videos and case studies were seen as essential because

"Numbers don't always tell the whole story"

"Success is different for everyone and one size does not fit all"

There was just one mention of the Programme for Government and Outcomes Based Accountability. Comments indicate a need to bring the community development in the health sector to a higher and more uniform awareness of the different levels of outcomes, performance measures and what might be measured and when in a way that makes sense.

"We can measure lots of things but need to be clear about the causal connection"

Participants flagged up a range of frameworks and measures already in use in

specific areas of health and social care and these will be integrated into the framework at the next iteration.

5.0 Next Steps: Developing a Strategic Framework

Structure, content and quality assurance at local level

A symposium is scheduled for the 21st February 2018 where it is intended to present the Draft Framework. There will also be a further opportunity to explore how to continue to share the learning to nurture the growth of effective CD practices as a means to tackle health inequalities and improve health and wellbeing.

Work is under way to ensure that the TIG approach to community development expansion takes account of the need to integrate with a number of other important processes, particularly:

- Programme for Government and related Delivery Plans;
- Community Planning Processes
- The Development of 'Healthy Places' and the plans to grow this approach to scale across Northern Ireland
- Other TIG Work streams
- Other Government policies and strategies

5.1 Timeframe

Community Development Approach: recommendations for the next ten years.

- Phase 1 (2017-2020): produce a framework for presentation in February 2018; share tools, resources, materials; system mapping; capacity building
- Phase 2 (2020-2025): embed good practices; initiate systemic change initiations; introduce procurement and measurement systems
- Phase 3 (2025-2027): Capture the Learning; facilitate positive practices and models; validate an established community development register of approaches and application

Evaluation of the Workshops

1.1. Workshop Evaluation

In addition to the analysis of the facilitated table discussions, participants were asked to complete a short evaluation form. A total of 152 evaluation forms were returned with 99% of the delegates highlighting that the objectives of the workshop were completely/ 'sort of' met. The evaluation forms have also been reviewed so that more general comment can also be used to contribute to the developing Framework.

1.2. How far do you think the aim and objectives of the workshop were met?

n = 152	Not at All	'Sort of'	Completely	No response
Number of responses	0	59	91	2
Percentage of responses	0	39%	60%	1%

Overall the feedback on the aims and objectives of the workshops were very positive. Typical comments by respondents include.

'Important to see Community Development work centre stage and acknowledged as the way to address health and wellbeing issues (in conjunction with other partners)'

'Good workshop in terms of organisation and context'

'Building on good work so far – needs continued.'

Several participants did suggest that the workshops could have been improved by having a longer time for discussion as it *'felt a little rushed'*

6.2 What was most relevant and useful to you?

A number of responses highlighted that they found the presentations informative.

The presentations were useful to understand the strategic vision and the government's direction and policies'

'To hear the logical approach to the development of the framework-presentations were clear and easy to understand'

Many participants enjoyed the facilitated discussion and welcomed the opportunity to influence the process.

'I appreciated the discussion on the definition and being able to make the point that we need to use language relevant to those within the communities, as we will need to bring the community with us to bring about change'

'I think this was an opportunity to influence-I felt listened to'

6.3 What will you do as a result of this workshop?

Overall there was a positive response from the participants at the workshops as to how the workshops will change or enhance their current community development practice:

'I will review how this process can be enhanced through community planning processes'

Today has provided the opportunity to reflect on our CD practice, and I will make use of the contacts made today'.

Participants also were keen to share the information from the workshop with their colleagues and wider networks:

'I will review with my team the definitions and understanding of what is meant by community development'

'I will relay what I learned tonight back to my organisation, I will explain to the BME groups I work with and I would like to stay involved in the process'

'I will share the info with communities who work within CD principles and practices to encourage them to input and get involved in the framework development'.

6.4 What would you like to see happen next?

The majority of participants would like to be kept informed on the process and more importantly, that the points raised during the engagement processes are listened to and actioned:

'That the points made today are put into action and to continue to recognise that there are many CD models and good practice already going on'

'Communication on how the issues raised will be addressed and to be kept informed of the framework development'

'Move from discussion to action'

7.0 Conclusion

There was an excellent level of participation and contribution to the developing Framework from participants at the local engagement events. There is a willingness to continue to work together to inform and influence the outcome of this process. The team has set an overall direction for this work and will continue to engage participants in this development. A second symposium is planned in Belfast for the 21st February 2018 in order to confirm direction and consider future action. If you require further information or would be interested in attending the symposium, please contact Sharon.kelly@hscni.net for further information.



List of Events

Ards and North Down

22nd August 2017 - 2.00pm – 4.00pm

Londonderry Park Pavilion, Londonderry Park, Portaferry Rd, Newtownards, BT23 8SG

Lisburn and Castlereagh

1st September 2017 - 10.00am - 12.00pm

Lagan Valley Island, 1 The Island, Lisburn, BT27 4RL

Derry/Londonderry and Strabane

14 September 2017 (Evening) - 6.30pm - 8.30 pm

Strabane Library, 1 Railway St, Strabane, BT82 8EF

Belfast

6th September 2017 - 10.30am -12.30pm

Belfast City Hall Banquet Room, Donegall Square, Belfast BT1 5GS

Causeway Coast and Glens

19 September 2017 - 2.00pm – 4.00pm

Flowerfield Arts Centre, 185 Coleraine Rd, Portstewart, BT55 7HU

Armagh, Banbridge and Craigavon

21 September 2017 (Evening) - 7.00pm – 9.00pm

Bannville House Hotel, 174 Lurgan Rd, Banbridge, BT32 4NR

Mid and East Antrim

29th September 2017 - 10.00am – 12.00pm

Studio Room, The Braid Town Hall, 1-29 Bridge St, Ballymena BT43 5EJ

Mid Ulster

3rd October 2017 (Evening) - 6.30pm - 8.30pm

Burnavon Arts & Cultural Centre, Burn Rd, Cookstown BT80 8DN

Antrim and Newtownabbey

9th October 2017 - 2.00pm – 4.00pm

The Yarn Suite, Mossley Mill, Lakeview Cres, Newtownabbey BT36 5QA

Fermanagh and Omagh

10th October 2017 (Evening) - 7.00pm – 9.00pm

Bawnacre Centre, Castle St, Irvinestown, Enniskillen BT94 1EE

Derry/Londonderry and Strabane

19th October 2017 - 10.00am - 12.00pm

Foyle Arena, Limavady Rd, Londonderry, BT47 6JY

Newry Down and Mourne

7th November 2017 - 2.00pm – 4.00pm

The Lodge Business and Cultural Centre, 1 Dublin Rd, Castlewellan, BT31 9AG

Acknowledgments

The HSC Transformation Community Development Work Stream would like to thank local Councils, the individual members of staff from Councils who provided an overview of the Community Planning process and made links with Community Development in each of the council areas, as well as those individuals from HSC Trusts and other organisations who generously shared their experience and examples of local practice.

Ards and North Down

Patricia Mackey, Community Planning Manager, Ards and North Down Council

Louise Little, North Down Community Network

Lisburn and Castlereagh

Catharine McWhirter, Community Planning Manager, Lisburn and Castlereagh Council

Gillian Lewis, Resurgum

Belfast

Sharon McNicolls, Director Community Planning, Belfast City Council

Mandy Cowden, CLARE project

Derry and Strabane

Rachael Craig, Business Support & Change Manager, Derry City and Strabane Council

John Mahon, Traveller Project, Western Health and Social Care Trust

Causeway Coast and Glens

Gary Mullan, Community Planning Officer, Causeway Coast and Glens Council

Hugh Nelson, Community Navigator Project, Northern Health and Social care Trust

Armagh, Banbridge and Craigavon

Jennie Dunlop, Community and Strategic Planning Manager, Armagh, Banbridge and Craigavon Council

Gerard Rocks, Verve Healthy Living Centre, Southern Health and Social Care Trust

Mid and East Antrim

Karen Hargan, Director Community Planning, Mid and East Antrim Council

Hugh Nelson, Dementia Friendly Communities, Northern Health and Social Care Trust

Mid Ulster

Martina Totten, Community Planning Manager, Mid Ulster Council

Gerard Rocks, Neighbourhood Renewal project, Southern Health and Social Care Trust

Antrim and Newtownabbey

Alison Keenan, Community Planning Manager, Antrim and Newtownabbey Council

Hugh Nelson, Northern Obesity Network, Northern Health and Social Care Trust

Fermanagh and Omagh

Kim McLaughlin, Head of Community Planning and Performance, Fermanagh and Omagh Council

John Mahon, Travellers Project, Western Health and Social Care Trust

Down Newry and Mourne

David Patterson, Director Community Planning, Down, Newry and Mourne Council

Fergal O'Brien, NMD Age Friendly Strategic Alliance, Southern Health and Social Care Trust

In addition, the PHA would like to thank Joanne Morgan, Community Development and Health Network NI, and Brenda Kent, Community Evaluation NI, for their valuable contribution to the workshops.

Finally, sincere thanks to all who attended and participated so fully in the events and we look forward to your further engagement in the process.

9.2 Appendix 2 Summary of Belfast Symposium

**Symposium on Community Development and Health and Wellbeing
Wednesday 21st February 2018 New Life City Church, 143 Northumberland
Street, Belfast**

Introduction

In October 2016, a 10 year approach to transforming health and social care was launched, “Health and Wellbeing 2026: Delivering Together”. This ambitious plan was the response to the review of health and social care in Northern Ireland. Led by Professor Bengoa, the Expert Panel was tasked with considering the best configuration of Health and Social Care Services in Northern Ireland.

A programme of work is underway to deliver the ambition set out in Delivering Together. This work places a strong emphasis on prevention and promoting health and wellbeing along with ensuring that the user’s voice is placed centrally in developing and implementing new services and care pathways. A number of Transformational Implementation Group (TIG) work streams have been established, including a Community Development (CD) Work Stream, which has been tasked to share the learning from effective community development practice and grow this practice over time in order to improve health and wellbeing and reduce inequalities. The CD work stream team, chaired by Mary Black, Public Health Agency (PHA), includes representation from across the statutory, community and voluntary sectors. Membership of the work stream is provided in Appendix 1. Following an initial symposium held in June 2017 and twelve local engagement events held August – November 2017, 122 key stakeholders (see appendix 2) attended a further symposium, hosted by the CD work stream on Wednesday 21st February 2018, at New Life City Church, Belfast. The purpose of the symposium was to report on the outputs of the Community Development work stream and set out draft recommendations to TIG for the next 12 – 18 months period. This report provides a summary of the proceedings of that symposium.





2.0 Aim and Objectives

The aim of the symposium was to provide feedback to stakeholders on the draft Framework for Community Development and outline future direction for transformation. It was important to provide an opportunity of reporting back on the outcomes of the engagement events and how they influenced and shaped the Framework to date.

2.1 Objectives

- To report the outputs of the Community Development Workstream and recommendations
- To provide feedback on the findings from the local engagement events
- To discuss the Implementation and Governance proposed processes and structures for taking the work forward.



3.0 Symposium Structure

The agenda was formatted to include a number of presentations with opportunities for facilitated table discussions, structured as follows:

Welcome and Setting the Scene

- Purpose of the Workstream
- Summary of progress
Mary Black PHA

Session 1: Developing Infrastructure and Skills

- Workstream findings from consultation
- Recommendations
- Discussion and advice
Joanne Morgan, Community Health Development Network

Session 2: Community Development Outcomes

- Process of developing outcomes
- Evidence and best practice
- Application to Northern Ireland
- Presentation and discussion of relevance and application
Brenda Kent, Community Evaluation NI

Session 3: Implementation and Governance

- Proposals for implementing the community
- Development recommendations in 2018 – 2019
Mary Black PHA

Session 4: Community Development Cross-cutting Impact

- Relevance of this Workstream to other PfG and TIG policy and strategy areas
 - Primary Care
Mark Lee, Director of Primary Care, DoH
 - Co Design and Co Production
Alison Briggs, Antrim and Newtownabbey Council
 - Community Planning and Local Government
Wendy Brolly, Antrim and Newtownabbey Council
 - Connecting Workstreams and Relevance to Communities
Tony Doherty, Healthy Living Centre Alliance

Next Steps: Finalisation of the Framework

- Review of the Symposium
- Reach and Participation
Mary Black PHA

4.0 Summary of Roundtable Discussions

A total of 122 participants attended the symposium from across the community and voluntary sectors, Government Departments, statutory agencies, Health and Social Care Trusts and Councils.

Key points from the table discussions were recorded and reviewed for recurring themes and comments

Session 1: Developing Infrastructure and Skills

Q1 What are the barriers preventing you from accessing training?

While the majority of the respondents welcomed the need for training, there was a strong consensus that cost and time away from their job role presented as main barriers to accessing CD training. Comments expressed such as:

'Financial cost is a barrier. Previous tenders/contracts have all been about meeting targets and delivering programmes, there is a lack of money for facilitation/capacity building. There is no focus on sustainability'

"Most organisations don't have a training budget and therefore it isn't prioritised"

Q2 What sort of CD training would you find useful?

There was a wide range of stakeholders consulted and therefore the responses identified a need for a range of training required to support both the paid and volunteer community development practitioners. It also clearly emerged that there should be opportunities for community development practitioners to co-design and identify their specific community development needs.

'CD Training needs to go out to consultation, be co designed with community and we need to get the language right'

'We need to define CD specialism and CD skills training, they are two different things and we need different levels of training for each'

Respondents also acknowledged the stressful environment that they often work in and clearly identified a need to build up a resilient workforce

'A key type of training required is personal development, pitched at various levels from participants through to peer support workers and beyond. Within such training is the need for leadership and personal resilience'

Q3 How could the CD Work Stream support you?

Participants widely welcomed the idea of the development of an online portal which would house training opportunities, examples of CD practice and on line tools and resources. Other suggestions included:

'The need to maintain adherence to consistent standards: recommended that consistent use of CD National Occupational Standards is used in monitoring reports to commissioner'

'There should be an attempt to co-design training with other relevant organisations such as DfC'

Session 2: Community Development Outcomes

Overall, the feedback about the outcome framework was very positive. People liked the clarity and structure and could see the value of having such as framework. Participants were asked to comment on indicators either at individual, communities, policy and society levels and the responses have been collated for consideration by the Workstream members.

The main suggestions about strengthening the framework were:

- Use plain language to make it more “consumable” for end users and community organisations
- Require clarity on what “timeframe” is short/medium/long term outcome. How do we agree the approach to recording the outcome?
- Indicators need robust measurement tools. Need to consider **baseline** and **follow up** measures to determine impact of CD approaches.

Session 3: Implementation and Governance

Respondents were asked to reflect on the proposed Implementation and Governance arrangements for the future. There was a broad welcome of the structure presented however participants also raised a number of questions:

- How does the proposed framework sit with other CD infrastructure in other Government Departments?
- How do the community and voluntary groups represented feedback to their member groups?
- Will there be a dedicated resource to drive the framework?

A number of other suggestions were also raised for the Workstream members to consider

- *Co-chair arrangements for the Implementation Board to come from the C&V sector*
- *A named person to drive the framework forward*
- *A clear process for selecting representatives to contribute to the Implementation Board*

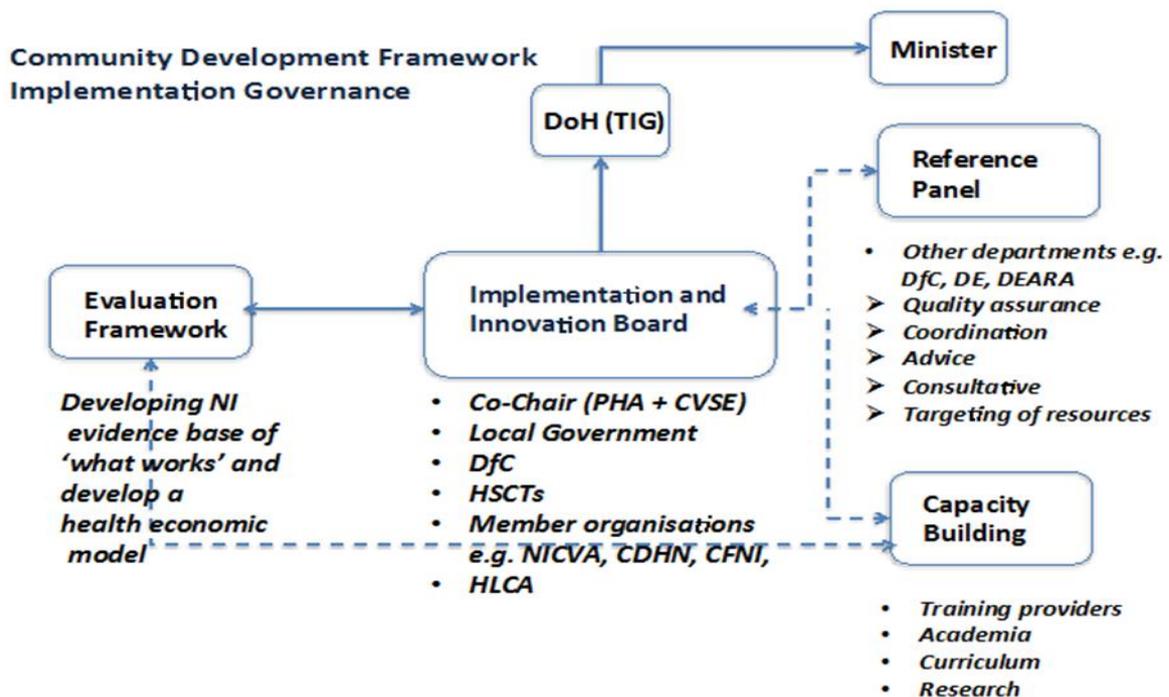
5.0 Next Steps: Developing a Strategic Framework and Implementation Plan

The rich vein of comment through the participation and co design process of the work stream will now be used to further refine the Community Development Framework before being presented to the TIG in May 2018. A detailed Implementation Plan has been prepared for Year One: 2018 – 2019. The plan is envisaged as a foundation year, during which the infrastructure and governance arrangements will be put in place. This will enable more detailed plans for years 2019 -2021 to be developed.

The stages and key activities for Year One implementation include the following:

- Where possible, align with other relevant process such as PHA’s procurement of Community Development, review of Neighbourhood Renewal, the development of ‘Healthy Places’, and the Community Plans led by local councils.
- Provision of a Programme Management role to support the implementation process and to oversee particular Task and Finish groups, initiation of new areas of work, as well as alignment with other TIG Work streams.
- Collate and share community development tools and resources and make available through a Community Development online “portal”, a fundamental aspect needed in order to build the dissemination of good practice
- Develop a Capacity Building curriculum with providers and community organisations which is relevant, accessible and evidence based
- Map the overall system of Community Development activity in Northern Ireland to provide a baseline against which future progress and impact can be assessed
- Secure resources and funding on a multi annual basis to rebuild community development practice and infrastructure in conjunction with other Government Departments
- Design and implement an evaluation framework to measure and assess the impact of the Community Development Framework and create a Northern Ireland evidence base which will inform future development in 2019-2021.

The diagram below sets out the proposed governance arrangements to oversee the implementation of the Community Development Framework.

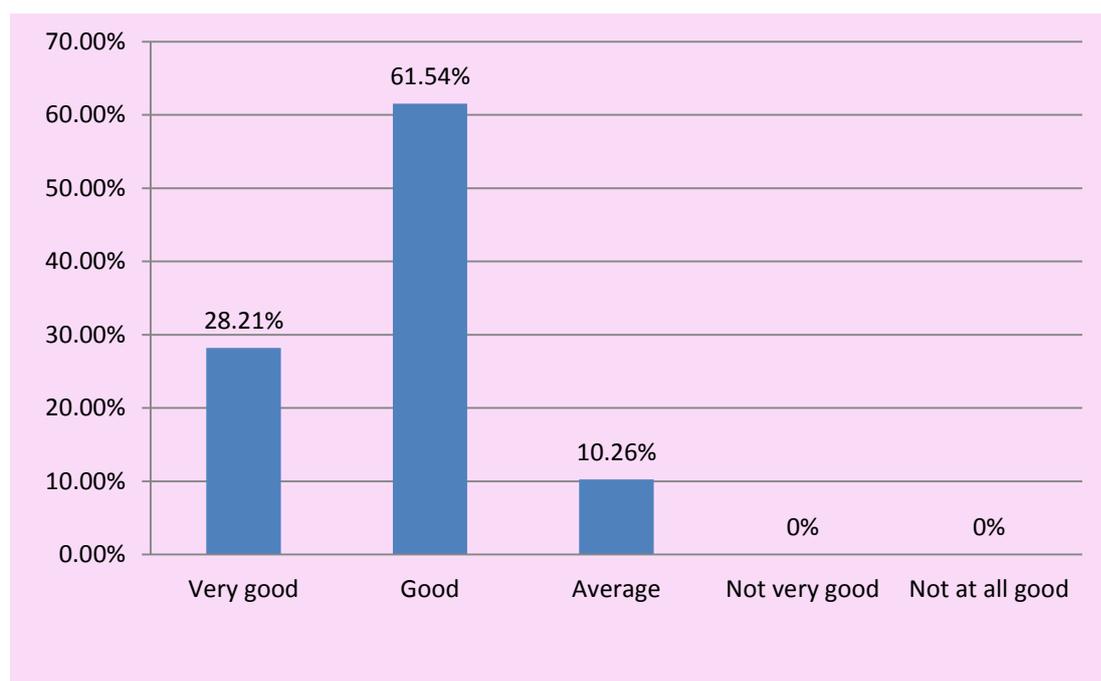


Following the symposium, it is proposed that the implementation structure now includes provision for a representative from the community and voluntary sector to Co-Chair the Implementation and Innovation Board. Membership of each sub group will be drawn from those sectors or organisations that have a direct impact on implementation of the Framework. Processes will be developed to select members in an open and transparent manner.

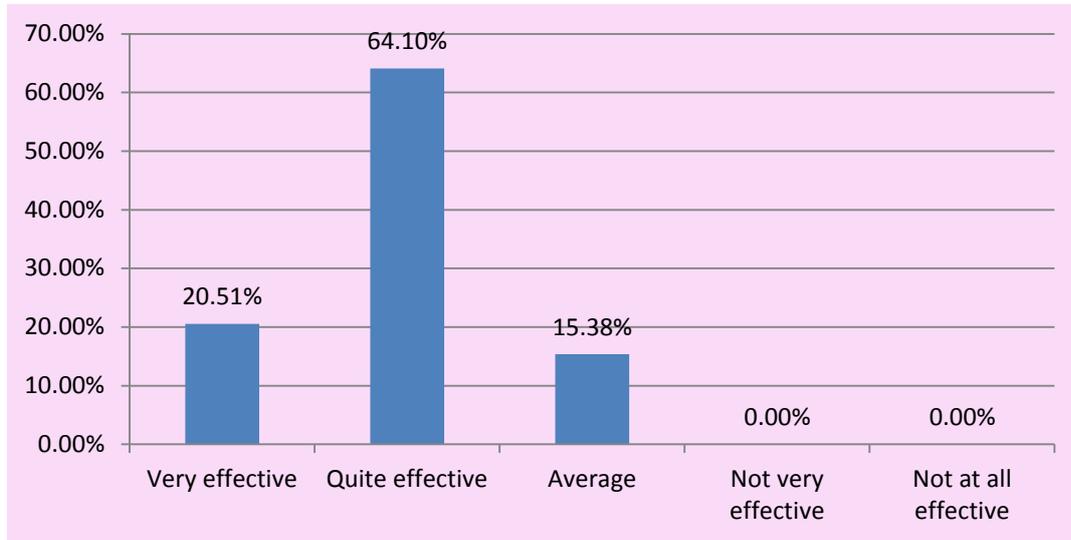
6.0 Symposium Evaluation

A link to a survey monkey evaluation was initially distributed on 23rd February 2018, with a further reminder on 22/03/2018. A total of 39 responses were received. Results of the symposium evaluation are shown below.

Overall, how would you rate the Community Development symposium? (39 responses).



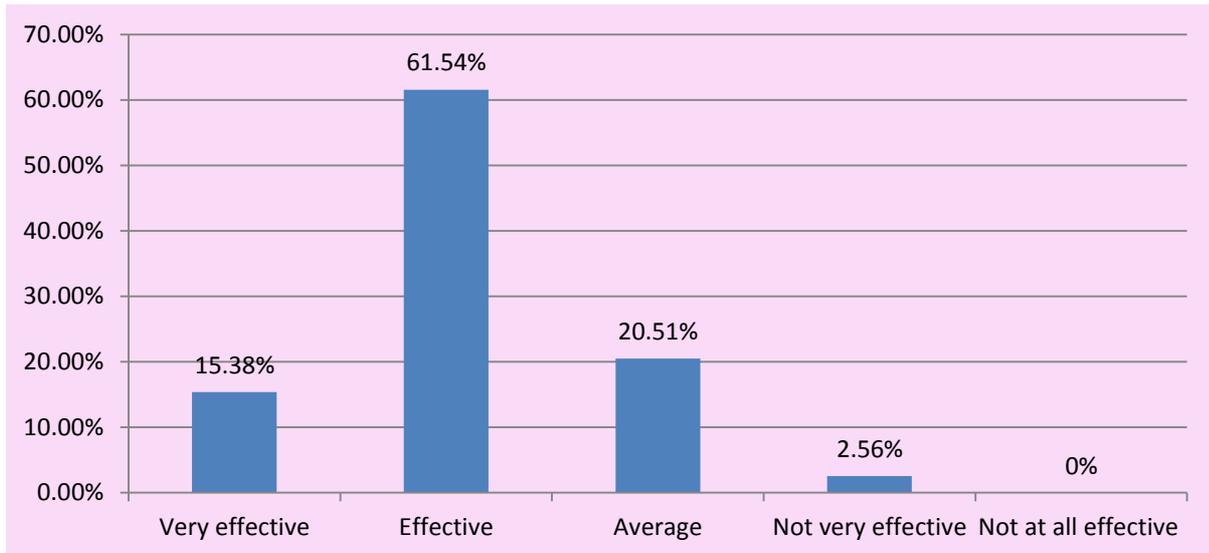
How would you rate the effectiveness of the symposium in relation to providing information on infrastructure and skills? (39 responses)



A number of responses were provided when participants were asked to comment on the infrastructure and skills section of the symposium. These responses are outlined below. Many comments were ‘one off’ comments unless otherwise stated.

- Still clarity needed on infrastructure(multiple)
- Would want to see the framework document
- Welcome the alignment with CD NOS
- Good vision of infrastructure and promoting professionalism
- Felt this was about telling everyone what was happening more than consulting
- References to training implied fundamental decisions already made
- Difficult/ impossible to reads screens (multiple)
- Too much information on day – some should have been sent out prior to event (multiple)
- Unsure of how this will actually be implemented into the statutory way of doing things to adopt a community development approach
- Learnt nothing new
- Outcomes not pitched at experienced CD audience
- Clear presentation
- Useful discussions
- Limited time (multiple)

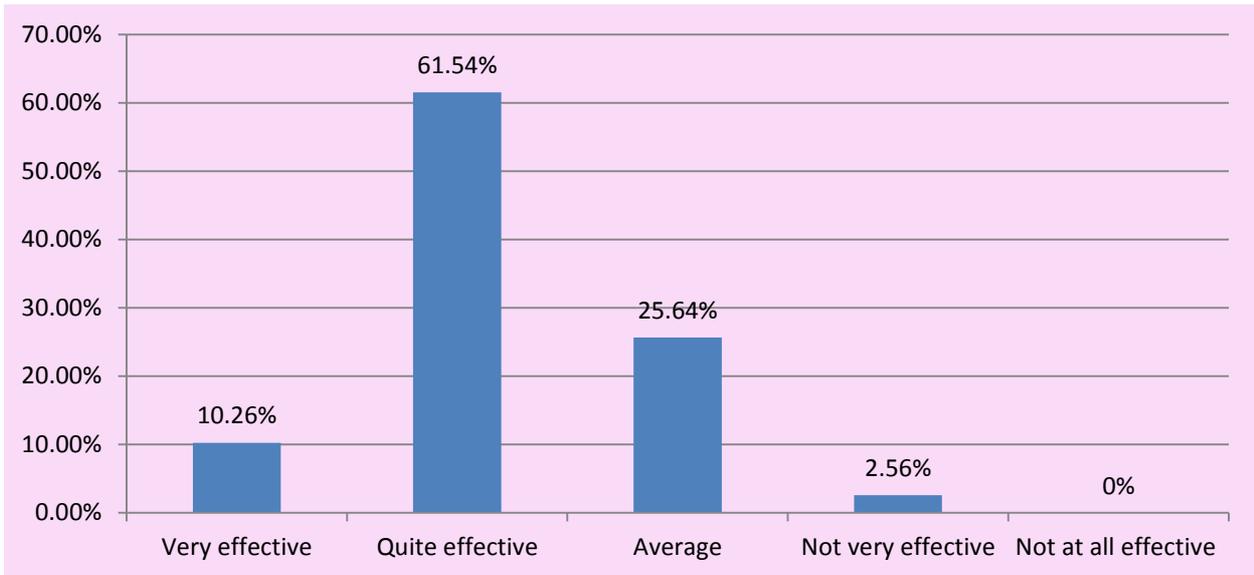
How would you rate the effectiveness of the symposium in relation to providing information on community development outcomes? (39 responses)



A number of responses were provided when participants were asked to comment on the outcomes section of the symposium. The responses are outlined below.

- Useful to see template - challenging area (multiple)
- Information prior to event would have been useful (multiple)
- Good discussion at tables
- Unclear as to who is the pitch to health professionals? other Departments?
- CD workers need to think more strategically like this
- This area of work is not understood by wide number of contributors.
- Needs wider statutory buy in
- Difficult to understand
- Effective
- Same people seem to present every time
- Participants left with no record of the outcomes, except by not submitting the feedback form. Maybe there are plans to send these by email?
- Reassured at commitment to this element of framework

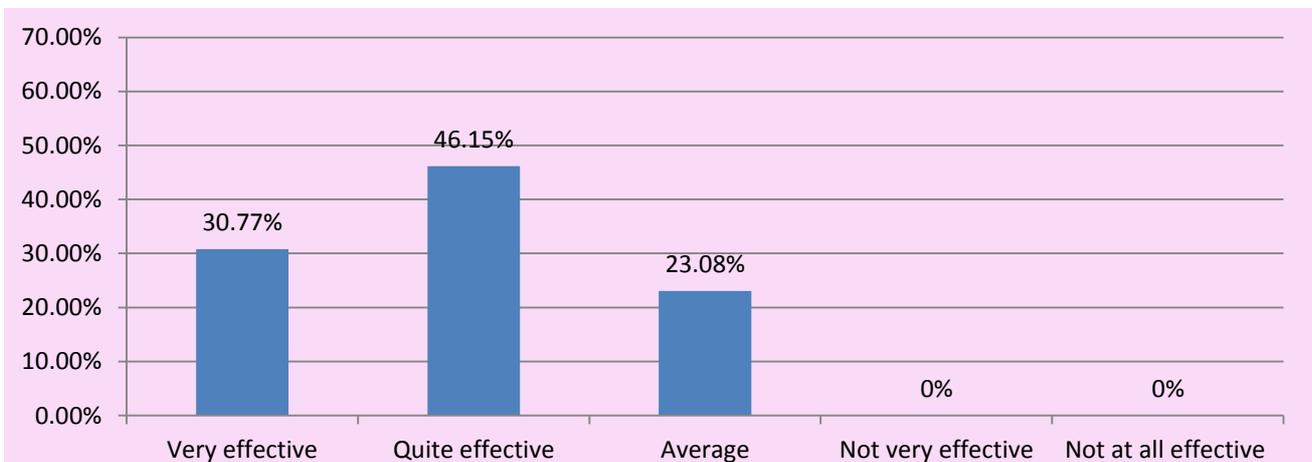
How would you rate the effectiveness of the symposium in relation to providing information on information and governance? (39 responses)



A number of responses were provided when participants were asked to comment on the information and governance section of the symposium.

- Good to see and have discussion (multiple)
- Way forward unclear – need more clarity from TIG
- Surprising information – clear communication in going forward is required.
- Requires more buy in across departments
- Too complex
- Not creative enough
- Useful discussions on this area
- Couldn't see slides

How would you rate the effectiveness of the symposium in providing information on the relevance of the community development work stream to other policy and strategy areas? (39 responses)



A number of responses were provided when participants were asked to comment on the symposium section on the relevance of the community development workstream to other policy and strategy areas.

These responses are outlined below.

- Very useful section (multiple)
- Other strategies outside HSC too far behind therefore hinder progress
- Would have been useful to have had input from housing/ homeless with this section
- Already aware of this
- Policy section was hard to listen to.

Overall how would you rate the symposium in terms of.....

	Achieving conference objectives (%)	Allowing adequate participant feedback time (%)	Symposium length (%)	Venue (%)
Very good	24	38	37	33
Good	65	44	50	46
Average	12	18	13	18
Poor				0
Very poor				2.6
Total respondents	34	39	38	39

Is there any additional information about the community development workstream (not provided on the day of the symposium) that you would like to receive

- Outcomes prior to event (multiple)
- Some examples of what is and is not community development
- Copy of slides (Multiple)
- Copy of framework and 1 year action plan
- Too top heavy with greatest emphasis on regional and statutory providers.
- Crucial to develop a structure/ framework/ principles that can be flexible enough to be applied at a local level to meet local need and build on local assets.

- Statutory providers for example could most benefit from training in community development this could link well with primary care multidisciplinary workstream and community planning partnerships.

Is there anything else you wish to tell us about the event:

- Very useful positive event
- Great opportunities for discussion
- Great to have so many skilled people brought together
- Everyone open and engaging
- Continue with the exchange of information – around the network of participants – perhaps by ezine?
- Clearer workshops session needed with information prior to event
- Not pitched at a community level

7.0 Conclusion

Engaging with the sector in co-designing the Community Development Framework has been an essential aspect of the process. The local engagement events highlighted overall support for a phased approach, welcoming clarity about definition and principles, as well as fundamentally adopting an asset based approach. A key area of concern remains the fragmentation and short term funding of such work and the need to support skills development along with evaluation of the impact of community development.

The task of expanding community development approaches within health and social care will therefore involve linking with action by other Government Departments. Where possible, actions identified within the strategic Framework should be linked to associated actions being taken forward under other relevant strategies in order to ensure that the potential offered through community development is fully realised and helps achieve common outcomes. In brief the work stream proposes a ten year approach.

Phase 1 – (2017 – 2020): finalise the framework for presentation to TIG in May 2018; establishes a website portal to share tools; resources; materials; begins system mapping; identifies and enables training and capacity building with academic and other providers as well as the development an on-line Academy with resources and training opportunities.

Phase 2 – (2020 – 2025): embeds good practice; initiates systematic change; builds on existing procurement and measurement system.

Phase 3 – (2025 – 2027): Captures the learning; facilitates positive practices and training modules; validates an established community development register of approaches and their application; application of quality standards.

In conclusion, the HSC Transformation Community Development Work Stream would like to thank all of those who have contributed to shaping the CD Framework, either through direct involvement in the engagement process, or by offering advice and comment. We look forward to your continued support and engagement, particularly as we move forward with implementation of the Framework.

9.3 Appendix 3 Delivering Together Action Plan

From Health and Wellbeing 2026: Delivering Together. DoH (2016)

- Investment in primary care to create multidisciplinary teams with a mix of skills
- Fully realise the potential of community pharmacy services to support better health outcomes from medicines and prevent illness.
- A programme of clinically led service configuration reviews, working in partnership with service users.
- Identify innovative HSC projects at the local level and scale these up across the region.
- Engage with staff and service users to build a collective view of how HSC services should be configured, and encourage a much wider public debate.
- Consult on proposals for the reform of adult social care and support.
- Develop a HSC Workforce Strategy.
- Expand the range of information and interaction available to citizens on-line and development of a patient portal for dementia patients.
- Explore innovative use of social procurement clauses
- Expand community development approaches
- Fully implement the Improving and Safeguarding Social Wellbeing Strategy
- Full delivery of Healthy Child, Healthy Future programme
- Continued development of the Family Support Hubs / Early Intervention Transformation Programme
- Mental Health (perinatal; trauma of past; parity of esteem)
- Carers (better uptake of assessments; short breaks; personalisation; access to information)

9.4 Appendix 4 Draft Programme for Government

Working Draft – Still subject to political agreement

PROGRAMME FOR GOVERNMENT OUTCOMES FRAMEWORK	
Our purpose: Improving wellbeing for all – by tackling disadvantage and driving economic growth	
Outcomes	Indicators
<p>1</p> <p>We prosper through a strong, competitive, regionally balanced economy</p>	<ul style="list-style-type: none"> • Private sector NI Composite Economic Index • External sales • Rate of innovation activity • Employment rate by council area • % change in energy security of supply margin
<p>2</p> <p>We live and work sustainably – protecting the environment</p>	<ul style="list-style-type: none"> • % all journeys which are made by walking/cycling/public transport • Greenhouse gas emissions • % household waste that is reused, recycled or composted • Annual mean nitrogen dioxide concentration at monitored urban roadside locations • Levels of soluble reactive phosphorus in our rivers and levels of Dissolved Inorganic Nitrogen in our marine waters • Biodiversity (% of protected area under favourable management)
<p>3</p> <p>We have a more equal society</p>	<ul style="list-style-type: none"> • Gap between highest and lowest deprivation quintile in healthy life expectancy at birth • Gap between % non-FSME school leavers and % FSME school leavers achieving at Level 2 or above including English & Maths • % population living in absolute and relative poverty • Employment rate of 16-64 year olds by deprivation quintile • Economic inactivity rate excluding students • Employment rate by council area
<p>4</p> <p>We enjoy long, healthy, active lives</p>	<ul style="list-style-type: none"> • Healthy life expectancy at birth • Preventable mortality • % population with GHQ12 scores ≥ 4 (signifying possible mental health problem) • % people who are satisfied with health and social care • Gap between highest and lowest deprivation quintile in healthy life expectancy at birth • Confidence of the population aged 60 years or older (as measured by self-efficacy)
<p>5</p> <p>We are an innovative, creative society, where people can fulfil their potential</p>	<ul style="list-style-type: none"> • Rate of innovation activity (% of companies engaging in innovation activity) • Proportion of premises with access to broadband services at speeds at or above 30Mbps • % engaging in arts/cultural activities • Confidence (as measured by self-efficacy) • % school leavers achieving at least level 2 or above including English and Maths
<p>6</p> <p>We have more people working in better jobs</p>	<ul style="list-style-type: none"> • Economic inactivity rate excluding students • Proportion of the workforce in employment qualified to level 1 and above, level 2 and above, level 3 and above, and level 4 and above • Seasonally adjusted employment rate (16-64) • A Better Jobs Index • % people working part time who would like to work more hours • Employment rate by council area • Proportion of local graduates from local institutions in professional or management occupations or in further study six months after graduation

Outcomes	Indicators
7 We have a safe community where we respect the law, and each other	<ul style="list-style-type: none"> • Prevalence rate (% of the population who were victims of any NI Crime Survey crime) • A Respect Index • % the population who believe their cultural identity is respected by society • Average time taken to complete criminal cases • Reoffending rate
8 We care for others and we help those in need	<ul style="list-style-type: none"> • % population with GHQ12 scores ≥ 4 (signifying possible mental health problem) • Number of adults receiving social care at home or self directed support for social care as a % of the total number of adults needing care • % population living in absolute and relative poverty • Average life satisfaction score of people with disabilities • Number of households in housing stress • Confidence of the population aged 60 years or older (as measured by self-efficacy)
9 We are a shared, welcoming and confident society that respects diversity	<ul style="list-style-type: none"> • A Respect Index • % who think all leisure centres, parks, libraries and shopping centres in their areas are "shared and open" to both Protestants and Catholics • % of the population who believe their cultural identity is respected by society • Average life satisfaction score of people with disabilities • Confidence (as measured by self-efficacy)
10 We have created a place where people want to live and work, to visit and invest	<ul style="list-style-type: none"> • Prevalence rate (% of the population who were victims of any NI Crime Survey crime) • Total spend by external visitors • % of the population who believe their cultural identity is respected by society • Nation Brands Index • A Better Jobs Index
11 We connect people and opportunities through our infrastructure	<ul style="list-style-type: none"> • Average journey time on key economic corridors • Proportion of premises with access to broadband services at speeds at or above 30Mbps • Usage of online channels to access public services • % of all journeys which are made by walking/cycling/public transport • Overall Performance Assessment (NI Water) • Gap between the number of houses we need, and the number of houses we have
12 We give our children and young people the best start in life	<ul style="list-style-type: none"> • % babies born at low birth weight • % children at appropriate stage of development in their immediate pre-school year • % schools found to be good or better • Gap between % non-FSME school leavers and % FSME school leavers achieving at Level 2 or above including English and Maths • % school leavers achieving at Level 2 or above including English and Maths • % care leavers who, aged 19, were in education, training or employment
<p><i>These Outcomes will be delivered through collaborative working across the Executive and beyond government and through the provision of high quality public services</i></p>	

Working Draft – Still subject to political agreement

Appendix 5 PfG actions relevant to building resilient healthy communities

- PHA to further develop and mainstream a “Healthier Pregnancy” programme to improve maternal and child health
- Programme of “Making Life Better” Healthier Places: projects in community settings; Community Plans to be consulted on by March 2017; further development of priority actions by March 2018
- HSC to collaborate with local government, and other community planning partners, to ensure place based approaches which scale up best practice in improving health and supporting communities are developed and embedded in each local government area.
- Healthier Lives programme for those living with long-term conditions
- Healthier Workplaces programme
- Expansion of Self Harm Intervention Programme
- Develop a programme for Making Every HSC Contact Count to improve healthy lifestyle choices with clients
- Work with local councils on a new programme for Business Start-up Support
- Provide individuals with skills to access the labour market; match those without entry level skills for work to relevant provision through local colleges, community and contracted training providers
- Develop a comprehensive Social Inclusion Wraparound Service: providing tailored interventions to support people at risk (targeting SIG customers) to access public services; it is anticipated that the service would involve: (a) identifying a range of (pre-existing) interventions and support services from across government, community and voluntary and other sectors that would potentially be effective in alleviating the worst impacts of poverty and social exclusion
- Implement new programmes to support people with physical and mental health issues to access employment
- Provide financial support and guidance for self employment, to include social enterprise business models
- Establish an Employability Forum in each council area to better match supply and demand for work, through the Community Planning process
- Implement the Active Ageing Strategy in full and continue with an emphasis on promoting benefit uptake, tackling financial abuse of older people, fuel poverty and digital inclusion
- Develop a Culture & Arts strategy to encourage greater social inclusion and cultural participation for all, and explore opportunities for sport, volunteering, culture, arts to have a stronger role in building confidence, capacity and skills; deliver a targeted programme to improve female participation in sport

- DfE and DfC to work together to improve teenage transitions from education to employment, based on evaluation of such programmes as the Community Family Support Programme and United Youth.
- Extend responsive, quality provision in early childhood education and care initiatives for families with children aged 3-4
- Develop a new homelessness strategy with a core focus on prevention and addressing chronic homelessness; make greater use of floating support funding to support vulnerable tenants in the private rented sector to maintain their tenancies; maintain advice services which prevent homelessness, including due to repossession
- Develop community based health and social services to better support homeless people who have more complex needs, including mental health issues and addictions.
- Deliver the Together: Building a United Community Strategy; support the work of the Commission on Flags, Identity, Culture and Tradition
- Deliver a programme of environmental improvement schemes, which will enhance public spaces, creating high quality, multi-use places that are in every sense shared spaces
- Develop Executive actions plans on hate crime, anti-social behaviour, early intervention, domestic and sexual violence and other community safety issues
- Early interventions with young people on the cusp of the Criminal Justice System
- Develop concept of place based approach to tackling crime which promotes collective efficacy and builds upon work of PCSPs and the local community planning process
- Pilot a substance misuse court
- Adopt and embed a coordinated and collaborative approach to the investment in and implementation of early childhood development policies and programmes to improve the social and emotional development of children aged 0-4
- Engage, empower and support parents in their role as their child's first and ongoing educator
- Extend responsive, quality provision in early childhood education and care initiatives for families with children aged 3-4 of up to 38 weeks per year.
- Improve the quality of early childhood development services by increasing the capacity of the workforce.
- Enhance Family Support Hubs
- Support schools to innovate and collaborate in focussing efforts to tackle underachievement
- Support more effective engagement with parents to help them support their children's education
- Strengthen relationships and partnership working to integrate early years health, education and community assets to meet the needs of children

- Ensure staff in front line benefit support teams are trained in identifying mental health needs and have appropriate partnership arrangements in place for referral to good quality support
- Develop an adult restorative justice strategy; support the development of further restorative justice initiatives
- Address the complexities of accommodation needs of offenders
- Establish a central regional disability forum involving people with disabilities; implement social clauses in services contracts to create opportunities for people with disabilities to secure paid employment.

9.6 Appendix 6 Existing strategies, programmes and networks

Below are current strategies, programmes or networks that can contribute to the expansion of a community development approach in addressing health inequalities

Improving and Safeguarding Social Wellbeing: A Strategy for Social Work in Northern Ireland 2012 – 2022	The Strategy sets out the agenda of action for social work and social workers in improving and safeguarding the social wellbeing of individuals, families and communities by promoting their independence, supporting their social inclusion and participation in society, empowering them to take control of their lives, and helping them to keep safe. The Strategy reflects the role of social work in early intervention and prevention as well as in more targeted and specialist services for those in need of care or protection. It includes action for promoting effective partnerships, and strengthening integrated multi-disciplinary and inter-agency working.
Learning to Learn – A Framework for Early Years Education and Learning (DE)	A high percentage of learning takes place during the early months and years of a child's life. Focuses on promoting more integrated service delivery, improving the quality of early years services, supporting parents, and engaging more directly with families - especially in areas of disadvantage.
Improving Children's Life Chances: the child poverty strategy (2011) OFMDFM	Growing up in poverty has negative impact on a child's health and wellbeing. Strategy supports the delivery of an improved childcare sector to enhance child development. Aims to: strengthen prevention and early intervention for families; improve school readiness; support disadvantaged families; ensure accessible childcare that supports child development; increase participation in youth services, sports and leisure provision; and improve family finances.
Ten Year Strategy for Children and Young People in Northern Ireland 2006 – 2016	Aims to ensure that all children and young people are fulfilling their potential; acknowledges that additional action is needed to improve the lives marginalised and disadvantaged children. Focus is on high quality universal services supported by targeted interventions where these are necessary to address development gaps – with an emphasis prevention and early intervention practice.
Healthy Futures 2010 – 2015: The Contribution of Health Visitors and School Nurses in Northern Ireland	Recognises that Health Visitors have a central role in identifying and supporting families in greatest need. Focuses on early intervention to prevent long term, behavioural, emotional and conduct disorders where Health Visitors work with the most complex and challenging families using evidence-based parenting programmes.
Families Matter: Supporting Families in NI (2009)	Focuses on early intervention and prevention to support effective parenting. A new strategy is in development.
Community Safety Strategy 2012 – 2017 (DoJ)	Sets direction for reducing crime (including hate crime), anti-social behaviour and fear of crime. Brings together government departments in addressing the wider issues linked to crime and anti-social behaviour. A major focus is on early intervention to reduce the risk of young people coming into contact with the justice system, and to help them away from offending through.

Active Ageing Strategy 2016 – 2021	As part of the “ <i>Delivering Social Change</i> ” initiative, the Active Ageing Strategy outlines the commitment to support older people to live actively to their fullest potential via the themes of: independence; participation in community life; health and social care; self-fulfillment; and dignity. Outcomes include that older people live independently for as long as they, are healthier for longer, are involved in their family & community, & participate in cultural, education & physical activity. Actions cover: warm housing, community safety, access to transport, opportunities for social participation, & lifelong learning opportunities.
Young People and Wellbeing Arts Programme	Programme developed and delivered jointly by the Arts Council and the Public Health Agency to raise awareness of mental and emotional wellbeing issues facing young people, address stigma associated with mental health and help-seeking behaviour, and build emotional resilience and promote positive mental health for young people through participation in the arts. Has a particular focus on the most disadvantaged & hard-to-reach young people.
Extended Schools & Full Service Schools policies	These policies enable schools to engage the services of delivery partners, including voluntary & community groups, in responding to the needs of pupils, parents, families & the wider community. Support is offered to schools, which draw pupils from the most disadvantaged communities, to provide extended services outside the traditional school day to enhance educational development and foster health and wellbeing of pupils and their families. Extra help is available for parents to help them improve the home learning environment.
Tackling Rural Poverty and Social Isolation Framework	Recognises that those living in rural areas often experience poverty and social isolation differently to urban dwellers due to issues relating to geographical isolation, & lower population density. Provides a broad framework within which public sector organisations and the rural sector can work collaboratively to lever additional resources & develop/pilot new ways to help alleviate the effects of poverty and social isolation in rural areas, particularly among vulnerable groups. The Interdepartmental Committee on Rural Policy oversees the implementation of the Framework.
Sport Matters: The Strategy for Sport and Physical Recreation 2009/19	The strategy contains proposals for promoting good health through training for sports clubs and supporting governing bodies of sports associations.
Working in Partnership: Community Development Strategy for Health & Wellbeing (2012 - 2017)	A community development strategy, developed by the Health & Social Care Board with the Public Health Agency, for: (i) strengthening communities & empowering people to get involved in improving their own health & wellbeing; and (ii) involving local people in the design & delivery of better services for those communities adversely affected by health inequalities. Aims to improve community development approaches across health & social care organisations. It brings an enhanced focus on early intervention & prevention of poor health & wellbeing.
Join In, Get Involved: Build a Better Future: A volunteering strategy and action plan	Aims to involve more people in volunteer action by creating the conditions for volunteering activity to flourish by: supporting and strengthening the volunteering infrastructure; enhancing access to volunteering opportunities; promoting the benefits of volunteering; and enhancing the volunteering experience.

Living with Long Term Conditions – A Policy Framework, April 2012

Outlines a general approach to developing services for adults with long term conditions. Emphasizes that that in assessing the needs of patients, it is important that their social, emotional and mental health needs are addressed as an integral part of this process. Provides a framework within which commissioners and providers - across all care sectors - can improve services and develop systems that deliver best outcomes for patients. It also outlines the contribution that self-management can make in ensuring the best outcomes for personal health.

Stopping Domestic and Sexual Violence and Abuse in NI: A Seven Year Strategy (2016)

Joint DoJ/DoH strategy which acknowledges the long-term adverse consequences of domestic and sexual violence on the victim's mental health, including the adverse impact of violence on children who witness domestic abuse. It aims to prevent domestic and sexual violence from happening – through increasing public awareness, promoting healthy relationships, changing societal tolerance of such violence, and providing early intervention for those at risk. It also aims to provide effective support to those who have been victims of domestic or sexual violence.

Neighbourhood Renewal

Cross Government programme, led by Department for Communities, for addressing the economic stresses (that are linked to poor health) experienced more acutely by people who live in deprived areas. Targets those communities experiencing the highest levels of deprivation to provide services needed to address the underlying causes of disadvantage and to improve the physical environment. Aims to help build confident communities and to improve social conditions, leading to a reduction in the differentials in health, amongst other things.

Integrated Care Partnerships (ICPs)

ICPs are local collaborative health and social care provider networks that aim to transform the system, deliver high quality integrated care, improve patient and carer experience, champion co-design and co-production, and facilitate the non HSC voice. To date, they have had a particular focus on frail older people and those with long-term conditions. They were developed in response to “Transforming Your Care”. The key themes of *Delivering Together*, particularly in terms of building capacity in primary and community care and in local communities, align well with the work of ICPs and their focus on a more joined up and coordinated approach to the use of community assets, including local community and voluntary groups. The approach seizes on the potential of multi-agency partners to deliver integrated care at scale, prioritising early intervention and prevention and enabling people to lead long, healthy and active lives with care and support provided closer to home.

Family Support Hubs

A developing network of centres providing multi-agency support for families in need of early intervention. The aim is to improve the life chances of children and young people who are living in families under pressure due to a complexity of need rooted in multiple causes and often inter-generational disadvantage. The hubs work with families in need of early intervention & help them to access the services on issues such as parenting, financial management/budgeting, lifestyle, & emotions/behaviours.

Early Intervention Transformation Programme

A cross-government programme to invest in early intervention services that improve outcomes for children and young people. Projects include: equipping all parents with the skills needed to give their child the best start in life; providing additional support for families when first problems emerge; promoting healthier pregnancy; and addressing the impact of adversity on children. Delivery partners include HSC organizations, the Education Authority, Youth Justice Agency, & voluntary/community sector bodies.

The Children's and Young People's Strategic Partnership
www.cypsp.org

A cross-sectoral / cross-government partnership led by the HSCB to promote joined-up planning and commissioning of services to improve outcomes (including those relating to mental health and emotional wellbeing) for children. It has committed to: developing an action plan for commissioning early intervention covering pre-natal to age 3; developing a framework for the evaluation of early intervention programmes; and reviewing existing strategies to consider how they can be harmonised to maximise impact on early intervention.

Sure Start

Supported by the Department of Education. Works with parents and children to promote the physical, intellectual, social and emotional development of pre-school children, particularly those who are disadvantaged.

Men's Health Forum in Ireland

The Forum works on an All-island basis to enhance the health & wellbeing of men & boys. It is a diverse network of organisations & individuals working to identify the key concerns relating to male health; increase understanding of these issues; tackle the impact of this inequality. It delivers research, advocacy, promotional events, information sharing, training, & demonstration projects. Much of its focus has been on the specific challenges to mental health & wellbeing that are faced by men.

