

# WORKING IN PARTNERSHIP

## Community Development Strategy for Health and Wellbeing

2012-2017

May 2012

# Foreword

Dear Colleague

The Health and Social Care Board together with the Public Health Agency, have agreed to bring forward a Community Development Strategy with the aim of improving community development approaches across health and social care organisations in Northern Ireland.

The Board and Agency want to see strong, resilient communities where everyone has good health and wellbeing, places where people look out for each other and have community pride in where they live. The Board and Agency seek a reduction in inequalities which means addressing the social factors which affect health and wellbeing.

The Community Development Strategy is an important way to address health and wellbeing inequalities and empower service users, families and communities to get involved in promoting their own health and wellbeing and helping to ensure the most effective use of resources.

The Board and Agency are seeking a number of benefits such as:

- helping to reduce inequalities;
- strengthening partnership working with service users, the community and voluntary sectors and other organisations;
- strengthening families and communities;
- supporting volunteering and personal development; and
- making best use of our resources.

Pre-consultation was carried out across all Health and Social Care Trust areas during 2011 at events which were attended by over 300 groups and organisations and 60 written responses were received by the end of the consultation period on 2 September 2011. We would like to thank all those who attended the pre-consultation events and those who provided written comments.

Yours sincerely



Mr John Compton  
Chief Executive  
Health and Social Care Board



Dr Eddie Rooney  
Chief Executive  
Public Health Agency

## Alternative Formats

This report can also be made available in alternative formats such as Braille, computer disk, larger print, audio tape or another language, for anyone not fluent in English. Contact the Communications Office of the Health and Social Care Board [www.hscboard.hscni.net](http://www.hscboard.hscni.net).

## Equality and Human Rights Considerations

This document has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these. Using the Equality Commission's screening criteria, no significant equality implications have been identified. The document will therefore not be subject to equality impact assessment.

Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

A copy of the Community Development Strategy, the Performance Management Framework and a summary of responses to the consultation are published as separate documents and can be viewed and downloaded from [www.hscboard.hscni.net](http://www.hscboard.hscni.net) or telephone: (028) 3741 4615.

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## 1.0 Aim

The aim of this strategy is to strengthen communities and improve health and social wellbeing by placing an increasing emphasis on community development, prevention and early intervention.

## 2.0 Purpose

The main purpose of this strategy is to recognise and support the important and pivotal role that community development plays in improving health and wellbeing. The Health and Social Care Board (HSCB) and Public Health Agency (PHA) want to see strong, resilient communities where everyone has good health and wellbeing - places where people look out for each other and have community pride in where they live.

Community development brings forward an agenda which tackles the root causes of inequalities and supports and promotes prevention. This can only be achieved in a full partnership which includes service users, carers, families, local communities, communities of interest, volunteers, and the community and voluntary sectors, as well as a range of statutory health and social care organisations such as Local Commissioning Groups (LCGs) and Health and Social Care (HSC) Trusts with a range of other public agencies.

## 3.0 Introduction

Legislation enacted on 1 April 2009 created a new commissioning system for Health and Social Care in Northern Ireland. It established the HSCB, including five LCGs and the PHA. This strategy sets out the community development commissioning priorities for the HSCB and the PHA.

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

There are about 340,000 people in Northern Ireland living in relative poverty, including 100,000 children<sup>1</sup>. Under current economic pressures, emotional and mental ill-health may increase. People who live in the most deprived areas of Northern Ireland have a life expectancy lower than the average for the region (males 4.6 years less, females 2.9 years less). Belfast is amongst the ten lowest life expectancy local authority areas in the United Kingdom at 73.9 years. (Glasgow is the lowest at 71.6 years and Kensington and Chelsea highest at 85.1 years).

(Source: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-223356> )

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<sup>1</sup> *The Office of the First Minister and Deputy First Minister Anti Poverty Strategy, Lifetime Opportunities (2007).*

## Key Statistics

A useful measure of inequalities in health is the gap in life expectancy, and disability-free life expectancy, between those living in affluent areas and those in disadvantaged areas. Some key statistics in this regard are set out below:

Office of National Statistics

Local areas with the highest and lowest male life expectancy at birth (years) 2008 - 2010

Local area	Country / Region	Life expectancy at birth
<b>Highest</b>		
Kensington and Chelsea	London	85.1
Westminster	London	83.8
East Dorset	South West	82.0
Elmbridge	South East	81.8
Crawley	South East	81.8
Hart	South East	81.7
North Dorset	South West	81.6
Epsom and Ewell	South East	81.6
East Cambridgeshire	East	81.5
Wokingham UA	South East	81.5
<b>Lowest</b>		
North Lanarkshire	Scotland	74.3
Manchester	North West	74.1
Eilean Siar	Scotland	74.0
Belfast	Northern Ireland	73.9
Dundee City	Scotland	73.9
Renfrewshire	Scotland	73.8
Blackpool UA	North West	73.6
West Dunbartonshire	Scotland	73.6
Inverclyde	Scotland	73.0
Glasgow City	Scotland	71.6

Figure 12. Life expectancy<sup>20</sup> at selected points along a Belfast Metro line (2006-08).



Source: Project Support Analysis Branch, DHSSPS

Northern Ireland is particularly vulnerable to public expenditure cuts. This was highlighted in the report 'UK Fiscal Restraint: Implications for Northern Ireland Community Organisations' Harrison and Morrissey, September 2010, which showed that there were more than 200,000 benefit claimants and that public expenditure amounting to 67% of regional income. There are more than 300,000 jobs in the public and voluntary sectors combined.

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

- a) increasing joblessness- with high levels of unemployment and inactivity likely to be around for a longer period of time.
- b) increasing levels of debt - together with the household and personal consequences.
- c) difficulties for young people, with unemployment in the 18-24 year old group at 18.6% (2009), this is the highest of any region across the UK.
- d) the impact of the recession on older people and lone parents.

Compared with the regional average, populations from deprived areas in Northern Ireland experience:

- Lower life expectancy;
- 23% higher rates of emergency admission to hospital;
- 66% higher rates of respiratory mortality; 65% higher rates of lung cancer;
- 73% higher rates of suicide;
- Double the number of self harm admissions;
- 50% higher rates of smoking related deaths;
- 120% higher rates of alcohol related deaths.

Source: (2009 Inequalities Monitoring Report, DHSSPS-  
[http://www.dhsspsni.gov.uk/inequalities\\_monitoring\\_update3.pdf](http://www.dhsspsni.gov.uk/inequalities_monitoring_update3.pdf))

The HSCB and PHA therefore need to do much more to narrow the gap in health inequalities and improve the health and wellbeing of the population in Northern Ireland. This means working to address the determinants of ill health and reducing risk factors, including those associated with poverty and social exclusion, and this can only be achieved in partnership with the community.

The Department of Health, Social Services and Public Safety (DHSSPS) have stated the following:

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

*skills, knowledge and experience, and by working in partnerships with other groups and statutory agencies' (DHSSPS 2002).*

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

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

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

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

### **3.1 Delivering the Commissioning Plan**

This strategy will be a significant way to deliver the HSCB and PHA's Joint Commissioning Plan, informing commissioning processes and practice on the ground. This approach enables local people to address their own health and social wellbeing needs and develop and improve co-operation with health and social care agencies, and others leading to better outcomes.

The HSCB and PHA see community development as a key instrument to improve health and wellbeing. It promotes health and social wellbeing and equality between different communities and helps to ensure the most effective use of the health and social care budget. The purpose of this strategy is to provide guidance and direction on how community development approaches are to be taken forward within health and social care. Commissioners therefore expect every health and social care agency to incorporate a clear and transparent community development approach into their programmes.

It is clear that health and social care organisations need to do more to narrow the gap in health inequalities and improve the health and wellbeing of the population. This means working to address the determinants of ill health and reduce risk factors, including those associated with poverty and social exclusion. The Commissioning Plan contains specific measures to address this challenging agenda, but it is equally important that health prevention and improvement is actively considered as an integral part of all of the commissioning strategies.

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

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

- how community development works;
- why community development is needed for health and wellbeing;
- The challenge faced by health and social care agencies; and
- the next steps.



The final section combines references and suggestions for further reading.

## 4.0 Definition

This strategy endorses the National Occupational Standards (2010) definition of community development as:

“enabling people to organise and work together to: identify their own needs and aspirations; take action to exert influence on the decisions which affect their lives; improve the quality of their own lives, the communities in which they live, and societies of which they are a part. It is a long term value based process which aims to address imbalances in power and bring about change founded on social justice, equality and inclusion”.

Values and principles include:

- equality and human rights;
- social justice;
- collective action;
- community empowerment;
- working and learning together;
- bringing about a sense of local ownership and control;
- tackling the root causes of inequalities, poverty and exclusion and strengthening prevention;
- strengthening the social fabric and support systems within disadvantaged communities and excluded groups;
- building the existing assets, strengths, skills and organisational capacities of groups, carers, families, volunteers and communities which creates social capital

## 5.0 The Importance of Community Development

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

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

So in a broad sense, as examples later in this document show, community development drives both the bottom-up and top down efforts. It will show that even very disadvantaged communities have abundant assets as well as needs. This ‘asset-based’ or ‘strengths-based’ approach may contrast with the tendency of official profiles of disadvantaged areas to depict them in terms of inadequacies, which can inadvertently reinforce a negative message.

Community development focuses on people - their needs and assets – and aims for better health and wellbeing. It works primarily by bringing people together in groups around a common interest or concern, strengthening the capacity of individuals and groups or bringing groups together in networks to achieve a common goal. Such groups and networks are also necessary to enable communities to form partnerships with public agencies. Chanan (2010) advises that strengthening communities and encouraging personal responsibility requires a community development approach. However, this should not be confused with the running of public services by voluntary organisations and social enterprises.

This requires skilled community development staff who typically work in the background facilitating and enabling community and group leadership. The journey from powerlessness to empowerment can go from blame and protest to confidence and partnership working. Health and social care agencies must understand and commit themselves to mainstreaming this process, and community development staff must be able to deal with tensions and dilemmas while keeping focused on the wider picture and maintaining a sense of optimism.

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

### **5.1 Key Benefits of Community Development**

The key benefits which are inherent in the community development approach are:

- it seeks to address inequalities, local needs and build capacity and skills;
- it maximises the sharing of resources at the local level, thus enhancing effectiveness and efficiency;
- it works in partnership with people, communities, and excluded groups.

### **5.2 Linking Community Development and Personal and Public Involvement (PPI)**

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

A joint PHA/HSCB PPI Strategy is being developed and actions associated with PPI are being taken forward through this avenue. PPI should not be seen as a replacement for community development within health and social care. PPI has a clear focus on quality engagement with individuals, service users, carers and the wider public in order to ensure their involvement in commissioning service design and delivery. Community development, whilst having engagement as an integral component, has a clear focus on the development of collective action within communities in order to bring about positive change. It works to ensure that communities are skilled and empowered to identify and help solve their own health needs and build social capital. It also helps health and social

care organisations and communities to understand the conditions that create inequalities in the first place and to challenge and tackle their root causes.

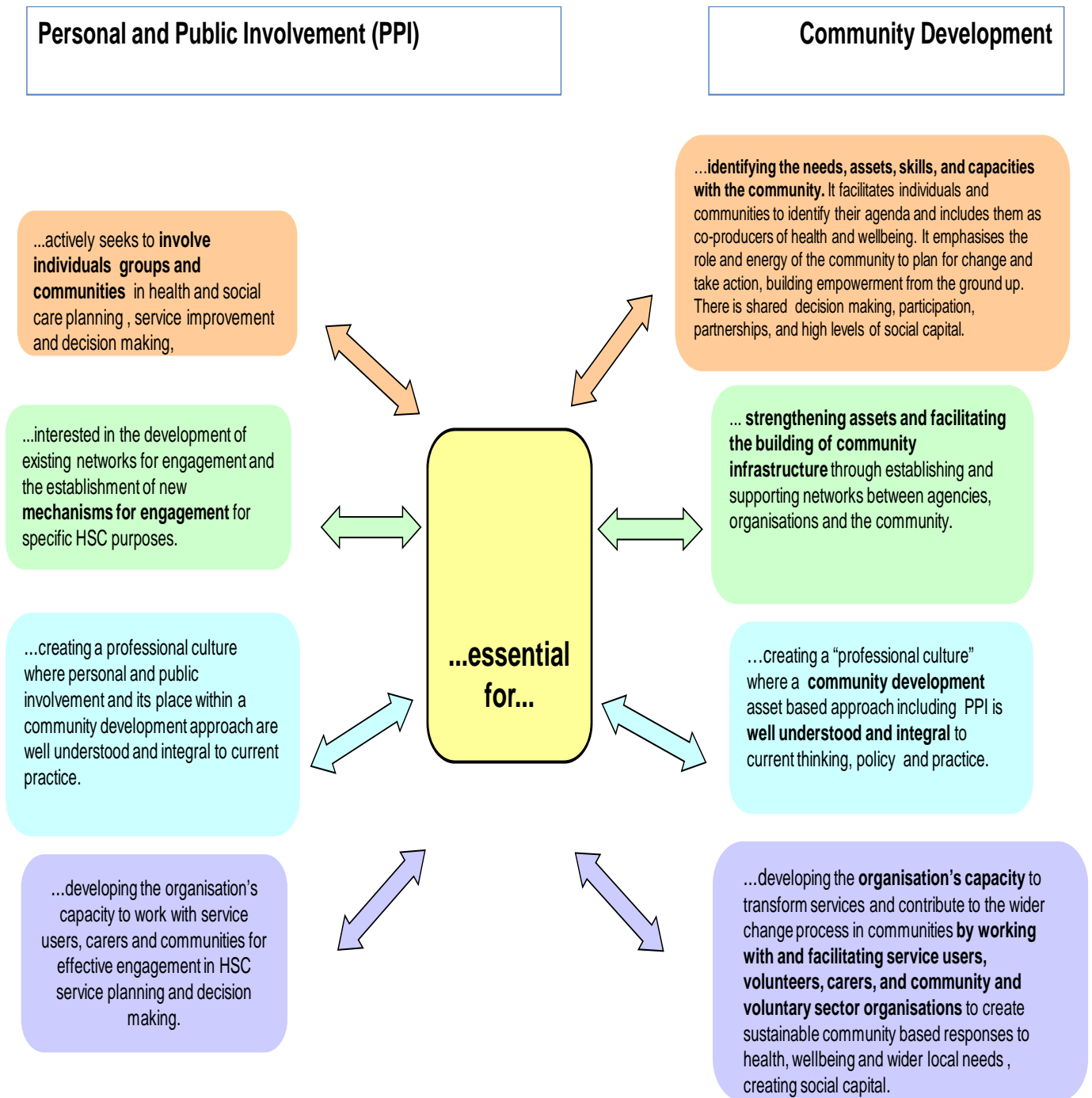
Community development recognises that improving service delivery to the poorest and most marginalised in society is not enough to create sustainable change. It is important to use community development methods to help communities and excluded groups to empower themselves and to find a place at the decision making table. (*Ledwith 2007*) (*Jones 1992*)

It is vital that PPI and Community Development approaches link well together in cross cutting themes and work in partnership to demonstrate positive change and value for money as well as avoiding potential duplication.

See Figure 1 below for a model of PPI and Community Development.

**Figure 1**

A model describing Community Development and Personal and Public Involvement.



Source: Adapted from Northern HSC Trust Community Development Strategy 2010-2015

## 6.0 Asset-Based Approaches

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

### 6.1 What is an Asset?

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

*A Glass Half Full*.<sup>2</sup>, demonstrates, how identifying and mobilising the social, cultural and material assets in communities, can help them overcome the health challenges they face. It demonstrates that when practitioners begin with a focus on what communities have (their assets) as opposed to what they do not have (their needs) a community's ability in addressing its own needs increases, as does its capacity to lever in external support.

Assets may include:

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

*(National Institute for Health and Clinical Excellence, 2009)*

According to Foot and Hopkins, the asset approach is a set of values and principles and a way of thinking about the world. It:

- identifies and makes visible the community based health-enhancing assets in a community;
- sees people and communities as the co-producers of health and wellbeing, rather than the recipients of services;
- promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment; values what works well in an area;
- identifies what has the potential to improve health and wellbeing;

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<sup>2</sup> *A Glass Half Full*:<sup>2</sup> how an asset approach can improve community health and wellbeing by Jane Foot and Trevor Hopkins, IDEA, 2010

- supports individuals' health and wellbeing through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources;
- empowers communities to control their futures and create tangible resources such as services, funds and buildings.

## 6.2 A Needs and Asset-Based Approach

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

Mini case studies are included in Appendix 1 to briefly illustrate community development practice and outcomes.

## 7.0 How Community Development Works

International evidence is clear that commissioners need to provide consistent leadership in relation to community development and that better outcomes are achieved when service users, carers, volunteers and communities are fully involved in decision making in their areas.

*(CES Evidence Review 2010) (Marmot Review 2010)*

A main key to success is in bringing forward a clear, straightforward and robust process which is focused on results.

Evidence demonstrated by the Marmot Review (2010) and others show that successful partnerships are win-win mechanisms. With better health and wellbeing comes better ability for children to learn, with better community interaction come safer communities, and front-line staff of all agencies find their jobs easier when communities take greater ownership of their issues, conditions and greater care of themselves and each other.

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

- put the empowerment of individuals and communities at the centre of action to address inequalities and promote equity by providing new ways of working;
- concentrate more on the "causes of the causes", that is invest a greater proportion of the Health Service effort in the material, social and psychosocial determinants of health and wellbeing;
- combat social exclusion and poverty;
- value resilience and support the role of local people in communities and their groups and organisations in promoting health and wellbeing through a community development approach;
- promote partnerships and collaborative intersectoral working, and co-ordinate and maximise the use of resources.

### 7.1 Working at a range of levels

There is a need to work at a range of levels: with individuals and at neighbourhood level, as well as with specific communities or groups in particular need, such as Black and Minority Ethnic Groups, Travellers, Looked After Children, Lone Parents, Homeless People, Lesbian/Gay Bisexual/Transgender Groups, Offenders, Victims and Survivors, Ex-Prisoners, Former Combatants, Victims and Survivors, Children and Young People, Older People, People with Disabilities, people with Mental Health issues and others.

Work is often undertaken with local councils on joint partnership arrangements for community development, and future community planning arrangements will be an important area for development. The community development approach guides intervention and practice to ensure the active engagement of those who are most marginalised. It is important that the HSCB and PHA support a clear position in order to shape future commissioning and planning of services. This will help to tackle some of the most challenging problems faced by communities, not just the most visible ones.

The kinds of health and social care issues which can be improved by better community activity include depression; isolation, falls amongst older people, child protection, teenage pregnancy, childhood asthma, postnatal depression, smoking cessation, drug and alcohol abuse, and ultimately also long term conditions such as obesity, diabetes and cancer. However, the effects may also be indirect. Community development produces multiple health and wellbeing benefits precisely because it fosters the interconnections of all issues affecting a community as well as building social capital. It builds bonds between individuals and communities, and this is known to be a protective factor, promoting health and wellbeing and increasing resilience. It therefore needs to be given the space to work with whatever issues emerge from dialogue with communities and excluded groups.

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



community and voluntary sector organisations. This will enable the targeting of services to be tailored to the articulated needs of specific communities and, in particular, excluded groups. In the Northern Ireland context it is important to note the legacy of the conflict, its impact on victims and survivors and support the work of the community to address identified need and promote peace building.

## 8.0 What Health and Social Care Agencies Should Do

Health and social care services currently face a challenging policy arena, within a very tight financial framework. The reform and modernisation of the commissioning process and “Transforming Your Care” – where improving health and wellbeing is a central goal – can greatly assist the goals of the Community Development Strategy: firstly, by taking a leadership role, championing community development and working collaboratively with other sectors to address the challenge; secondly, by shifting resources and commissioning to ‘upstream’ interventions, and thirdly by taking a role in creating healthy workplaces and by ensuring that the entire health and social care workforce uses every interaction with the public to promote health and wellbeing.

Service commissioners and providers should continue to strengthen and mainstream community development as a key priority by:

- working with individuals and local communities to build knowledge and skills, and release the energy of communities, carers and volunteers;
- helping to strengthen communities and enable local people to take the lead (often by statutory representatives taking a step back from positions of power);
- working in partnership with communities, service users, voluntary sector and community sector and with other public bodies to improve services;
- recognising the different needs of urban and rural communities;
- identifying the needs of the most disadvantaged individuals, families, groups and communities, recognising that very often communities are best placed to identify and support local needs.

### 8.1 The Role of HSC Trusts and Partners

In terms of commissioning, the most critical agencies in the first place will be the HSC Trusts who have been active in this field for many years and have a wealth of experience in providing community based services. HSC Trusts have developed their services in partnership with the many diverse groups, service users and communities and organisations within their respective geographical areas. The HSCB, PHA and HSC Trusts are expected to allocate a specific percentage of resources overall to community development, distributed between headings such as:

- community development support to the community sector and voluntary sector;
- appointment or deployment and support for specialist community development staff;
- training;
- supporting locality planning and partnership processes;
- supporting networks;
- contracts with organisations delivering community development;
- building assets and capacity in the community;
- grants; and



- evaluation of community development approaches.

It is recognised that sustained and appropriate levels of investment will be required in the long-term for community development to support the capacity of local communities to deliver better health and wellbeing outcomes. However, in the current financial climate, community development should be integrated within existing resources.

Community development requires specific skills and aptitudes. The HSCB, PHA and HSC Trusts should therefore appoint, train, or confirm specialist staff, but also actively promote involvement from all staff with communities. The role of the specialist staff should be both to take the lead on direct work with groups and communities and also to guide and advise other staff on how to contribute from within their particular areas of responsibility.

The HSCB, PHA and HSC Trusts are required to produce a baseline of current community development investment together with an annual Action Plan which demonstrates how they are taking forward community development approaches within their organisations, setting out progress in relation to the headings above. This should also be integrated into and reflected in other related HSC Trust action plans. In addition, the Performance Management Framework should be used on an annual basis to track progress. The Performance Management Framework is available at [www.hscboard.hscni.net](http://www.hscboard.hscni.net)

The HSCB and PHA aim to identify and encourage models of health and social care that facilitate the transfer of resources to maximise community development. As a result we should see:

- an increased focus on early intervention and prevention;
- tangible differences to health and wellbeing outcomes;
- decreasing incidence of major causes of ill health;
- maximising independent living;
- improving mental health scores of population;
- reductions in the health inequalities gap;
- support for and building sustainable communities and increased social capital; support for volunteering.

HSCB and PHA will endeavour to seek coherence between the many linked strategies such as Community Development, PPI, Patient Experience, Equality, Human Rights to maximise effectiveness and ensure that duplication and confusion are avoided.

## **9.0 Performance Management Framework**

The HSCB and PHA have a key role in developing programmes to drive this agenda forward as part of the new Public Health strategy, the Children and Young People's Plan, the PPI agenda and other key strategies. Strong performance management will be central to achieving an outcome which is positive and publicly understood, and ensures compliance with standards, statutory obligations and targets set annually by the DHSSPS. This strategy therefore includes a Performance Management Framework.

The Performance Management Framework was developed by Community Development and Health Network and Community Development Managers in 2007 to assist in measuring outcomes and to provide strategic advice and guidance at management board

level within health and social care on how to mainstream community development approaches. This ensures that empowerment, user involvement and community development are at the heart of the core business of all health and social care organisations.

### 9.1 Outcomes Framework

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

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

The Strategy and Performance Management Framework will support organisations to:

- take stock of their attitudes, aspirations, and practice in relation to community development;
- systematically develop community development approaches in all aspects of their business;
- ensure a realistic practical progress route for community development;
- measure progress on mainstreaming community development approaches; and
- incorporate community development into overall performance management arrangements.

Further details including timelines are set out in the full Performance Management Framework.

Each outcome area in the Performance Management Framework is structured to allow a three-step approach to full achievement. Within each of these three steps, a list of indicators against which to measure progress has been listed. A baseline audit against the seven key outcome areas should be completed by the relevant Director, Senior Manager and Community Development personnel within each HSC Trust. From this audit, action plans will be drawn up with each HSC Trust to ensure a measurable approach to achieving outcomes in full.

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

Steps will be taken by HSCB and PHA to seek congruence between the reporting mechanisms for community development, PPI, Patient Experience and equality in order to maximise effectiveness and reduce the reporting burden on Trusts.

The panel on the following page is a condensed version of the Performance Management Framework. The outcomes reflect what mainstreaming community development would look like in practice for staff, service users, communities and partners.

**Diagram 2:  
Condensed Version of Performance Management Framework**

<b>Stages ⇒</b>	<b>1: Slow uptake</b>	<b>2: Solid progress</b>	<b>3: Fully engaged</b>
<b>1. Leadership and corporate commitment</b>	The organisation agrees a Community Development (CD) Strategy	The organisation incorporates CD into each corporate priority	CD is integral to the way the organisation sets priorities, reviews progress and makes decisions
<b>2. User and carer involvement and community engagement in service planning, commissioning and provision</b>	The organisation has assessed community involvement and identified excluded groups, and barriers to involvement and arrangements with local voluntary and community sector organisations are being developed	The organisation sets and pursues objectives ensuring that users, carers and communities are meaningfully engaged in service planning, commissioning and provision, and reviews them regularly	There is full engagement with communities – equal partnerships, fully supported and long-term resourced – where users, carers and communities are integral to planning, commissioning and service provision
<b>3. Tackling inequalities in health and wellbeing</b>	The organisation has published up to date information on the health and wellbeing inequalities experienced by local people and communities	The organisation sets and pursues objectives and targets on health inequalities and CD approaches to health and wellbeing inequalities, analyses results and reports regularly on progress	The organisation works effectively on the root causes of health and wellbeing inequalities across local areas and partnerships, and promotes CD approaches to tackling health inequalities as an integral part of its programmes
<b>4. Workforce</b>	The organisation arranges for all staff to be trained in CD approaches to health and wellbeing	The organisation ensures that staff have ongoing support on CD in the form of practice-based learning, peer support and coaching .	The workforce includes staff highly skilled in CD, and appropriate levels of CD skills are present throughout the workforce
<b>5. Partnership</b>	The organisation seeks out and develops local and/or community based partnerships	Partner organisations incorporate action on community development into their action plans	Locality partnerships flourish. Partner organisations monitor and show their progress in promoting CD.
<b>6. Finance and procurement</b>	Financial plans, including contracts with other bodies, include investment needed to implement CD	Mainstream budgets include costs of supporting CD, voluntary and community sector partnerships and capacity of these sectors to be service providers	Appropriate funds allocated to achieve user involvement, community engagement, support for community and voluntary sector partnerships and to support capacity of the sector
<b>7. ICT</b>	The organisation arranges to ensure access to data on community development for use of staff, service users, carers and communities	High quality community development practice data is available and used to identify areas of concern and monitor progress	The organisation demonstrates joined up working between departments on meeting the information needs of staff, users and communities

**MINI CASE STUDIES**

**1. Mini case study: Community Sector Training; Child Protection and Community Development**

- Community based child protection training sponsored by the Southern Area Child Protection Committee (RCPC) managed by the Southern HSC Trust.
- Partnership approach of the Management Group drawn from the statutory, voluntary and community sectors promoting ownership of the Project.
- Engagement of community and service users, church groups, bands, early years groups, youth clubs. Close liaison with groups to meet their needs.
- A flexible community based approach across the Southern HSC Trust area, using community based trainers.

**Outcomes:**

- Delivered training to more than 6,000 people in 8 years.
- Independent evaluation found that; Community Sector Training has made a very significant contribution in terms of building capacity with local communities and communities of interest across its area.
- 80% of groups have made substantial changes improving practice and procedures as a result of the training.
- People felt more confident about child protection issues and about approaching social workers with any concerns; Strengthening groups in their community activity by building knowledge and skills.
- Enabling communities to provide safer environments in their work with children.
- Raising awareness in the community of Family Support Services for children in need.

**2. Mini case study: Rural Priority Areas Project / Warm Zone Pilots and Community Development**

Western Investing for Health and Health Action Zone (now Public Health Agency) developed a model in which vulnerable households are identified by the local community, contacted by trusted people and signposted to key services/grants, supported by trained enablers in the community. **Outcomes:**

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

3. *Mini case study: Southern Area Action with Travellers Multisectoral Partnership and Social Inclusion, a Community Development Approach:*

**Outcomes:**

- Travellers residing in HSC Trust area; 1,200 or 200 families.
- School attendance increased from 45% to 70%.
- GP registration from 46% to 100%.
- Health Visitor registration from 92% to 100%.
- Immunisation rates increased from 45% to 100%.
- Pre-school attendance from 0% to 70%.
- After school attendance increased from 25 to 45%.
- Youth club attendance increased to from 10 to-50%.

4. *Mini case study: The Pathways Project Belfast: Community Development and Emotional Wellbeing*

The Belfast Trust Community Psychiatric Service identified increasing numbers of former combatants/ex paramilitaries living in Greater East Belfast referred by their GP to mental health services. Reasons for referral included depression, anxiety, social isolation, drug and alcohol abuse, self-harm, suicide attempts, and seeking mental health advice. A series of meetings organised by the Community Development Unit with a wide variety of ex prisoner groups and organisations who work with ex prisoners/combatants revealed a number of issues:

- Inappropriate referrals to mental health services were often due to lack of support systems within the community.
- Confidentiality was a problem for some who preferred to access community led/voluntary ex prisoners organisations.
- Anonymity was also important to some who preferred to access services on the other side of town

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

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

**Outcomes:**

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

5. *Mini case study:* **Children and Young People's Locality Partnership and Community Development**

- Involving communities in the planning of services is one of the foundations of the Northern Ireland Children's Services Plan. Locality partnerships with membership from the statutory, voluntary and community sector organisations have been and are being developed across Northern Ireland. They monitor and aim to improve the six high level outcomes for children as set out in the Office of the First Minister and Deputy First Minister's 10 year strategy for children.
- The Larne Children's Locality Partnership has been developing 'local solutions to local need'. The partnership's mission statement highlights the key role the local community plays in the drive to improve outcomes for children and young people:

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

**Outcomes:**

- People have been listened to find out their views and needs.
- Existing social partnerships have been built on,
- Stronger community ownership has been developed,
- A needs-led range of leisure, social, health, educational and housing services in locally agreed and accessible locations is being provided."

6. *Mini case study:* **User Engagement and Personal and Public Involvement**

The Community Development Unit of the legacy Western Health and Social Services Board developed a strong partnership arrangement with community and voluntary sector networks in each council area. The networks were engaged on a contractual basis to advise on and facilitate community engagement, using surveys, public meetings and focus groups. There were over 2,000 organisations on the networks' databases. Service users and the wider public often preferred to talk to network members rather than officials. Findings were shared with those who had contributed.

**Outcomes:**

- Significantly increased levels of user involvement and engagement with the wider community.
- A sense of genuine partnership working with community and voluntary sector and service users.
- Improved understanding by health and social care staff and managers of the needs of people.
- More tailored and targeted services.
- Partnership in policies and service developments.
- Other statutory bodies recognised the value of this approach.



### 7. Mini case study: **Social Economy**

The South Eastern HSC Trust works with both the Colin Neighbourhood Renewal Partnership and the Kilcooley Neighbourhood Renewal Partnership to develop new social economy initiatives. This builds on the partnership between the Colin Partnership and the HSC Trust in developing Colin Care - a social enterprise company, owned by the Colin Partnership, delivering domiciliary care across Lisburn and Belfast.

#### **Outcomes:**

This scheme now employs 30 members of staff, most of whom were long term unemployed people from the Colin area.

### 8. Mini case study: **The Building the Community-Pharmacy Partnership Programme**

This is a partnership initiative developed by the Community Development and Health Network (CDHN) and the Pharmaceutical Branch of the Department of Health, Social Services and Public Safety (DHSSPS).

#### **Outcomes:**

The programme is delivered through a partnership approach between local communities and community pharmacists addressing local health needs using a community development approach.

It aims to establish stronger partnerships between local communities and community pharmacists and to address local health needs using a community development approach. One such example is the ARC Healthy Living Centre in Irvinestown which aims to improve the wellbeing of local people by bringing together a partnership of community health activities and services. The Healthy Living Centre delivers a range of services to address this aim over eight rural wards in Fermanagh, with high levels of deprivation and poor access to a range of services.

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

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

9. Mini case study: **Empowering Travellers in Health and Wellbeing**

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

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

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

**Outcomes:**

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

#### 10. Mini case study: **Reform of Northern Ireland Wheelchair Service**

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

##### **Aim**

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

##### **Objectives**

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

##### **Outcomes:**

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

The Project Manager had formal and informal discussions with individual wheelchair users and groups of wheelchair users in order to learn from their experiences. Focus group discussions were found to be most helpful as they inspired confidence in participants as they expressed their views. The synergy developed in these discussions culminated in the recommendations for the reform of the Wheelchair Service. The involvement of service users working alongside professionals and managers from the beginning of this project was vital to its success.

#### 11. Mini case study: **Newry Neighbourhood Renewal project - Emotional Overeating**

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

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

## 11. (Continued)

The planning group met to develop a 12-week pilot self-esteem course that would examine many aspects of emotional overeating with a view to providing skills and tools to break this cycle. The planning group have discussed the possibility of setting up an Emotional Overeating Group.

### **Outcomes:**

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

## 12. *Mini case study:* **East Belfast Men's Health Clinic**

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

Most of the men presenting are targeted via their GPs. The service targets men over 35 years who have not been seen by their GP in the last two years. Men can also access the service by asking for an appointment. A follow up phone call is made to each of the men several days prior the appointment to allay any concerns.

The clinic is staffed by two nurses from the HSC Trust and two local male volunteers from the Healthy Living Centre and it operates on an appointment system. Male volunteers meet and greet men as they arrive offering refreshments, and volunteers are trained to provide opportunistic health promotion and a sign posting service to local health programmes and activities.

### **Outcomes:**

- Men are offered a half hour appointment, which includes screening and an opportunity to discuss general health and wellbeing, including mental health. Assessment results are sent onto the GPs informing them of any concerns or advice given.
- The clinic has proved very popular. Feedback from users and staff has been very positive. A number of men have been referred on to other services and several are receiving smoking cessation support.

### 13. *Mini case study:* **Co-operation and Working Together (CAWT) Adopting Community Development on a Cross Border basis**

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

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

#### **Management and Prevention of Obesity**

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

#### **Outcomes:**

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

### 14. *Mini case study:* **Multi-level Alcohol Harm Reduction**

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

#### **Outcomes:**

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

#### 15. *Mini case study: Dove Gardens, Derry – ‘Heaven’*

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

##### **Outcomes:**

"Heaven" - That's how a resident summed up her new home in Dove Gardens in Derry. Born and reared in the Bogside estate, she lived elsewhere for five years while it was demolished and completely rebuilt. She was among the first families to move back in - just in time for Christmas. "My family were one of the first to move into Dove Gardens, and it has a lot of memories for me. One of the best-known estates in the city, it was a state-of-the-art development when it was built in the 1960's, but by the 1990's had become run-down and was notorious for anti-social behaviour. There was drinking on the steps, there was drugs, and they were torturing the old people. It was no place to bring up children. Things came to a head when the block of flats I lived in got burnt down. We were lucky to get out alive. We knew then it was time for the flats to go. To see the sitting room I'm in now, and the kitchen, and to have a garden it's lovely getting up in the morning and knowing this is your house."

#### 16. *Mini case study: Healthy Living Centres*

In Belfast, the Western area and the South Eastern area, the PHA commissions a number of Healthy Living Centres (HLCs). HLCs are community-led initiatives delivering health and wellbeing programmes on a range of issues such as drugs and alcohol, physical activity, mental wellbeing, obesity and smoking cessation in disadvantaged areas. HLCs are concerned with supporting communities, which are experiencing disadvantage and poor health outcomes, to identify and define their own health needs and how they can best be addressed. The community-led approach recognises the many and complex factors that affect people's health. It is based on values and principles, such as partnership working, empowerment and participation.

##### **Outcomes:**

- Delivery of innovative approaches to health improvement including high level strategies implemented at neighbourhood level;
- The adoption of a social or community-led model of health and self-help focusing on the underlying social and economic determinants of health;
- The use of a community-led approach to health improvement, in the context of community development, which involves a process of social change in situations of disadvantage and social injustice;
- Flexibility to respond to challenging issues;
- Acting as a key link, or bridge, between the health services and disadvantaged communities, and having close links to mainstream service provision.



## National and International Examples

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

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

#### Outcomes:

- Post-natal depression down by 70%;
- Number of children on child protection register down 60%;
- Overall crime rate down by 50%;
- Childhood asthma rates down by 50%;
- Residents' fuel bills cut by a total of £180,000 per annum.;
- Unemployment rate down by 71%;
- Education: 10/11 year old boys' SATS scores improved 100%, girls SATs 25%.

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

### 2. Entre Nous Femmes, Vancouver, Canada

Founded by lone parent women, this project in Vancouver Canada is an example of women in shared personal circumstances deciding to act collectively.

#### Outcomes:

It created safe and affordable housing in the area for families getting them out of poverty. The project developed seven group housing initiatives for 253 people demonstrating a remarkable integration of learning, empowerment, and social action. The project has developed partnerships and networks with many agencies and community initiatives during the past ten years.

### **3. Residents Making a Difference – Whitehorse, Melbourne Australia**

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

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

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

#### **Outcomes:**

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



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# Glossary

## **Community**

“Community” is the web of personal relationships, groups, networks, traditions and patterns of behaviour that exist amongst those who share physical neighborhoods, socio-economic conditions or common understandings and interests. Community tends to exist in three broad categories: locality or territory; a shared experience or interest group such as Black Minority Ethnic groups; and a group composed of people sharing a common condition or problem such as drug and alcohol dependency or cancer.

## **Community Activists**

People who are active on a voluntary basis in the development of their communities.

## **Community Capacity Building**

This supports individuals, groups and organisations to enable them to play a part in the regeneration of communities. It is about building skills and competencies and is increasingly being used amongst policy makers and managers to increase their understanding of communities.

## **Community Development Learning**

This takes place when individuals and groups/organisations come together to share experience, learn from each other, and develop their skills, knowledge and self-confidence. It is a developmental process that is both a collective and individual experience, based on a commitment to equal partnership between all those involved to enable a sharing of skills, awareness, knowledge, and experience in order to bring about sustainable desired outcomes. (Federation of Community Development Learning)  
[www.fcdl.org.uk](http://www.fcdl.org.uk)

## **Community Development Workers**

These people undertake Community Development as their main role. They work in accordance with recognised occupational standards. They may focus on specific issues with communities, e.g. health and wellbeing, and/ or have a neighbourhood brief.

## **Community Involvement has two components:**

1. involvement in community activities in a variety of different ways. Community involvement often starts with agendas and programmes that originate outside the community, for example with Statutory agencies.
2. enabling people to become active partners in the regeneration of communities by contributing and sharing in the decisions that affect their lives. Participation should enable people to have a strong degree of power and control in the processes with which they are involved.

## **Community Networks and Hubs**

Independent community led organisations with multi-purpose functions, which provide a focal point for local communities and community organisations, and for community services. They often own and manage community assets, and support small community organisations to reach out across the community.

## **Community Sector Organisations**

These are also located within communities of geography or interest. They are formally constituted, controlled by their users and can have a small number of paid staff and volunteers. They are often referred to collectively as the community sector. In N Ireland the Community sector has grown over the years due to a relatively supportive funding environment.

## **Social Exclusion**

The government has defined social exclusion as "a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown." This is a deliberately flexible definition and the problems listed are only examples. The most important characteristic of social exclusion is that these problems are linked and mutually reinforcing, and can combine to create a complex and fast moving vicious cycle. The term includes poverty and low income, but is broader and addresses some of the wider causes and consequences of poverty.

## **Social Justice**

Enabling people to claim their human rights, meet their needs, and have greater control over the decision-making processes which affect their lives.

## **Stakeholders**

Groups and organisations with an interest (stake) in what happens with a project, programme or development.

## **Voluntary Sector**

Organisations whose activities are carried out other than for profit and on a wider geographical area, but which are not public or local authorities. These organisations would normally be formally constituted and employ paid professional and administrative staff. They may or may not use volunteer help.