Expansion of Community Development Approaches – Summary

Full report can be found at pha.site/cdreport

Health and wellbeing 2026: Delivering Together

Health Inequalities

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

Gap: 141%

170 Per 100,000 population

Most Deprived

Least Deprived

Health inequality: 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 above starkly demonstrates, there is a social gradient in health – the lower a person's social position, the more likely his or her health will be worse. 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.

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 Travellers' life expectancy is 61.7 years – fifteen years less than the general population.

Focusing solely on the most disadvantaged 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 therefore requires co-ordinated action across government, health and social care, and a range of partners across community, voluntary and independent sectors.

Responses to the problem

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) which 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 the full report and this summary) 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.

The full report (available at: pha.site/cdreport) charts the progress of this initiative and presents a draft implementation plan for how this work should be taken forward.

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.

The Potential of Community Development

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.

Challenging unequal power relationships and promoting equality are central tenets of community development, as defined by the UK 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.

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. 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.

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	
Anti-discrimination	Challenge unequal power relationships	**Inclusivity**		
Social justice and equality	Promote social justice, equality and inclusion	**Influence**	Fairer distribution of power, wealth and resources	**Improved health**

Outcomes arising from community development principles

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.

The approach of the Work Stream

The Public Health Agency brought the members of the Community Development Work Stream together early in 2017. It is comprised of volunteers from various sectors (who are named at the end of this document).

The Work Stream approached their task by

• Scoping current Community Development (CD) practice through desk research

• Exploring the state of CD practice, existing supports and the critical success factors or enablers for CD through consultation with practitioners

• Devising and taking feedback from practitioners on a draft outcomes framework for CD

• Analysing the results and arriving at proposals for an action plan, or Framework, for expanding the contribution of CD to the transformation of health in Northern Ireland

The team held 12 consultations, across all local authorities in Northern Ireland, during the second half of 2017. This initial consultation process involved over 400 people. Their feedback shaped the draft report which the Work Stream presented to a symposium held in February 2018. Further comments taken from the participants in the symposium were reflected in the final report (available at extracts from which are the basis of this document.

Future plans

The Work Stream proposes a three phased approach across ten years:

• **Phase 1 – (up to 2020):** develop the framework through further research and consultation; strengthen access to good practice 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.   The implementation plan for the Community Development Framework has been created in detail for Year One: 2018 – 2019, and is set out below

- **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 training modules; validate an established community development register of approaches and their application; apply quality standards.

More detailed recommendations for Year One: 2018-2020

The focus for this initial period is on establishing the infrastructure and enabling the development of more detailed plans for future years. The priorities, based on the consultation and research into the sector, are to embed the outcomes framework, builds capacity and establish governance arrangements.

The stages and activities for Year One 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, and the development of Healthy Places, Community Plan 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 building the 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 reserves 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

Acknowledgments

The HSC Transformation Community Development Work Stream would like to thank all of those who have contributed to shaping this Framework through the engagement process. Particular thanks are due to individual team members for leading areas of work. Team members already carry demanding workloads; making a contribution, particularly by those outside of the health and social care system, is admirable. Special thanks are also due to Brenda Kent from Community Evaluation Northern Ireland, who worked closely with the team in order to develop an outcomes framework, (something which we believe will be of enormous value to the sector), and to Anne McMurray, who has facilitated, stimulated and provoked in order to progress the task.

TIG Community Development Work Stream Team

Mary Black (Chairperson), Public Health Agency

Fionnuala McAndrew, Health and Social Care Board

Joe Brogan, Health and Social Care Board

Dr Grainne Bonnar, Integrated Care Partnership

Dr Ian Kernohan, Integrated Care Partnership

Eleanor Ross, Public Health Agency

Brendan Whittle, South Eastern Health and Social Care Trust

Karen Meehan, Western Health and Social Care Trust

Gerard Collins, Department of Health

Joanne Morgan, Community Development and Health Network

Paul Braithwaite, Building Change Trust, Community Foundation for Northern Ireland

Seamus McAleavey, Northern Ireland Council for Voluntary Action

Tony Doherty, Health Living Centre Alliance

Diane McIntyre, Public Health Agency

We also had support from two important 'critical friends', Avila Kilmurray and Jackie Redpath. I am grateful for their wisdom and expertise. Northern Ireland is much the better for their vision and years of dedication to communities.

Mrs Mary Black CBE
Assistant Director Public Health
Health and Social Wellbeing Improvement

DoH
www.health-nl.gov.uk

HSC Health and Social Care