Document Pack

Democratic Services Section
Chief Executive's Department
Belfast City Council
City Hall
Belfast
BT1 5GS

18th August, 2011

MEETING OF DEVELOPMENT COMMITTEE

Dear Alderman / Councillor,

The above-named Committee will meet in the Lavery Room (Room G05), City Hall on Tuesday, 23rd August, 2011 at 5.15 pm, for the transaction of the business noted below.

You are requested to attend.

Yours faithfully

PETER McNANEY

Chief Executive

AGENDA:

1. Routine Matters
   (a) Apologies
2. Requests for Deputations
3. Presentation from Forum for Alternative Belfast
4. Translink Metro Service - Update (Pages 1 - 4)
5. Rapid Transit - Study Visit to Nantes (Pages 5 - 6)
6. Support for Independent Traders (Pages 7 - 10)
7. Tall Ships Event 2015 (Pages 11 - 34)
8. Christmas Lights Switch-on 2011 (Pages 35 - 36)
9. B-Team (Pages 37 - 48)
10. Belfast International Airport - Consultative Forum (Pages 49 - 52)

11. Cities of the Isles (Pages 53 - 54)

12. Health and Social Care Board and Public Health Agency - Consultation 1 (Pages 55 - 90)

13. Health and Social Care Board - Consultation 2 (Pages 91 - 116)

14. Play Clubs (Pages 117 - 124)

15. Membership of Community Centre Committees - Update (Pages 125 - 128)

Agenda Item 4

Belfast City Council

Report to:	Development Committee
Subject:	Changes to the Translink Metro Service
Date:	23 August 2011
Reporting Officer:	John McGrillen, Director of Development, ext 3470
Contact Officer:	Shirley McCay, Head of Economic Initiatives, ext 3459

1	**Relevant Background Information**
1.1	Sustainable Transport Enabling Measures (STEM) is part of the overall 'Belfast on the Move' short term transport proposals for Belfast City Centre being developed by the Department for Regional Development (DRD). The main aim of the STEM proposals is to reorganise traffic management within Belfast City centre to facilitate walking, cycling and public transport use.
1.2	Work is commencing as part of the joint initiatives comprising the first phase of 'Belfast on the Move' transport and new traffic arrangements associated with the Department for Social Development's (DSD) Streets Ahead Public Realm scheme for Donegall Place and the surrounding streets. Alongside the physical works there are a number of changes being implemented to the Translink metro services in the City Centre.

2	**Key Issues**
2.1	The Translink Metro Services changes will come into effect from the 1 September 2011 in line with the completion of the first phase of the Sustainable Transport Enabling Measures (STEM).
2.2	The first phase of 'Belfast On The Move' work is underway and will be completed shortly. This phase involves the installation of new traffic lights, extension to bus lay bys and new bus shelters on Castle Street/Queen Street/Upper Queen Street.
2.3	The main changes to the Translink Metro service linked to the physical works are: – Relocation of bus services from Donegall Square West to Upper Queen Street (Metro 1 & 2 and the City Express) with Upper Queen Street becoming two-way for buses – Changes to bus service routing using Queen Street and Castle Street

	– Provision of a coach 'drop off and pick up' bay at Donegall Square West – The relocation of tour bus parking from Castle Place to High Street – A number of Metro bus terminal points within the city centre will be relocated, full details of the City Centre terminal changes are outlined in Appendix 1.
2.4	Whilst the first phase of the changes are noted it may be appropriate to reiterate a number of issues: – The effective enforcement of moving traffic offences as an essential support to the increased provision of bus lanes throughout the city to the full benefit of the measures being proposed. Consideration could be given to commence the transfer of powers from PSNI to DRD in relation to Moving Traffic Offences. – Clarification is sought on the ability and capacity to ensure enforcement of restrictions on those using the new coach 'drop off and pick up' bay on Donegall Square West. Whilst it is proposed that the bay will only allow 20 minute duration for coaches to stop, drop off or pick up passengers there are concerns that the limited provision could be ineffective if restrictions on visiting coaches are not enforced.
2.5	Translink are also proposing to make timetable adjustments from 1 September 2011 to ensure service provision takes account of the available resources under the DRD allocation. They are currently examining the network to assess where savings can be made. It should also be noted that Translink have committed to capping the fares at current levels for the next year.

3	**Equality and Good Relations Considerations**
3.1	A draft Equality Impact Assessment on the proposals is currently being carried out.

4	**Recommendations**
4.1	Members note the contents of the report

5	**Decision Tracking**
There is no specific Decision Tracking attached to this report.	

6	**Key to Abbreviations**
DRD – Department for Regional Development DSD – Department of Social Development STEM – Sustainable Transport Enabling Measures PSNI – Police Service of Northern Ireland	

7	**Documents Attached**
Appendix 1 – Translink info	

Changes at a glance

SERVICE	CURRENT LOCATION	NEW LOCATION	MAP REF	OTHER CHANGES TO ROUTE (NEXT STOPS)
1,2,13,14	D'gall Sq West	Upper Queen St	1,2,F	via Queens St & Castle St to Royal Ave
61	Wellington Pl	Queen St (Athletic Stores)	B	via Castle St, Castle Place, High St & Dunbar Link
64	D'gall Sq West	Queen St (Athletic Stores)	B	via Castle St, Castle Place, High St, Dunbar Link & Corporation St
12	Wellington Pl	D'gall Sq North	12	
96	D'gall Sq West	Upper Queen St	F	via Castle St, Castle Place, High St & Dunbar Link
11,57	Wellington Pl	Chichester St (Arthur St)	11	
80	Upper Queen St	Queen St	A	via Castle St, College Ave, College Sq North & Durham St
81	Upper Queen St	Queen St	A	via Castle St, College Ave, College Sq North & Durham St
10A,10H	Queen St	Queen St (one stop up)	10*	
10B,10C, 10D,10F, 10X[1]	Queen St	Queen St (one stop up)	10	
4,20,23	D'gall Sq West (City Hall side)	D'gall Sq West (Centra Shop)	4	
18,19	D'gall Sq West (City Hall side)	D'gall Sq West (Northern Bank)	5	
3,27,28	D'gall Sq West (City Hall side)	D'gall Sq West (Metro Kiosk)	3	
5,31	D'gall Sq North	D'gall Sq West (Northern Bank)	5	
6	Chichester St (Arthur St)	Chichester St (Malcolm's Jewellers)	6	
26	D'gall Sq West	Wellington Pl	D	
77,78,79	Chichester St	Wellington Pl	C	77 via D'gall Sq East & Adelaide St (no changes to 78,79)
East/Northside P&R	Chichester St	Chichester St (Victoria Centre)	I	
Airport Exp 600 (GBBCA)	Europa Buscentre (via Chichester St)	Europa Buscentre (via Wellington Pl)	D (city centre pickup)	Additional pick up points: Wellington Pl and Chichester St

[1]New 10X service replaces 214 and extends to Lagmore via Black's Road & Poleglass; this will be operated as a Metro service

Important changes to Metro Bus stops and services in Belfast City Centre from 1st September

New road traffic arrangements are being introduced to reduce general traffic levels in Belfast City Centre

Because of these changes some Metro bus stops, routes and services will be altered. Changes to stops and services are listed on the reverse of this leaflet. Inside you will find a city centre departure map showing service departure points and their locations.

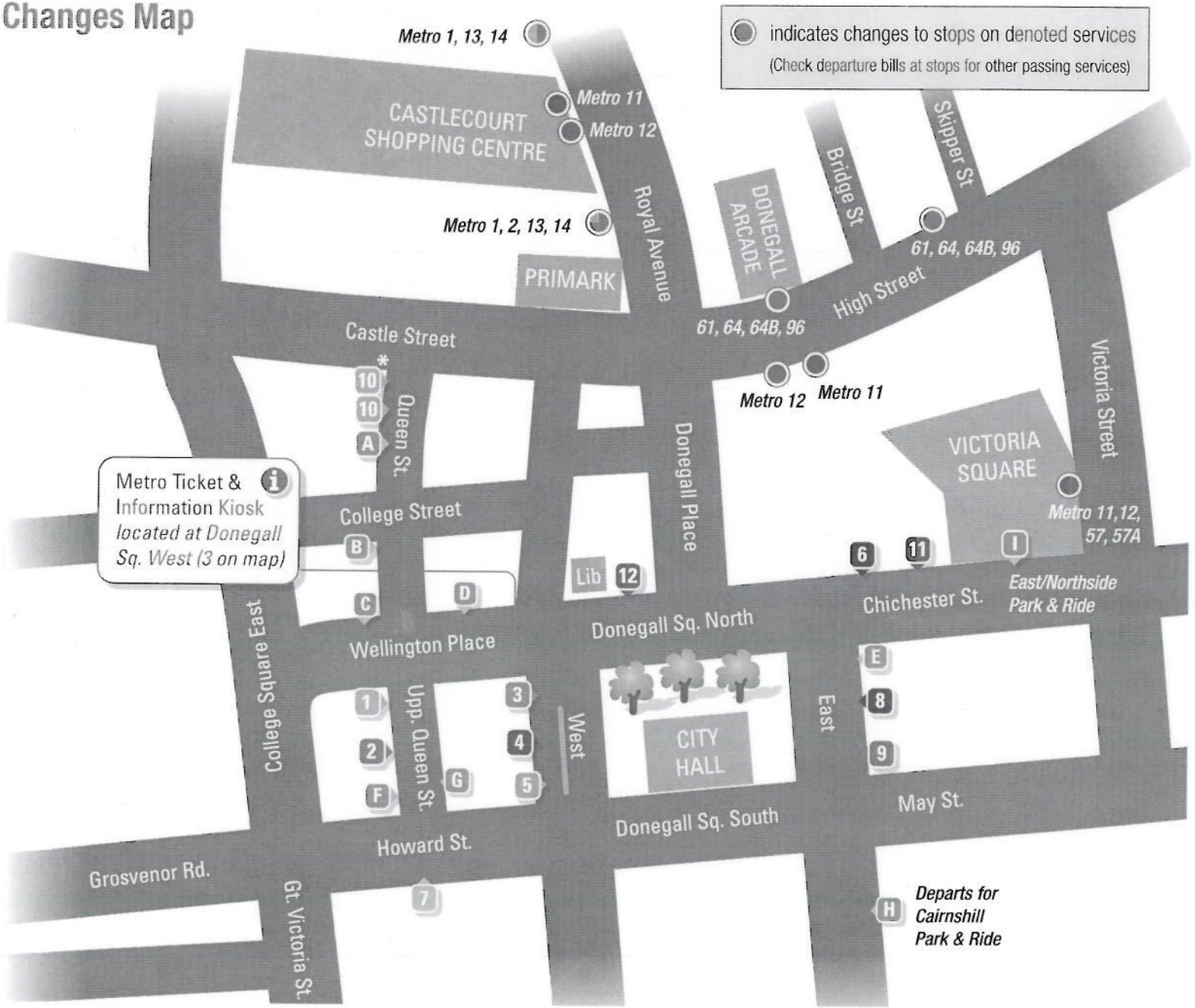
For additional information or queries about these changes please visit us online at www.translink.co.uk or call the Contact Centre on 028 90 66 66 30

For a copy of this leaflet in large print, Braille or audio tape please call Translink Contact Centre on 028 90 66 66 30

let's go together
translink.co.uk

Translink Metro

Changes Map



Main Metro Corridors

1. **Antrim Road**
2. **Shore Road**
3. **Holywood Road**
   Also: 27, 28
4. **Upper N'ards Rd**
   Also: 20, 20A, 23
5. **Castlereagh Road**
   Also: 18, 19, 31
6. **Cregagh Road**
7. **Ormeau Road**
   Also: 29, 29C, 30
8. **Malone Road**
   Also: 93
9. **Lisburn Road**
10. **Falls Road**
    Also: 10A*, 10H*, 82, 82A, 104, 506, 532, 536
11. **Shankill Road**
    Also: 57, 57A
12. **Oldpark Road**

Other Services

- A 80, 80A, 81
- B 61, 64, 64B
- C 77, 78, 79
- D 26, 26A, 26B, 26C, 600
- E 89, 90, 91, 92, 95
- F 13, 13A, 13B, 14, 14A, 14B, 96
- G 523, 524, 525, 527, 528, 529, 530, 531, 538, 551, 572
- H Cairnshill Park & Ride
- I East/Northside Park & Ride, 600

Agenda Item 5

Belfast City Council

Report to:	Development Committee
Subject:	Rapid Transit Study Visit to Nantes
Date:	23 August 2011
Reporting Officer:	John McGrillen, Director of Development, Ext 3470
Contact Officer:	John McGrillen, Director of Development, Ext 3470

	Relevant Background Information
	Bus Rapid Transit is proposed by the Department for Regional Development (DRD) as the preferred option for the rapid transit system in Belfast. In 2007, DRD commissioned transport consultants to undertake a feasibility study looking at possible routes and technologies for rapid transit in Belfast. The study concluded that a bus based rapid transit system is the viable option for Belfast rather than light rail technology. In addition the study identified a pilot network of three routes connecting East Belfast, West Belfast and Titanic Quarter with and through the city centre.

	Key Issues
	The Minister for Regional Development will be undertaking a study visit to Nantes, France on 21-22 September 2011 to look at the Bus Rapid Transit system which operates within the city. Nantes is recognised as demonstrating best practice for rapid transit systems in Europe and will act as a benchmark for the Belfast Rapid Transit System. The Minister is keen to have the support of the Council for the Belfast Rapid Transit project and to work closely with the Council as it develops. As a result the Minister would like representatives from the City Council to accompany him on his visit to Nantes.

	Resource Implications
	The final cost will depend on the total number of delegates, however it is anticipated that the cost of Council's participation in the visit would not exceed £2000.

	Equality Implications
	There are no equality issues associated with this request.

	Recommendations
	It is recommended that the Chair and Deputy Chairman, or their nominees, join the delegation along with the Director of Development and/or his nominee.

	Decision Tracking
	The Director will make the appropriate arrangements based upon the Committee's decision.

Agenda Item 6

Belfast City Council

Report to:	Development Committee
Subject:	Support for Independent Traders – Proposed Approach
Date:	23 August 2011
Reporting Officer:	John McGrillen, Director of Development, ext 3470
Contact Officer:	Shirley McCay, Head of Economic Initiatives, ext 3459

1	**Relevant Background Information**
1.1	Members will be aware that, at the 15 June meeting of the Development Committee, a range of economic and business growth measures was endorsed. This covered – among other themes – support for sectoral initiatives, including activities to support the independent retail sector in the city.
1.2	Since that endorsement, some preliminary discussions and preparatory work have been undertaken with a range of trader groups to clarify their needs and to develop a proposal to support the groups, according to their stage of development, their specific requirements and their capacity to deliver and collaborate with other partners.

2	**Key Issues**
2.1	The retail sector, and in particular the independent retailers, are under considerable pressure in the current economic climate. Retailers have been trying to develop a range of initiatives to increase footfall and spend in their areas and have, increasingly, been working collaboratively under the guise of traders' forums to carry out this work.
2.2	At the 15 June 2011 Development Committee, a budget of up to £200,000 was committed to promote the development of the sector through a range of activities including trader group development, local area campaigns, Retail Therapy business development programme, market start up programme and Independent Retail week (proposed to take place in March 2012).
2.3	Under previous retail initiatives, support has been provided to help traders' groups become constituted; to assist them in prioritising areas requiring collaborative support and to deliver some initial activity aligned to this support.
2.4	Support has also been provided to a number of existing trader groups including Lisburn Road Business Association; East Belfast Traders (incorporating Ballyhackamore, Belmont Road and Bloomfield Avenue), West Belfast Traders' Association and the Shankill Road Business Association. This support was provided on the basis that groups were incorporated, had a management structure in place and were committed to a programme of activities to market and promote the areas.

2.5	The Retail Therapy programme has now helped 90 independent traders across the city and is currently open to recruitment for up to 30 participants – the deadline for this programme is 16 September. Retail Therapy focuses on helping individual traders grow their business. It does this through a mystery shop process, after which a tailored development plan is put in place and a small grant element is provided to allow the trader to implement to issues identified as part of the improvement process.
2.6	With regard to retail support activities in the 11/12 financial year, it is proposed that support be provided as follows:
2.7	<u>Trader group development support</u> Some initial discussions have taken place with a range of new and fledgling traders groups, all of which are at varying stages of development. These include the Antrim Road Business Group, Lower Lisburn Road Traders, Ormeau Road Traders and Bloomfield Road traders.
2.8	It is proposed that work should continue in helping these and other groups link into existing support; identify their priorities for action to address the challenges and help deliver on these. It will be important for the groups to consider becoming constituted if they are to draw down resources or to consider a management structure which might allow them to access and manage funding.
2.9	It is proposed that some seed funding should be made available to work on issues such as collaborative promotion and marketing campaigns, events to increase footfall and customer loyalty initiatives. Experience suggests that the traders may also be concerned with a wider range of issues such as business rates; street cleansing; car parking and environmental improvements. Whilst we can advise on these issues and advocate on their behalf to relevant agencies, through local elected representatives, it is suggested that the focus of this particular support should remain on those marketing-related issues identified above.
2.10	Given that these groups are either newly-formed or in the process of being established, it is proposed that funding of up to £3,000 per group maximum be made available for eligible expenditure. The support will be provided against a range of pre-arranged eligible activities and should be incurred in the current financial year.
2.11	While a number of groups have made contact directly with officers, members are asked to consider additional groups and areas that may benefit from this type of support. We will engage with a range of new trader groups using a budget of up to £25,000.
2.12	<u>Area campaigns</u> Under the previous retail support plan, provision had been made for local campaigns to enhance the profile of designated shopping areas through a range of targeted support initiatives. This enabled groups to undertake activities such as producing local trader maps and business directories, creating a website for promotion and online trading and organising local events to increase footfall and trading in specific areas.
2.13	A number of established groups have expressed an interest in committing to an agreed programme of support to build on the previous work. In order to allow the groups to implement the ideas, it is proposed that an amount of up to £20,000 is allocated to the designated groups for expenditure against a range of agreed

	promotional activities, similar to those identified above, within the current financial year.
2.14	It is accepted that a number of the traders groups are more advanced than others and that some may be able to bring resources to supplement the council contribution. In recognition of this, it is proposed that, beyond the £20,000 support provided, Belfast City Council can match the trader contribution £ for £, up to a total maximum contribution from council of £40,000. Consideration should be given to the sustainability of the proposed intervention, given that funding levels cannot be guaranteed in future years.
2.15	Where this funding is provided, Belfast City Council should ensure that the proposed activity does not duplicate or conflict with the work undertaken by other partners (particularly Belfast Visitor and Convention Bureau and Belfast City Centre Management) and that additional funding is levered in to support the council and partner contribution, where possible. Trader groups will also be encouraged to collaborate on issues in which they have a common interest.
2.16	In considering the trader group development support and the area campaigns, a number of wider issues should also be taken into account: • The work should support other council activity, where possible (e.g. Renewing the Routes) • The work should support additional business and should not lead to displacement i.e. moving business from one area to another or supporting one business or area to the detriment of another • The trader representatives should be encouraged to take responsibility for the work and should be committed to making the initiative sustainable, when the funding comes to an end • The trader groups should be acting collectively for the benefit of an area rather than on a business-by-business basis • We will engage with at least two traders' groups on area campaigns, using a budget of up to £85,000.
2.17	<u>Market start up programme</u> This programme will support potential entrepreneurs and new start businesses to explore market trading as a possible business model, in advance of progression to a retail outlet. Participants will complete the National Market Traders' Federation's NMTF First programme. They will be supported by specialist mentors and will have an opportunity to test trade at St. George's Market. This programme will get under way in September 2011 and a budget for the programme has already been approved by this committee. We will involve at least 10 new traders in the programme, at a budget of up to £13,500.
2.18	<u>Retail Therapy programme and master classes</u> This tailored support programme will help independent traders to assess their business and will provide mentoring and financial assistance to move their business forward. The programme is currently open to recruitment for 30 independent traders. The Retail masterclasses will focus on a number of topics of particular interest to independent traders including visual merchandising and customer service. The budgets for these activities have already been approved by this committee. Thirty independent retailers will take part in the programme at a budget of up to £42,000. Up to 30 traders will attend each master class.

2.19	Independent Retail Week It is proposed that a range of events and activities will take place in early March 2012 to draw attention to the range or independent traders and the services they offer. Traders will be encouraged to organise local events and to present offers and packages to increase footfall within their area. The budget for this initiative has already been approved by this committee, and will be a maximum £35,000.

3	**Resource Implications**
3.1	Financial The independent retail support budget was approved by the Development Committee in June 2011.

4	**Equality and Good Relations Considerations**
4.1	No specific equality or good relations considerations.

5	**Recommendations**
5.1	Members are asked to: • Note the proposals to provide business development and promotion support to local independent retailers, alongside wider council initiatives • Endorse the proposed payment thresholds and approach for supporting the trader group development and area campaigns work. • Note the proposed funding allocation for each of the elements of the programme.

6	**Decision Tracking**
A report on progress will be brought back to Development Committee in April 2012.	

7	**Key to Abbreviations**
NMTF – National Market Traders' Federation	

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Belfast City Council

Report to:	Development Committee
Subject:	B-Team
Date:	23 August 2011
Reporting Officer:	John McGrillen, Director of Development, ext 3470
Contact Officer:	Shirley McCay, Head of Economic Initiatives, ext 3459

1.	Relevant Background Information
1.1	Belfast City Council is the Lead Partner in the ERDF funded INTERREG IVC project B-Team. The B-Team project brings together specialists in Brownfield regeneration from different countries to exchange knowledge contributing to improved developments and enhanced regional policies focussing on the resolution of practical challenges on case study sites in the partners' countries.
1.2	The partners include Dublin/Ireland, Sevilla/Spain, Oulu/Finland, Dresden/Germany, Ruda Slaska/Poland, County Council Hajdu-Bihar/Hungary, Torino/Italy and Vilnius/Lithuania.
1.3	The support and exchange of technical knowledge takes place during "Brownfield Days" events with the experience and practical approaches discussed and disseminated to a broader public at European Dissemination Events scheduled to take place at different stages during the life of the initiative. The dissemination events are also opportunities for the partners to "pledge" to change or address problems that are identified as hindering regeneration. In these dissemination events the participation of elected representatives is a key factor for success.
1.4	The work programme for the project has progressed from the previous updates provided to Committee with five Brownfield Days (Oulu, Torino, Ruda Slaska, Sevilla and Dresden) and two European Dissemination Events (Dresden and Hajdu-Bihar) being completed and arrangements for the next stage of the programme agreed with the partners.
1.5	This report seeks to secure approval for the attendance of Members at the next European Dissemination Event which is scheduled to take place in Ruda Slaska/Poland on the 5– 6 September 2011.

2.	**Key Issues**
2.1	The European Dissemination Events are scheduled to take place in regular intervals during the three year lifespan of the project. The project partners have the opportunity to broaden the participation at these dissemination events to encourage a wider audience and the participation of elected representatives from each of the participating local authorities.
2.2	The dissemination event will seek to: – Progress the practical process for identifying viable solutions to common Brownfield challenges (case studies will be presented with experts from different regions developing solutions or alternative approaches); – Explore the potential to use new unconventional methods (more innovative approaches successful in other countries are assessed for broader application); – Encourage engagement within the partnership to explore the potential for shared learning; – Identify the potential for more effective use of resources - time, money, assets (through improved policy and approaches to Brownfield regeneration future development processes can become more effective and sustainable); and – Explore the potential for the development of Brownfield pledges for adoption by the partnership as a means to secure future improvements in policy and practice.
2.3	The next European Dissemination Event (EDE) will take place in Ruda Slaska, Poland on 5-6 September 2011. As it coincides with the Polish EU Presidency the local partners will seek to secure a significant level of political engagement from the local administration and up to the European level (the Polish partners have already secured speakers from their state departments and European level).
2.4	This EDE presents the opportunity for the Council to contribute through both officer and political participation during the event. In seeking to address the regeneration challenges of redundant Brownfield sites the event focuses on some of the issues frequently encountered by the Development Committee and Council. It is therefore suggested that participation by the Chair and Deputy Chair of the Development Committee, or their nominees, would be appropriate at this event.

3.	**Resource Implications**
3.1	The provision for the participation at the dissemination event of operational staff along with political representation is contained within the agreed project plan. There are no fees for the event and the costs for travel and accommodation is estimated at £500 per person which will be covered by the project. There are no additional resource implications arising from the EU funded INTERREG IVC initiative.

4.	**Equality and Good Relations Considerations**
4.1	There are no Equality and Good Relations Considerations attached to this report.

5.	Recommendations
5.1	The Committee is asked to approve the attendance of the Chair and Deputy Chair or their nominees, at the Ruda Slaska dissemination event on 5-6 September 2011 as an approved duty.

6.	Decision Tracking
There is no decision tracking attached to this report.	

7.	Key to Abbreviations
ERDF – European Regional Development Fund EDE – European Dissemination Event	

8.	Documents Attached
B-Team newsletter	

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B-Teamnews
THE NEWSLETTER OF BTEAM PROJECT
#1 APRIL-JUNE 2011

Welcome
to the first edition of B-TEAM News

Sabine Kalke
Project Manager, B-TEAM
June 2011

B-TEAM News is the official newsletter of the Brownfield Policy Improvement Task Force project. The B-TEAM project is under the umbrella of the INTERREG IVC programme which focuses on interregional cooperation to improve the effectiveness of regional development policies.

The regeneration of Brownfields is an increasingly important element in the sustainable development strategy across Europe. B-TEAM provides policy support in the regions that contribute to the development of Brownfield sites before greenfield land, as a principle of sustainable growth.

B-TEAM project is a collaborative effort by 14 partners from 11 different countries to influence policies on Brownfields through sharing their successes and experiences. The partnership was developed to include different cities and academic institutions across Europe.

The publication of B-TEAM News is an important means of communication to reach out to all its stakeholders. This is a step forward in disseminating relevant information to project partners as well as to the general public. It highlights the process, the partnership and the contribution of the project to each partner and vice versa.

Since this is the first issue, we are trying to present the highlights of the project activities so far and the planned activities throughout the project lifespan of three years. There is information of upcoming events and the identified good practice of the project. Some of the partners' contributions are also highlighted in the news.

We would like to thank all project partners and individuals who contributed to this newsletter. We hope this document will provide interesting information about the project and its activities, and will inspire to continue the initiatives in Brownfield regeneration across Europe.

Hajdú-Bihar

Dissemination Event Successful

The 2nd European Dissemination Event (EDE) was successfully held in Debrecen, Hungary last 19 April 2011. The representatives from 14 B-Team partners and other participants were welcomed by Mr. Attila Tóth, Vice-President of the Assembly of Hajdú-Bihar County.

In the event, the national and regional officials from Hungary, officials from partner cities, members of the B-Team and general public shared their experiences in Brownfield regenerations.

The recent updates and results from the completed Brownfield Days in Oulu/ Finland, Torino/Italy and Ruda Slaska/ Poland were also presented.

The partners' cities like Belfast, Oulo, Sevilla, Dresden, Vilnius and Dublin had presented their case studies and good practice in brownfield regeneration. The respective presentations were focused on the economic aspects of Brownfield redevelopment.

Experimental Laboratory identified as Good Practice

The experimental laboratory showing the different brownfield soil remediation techniques in Torino, Italy was identified and submitted to the Joint Technical Secretariat (JTS) as a project good practice.

The experimental laboratory is initiated by the B-Team partners; the Municipality of Torino and University of Torino, together with a private institution Reviplant s.s- R&D Department.

The experimental project deals particularly with the utilisation of soil materials in a Brownfield area and turns them into useful greening agents. Local communities have the opportunity to visit the laboratory field and learn about the decontamination process. It is envisaged that this will increase the community confidence in public authorities managing contaminated sites and will improve the reputation of Brownfields.

The role of historical industry
in the revitalisation of the hybrid city

Julián Sobrino Simal
Professor at the Higher Technical School of Architecture, Seville

Since the last third of the 20th century the global economy has been in a state of major flux with exceptional consequences for many cities traditionally characterised by their mining or industrial activities. One of the most discernible effects of this change was the emergence of brownfield sites, that is, abandoned industrial sites. Brownfields come in many forms and can be classified depending on implementation scales, production sectors, industrial chronologies, geographical locations, socio-economic problems, demographic status or infrastructure provisions. In addition, it is important to remember that these industrial spaces have been internationally considered as heritage assets since the emergence of industrial archaeology in the 1960s. This fact has transformed these post-industrial spaces into areas of heritage interest with legal protection and has given them a new status as active territorial assets.

This situation reveals the need for comprehensive adaptation projects for new uses to allow the preservation of industrial heritage, environmental regeneration, social cohesion, the revitalisation of economic activities, job creation and planning in the territory affected.

Former industrial spaces need to be considered with an eye to renewal so that important examples of European industrialisation are prevented from disappearing. Cities need to set out urban policies that combine different functions such as housing, industry, leisure and culture. This is a time of recession and reassessing social policies and is ideally suited to maintaining the productive activities of industrial spaces in crisis through a new urban-planning culture which is able to develop a comprehensive concept of cities from two complementary standpoints: preserving listed historical industrial buildings to guarantee the survival of their heritage values and offering these spaces to non-polluting companies in new technologies, creativity, research and with new models of socially responsible co-operative work.

All this can be implemented with a new methodology that conceives the intervention project as an opportunity aiming to generate a bold framework for management and architecture and one which is sensitive to pre-existing historical elements, while at the same time promoting the generation of new heritage through current architectural intervention.

Historical factories in the inherited city are a material record with a significant interpretive, not just descriptive, ability, which can reconcile the preservation of these industrial assets with new uses so that their creative potential can emerge.

The sustainable city is one which manages to plan for the future by combining inherited heritage, in this case the industrial, with new urban-planning projects which meet criteria for efficiency so that heritage can become a part of the environment, as a tool for cohesion for the territory and a factor for growth.

Brownfield Days in Seville

The fourth Brownfield Days (BDs) were held in Seville, Spain last 31 May- 3 June 2011. Seville is one of the most important cities of Southern Europe. Located in the heart of Andalusia, Seville is not just a prime tourist destination, but in recent years has also proved to be an important commercial, economic and industrial city.

The focus of these particular Brownfield Days were to share and exchange partners' experiences in re-imagining the productive spaces: the industrial spaces in historical cities.

On the first day, activities include; welcome of participants, presentation of B- Days in Seville, visit to the Interpretation Centre of the Port Authority of Seville, and an exhibition of B-TEAM at the University of Seville.

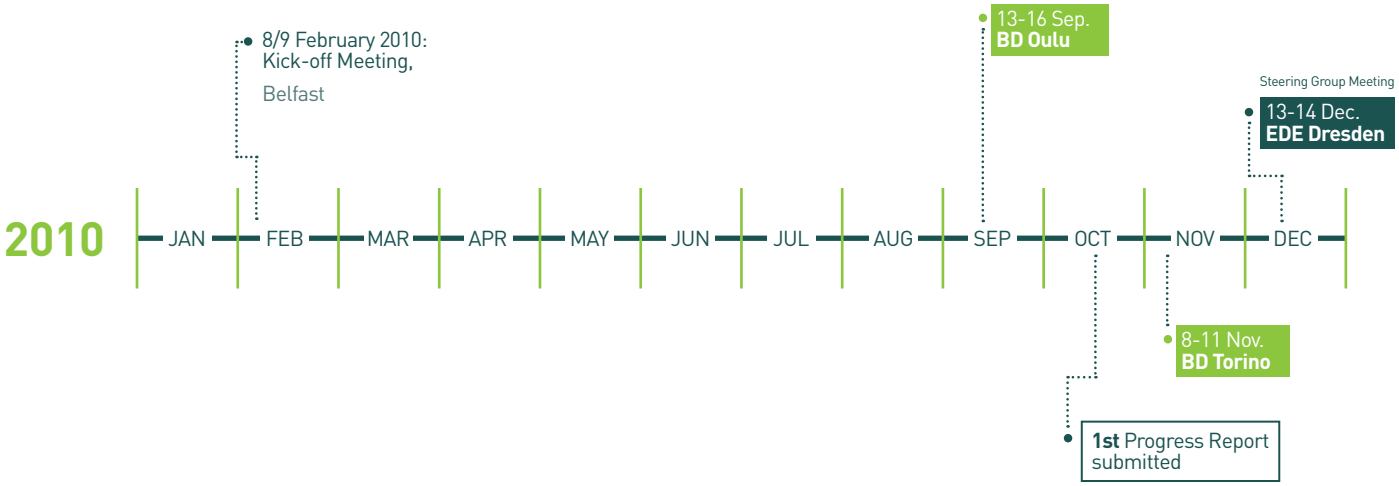
The next day activities include; tour to the industrial Seville and workshop which focused on 1) the role of the historical industry in the revitalization of the hybrid city; 2) the compatibility of the new productive sectors in the historical industrial spaces; 3) the multifunctional city as a net for the integration of the historical industrial spaces.

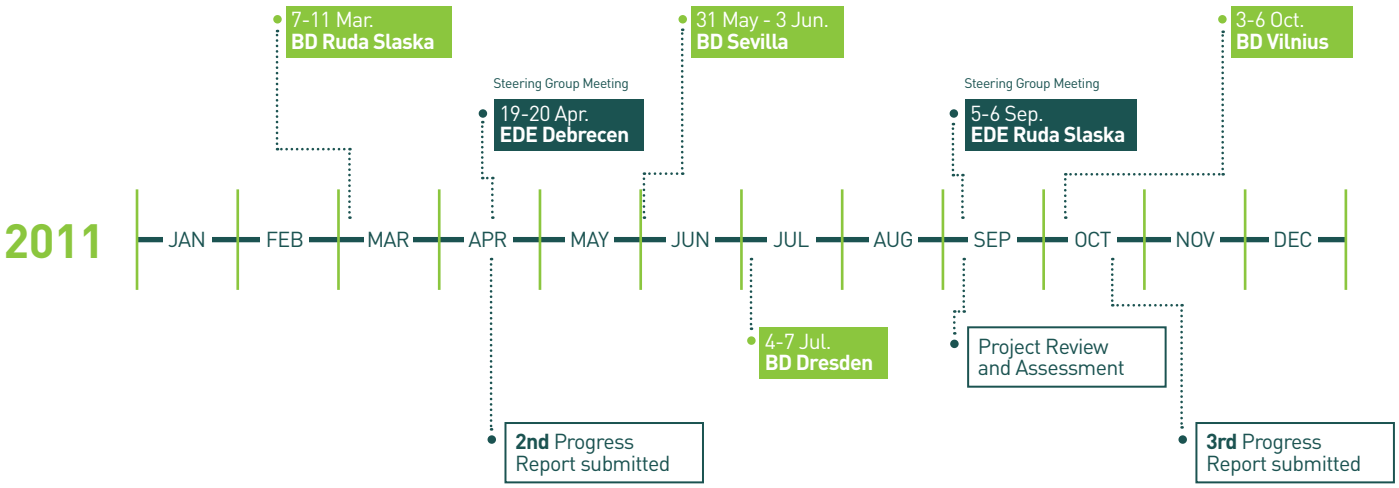
The third day activities includes; Bike Tour to five (5) 'revitalized industrial sites' in Seville and a guided tour to the Real Fábrica de Artillería, the identified Brownfield site. The workshop was attended by B-TEAM members, professors and students of the University of Sevilla and the University Pablo de Olavide.

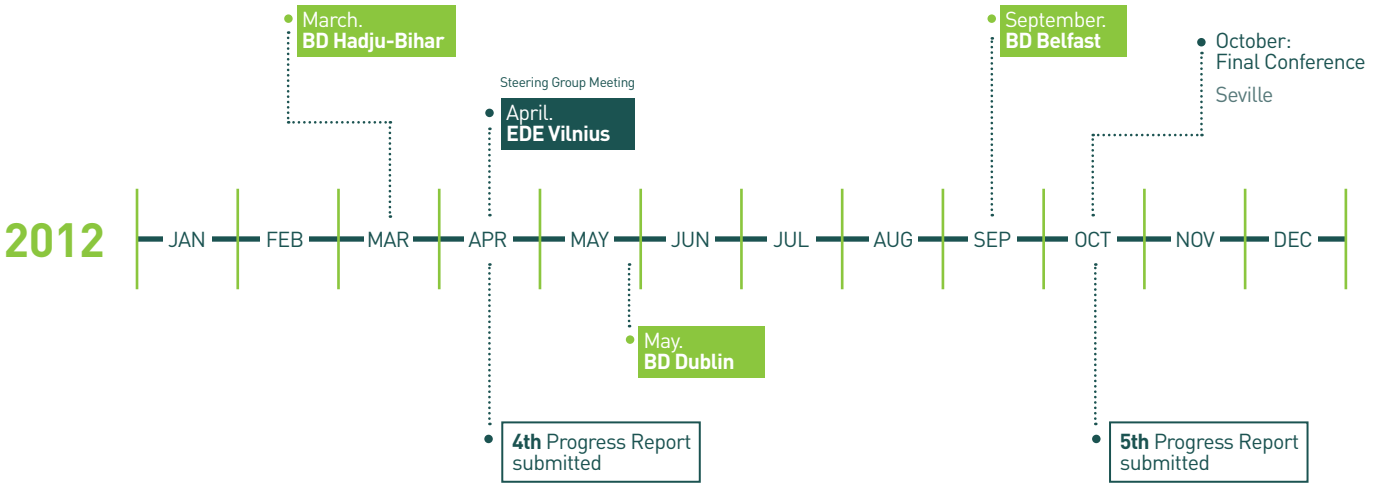
On the final day, a closing session was facilitated and outputs of the workshops were presented. B-Team members discussed their strategic and site-specific recommendations that could be part of the Brownfield Pledge of Seville.

Brownfield Policy Improvement Task Force

Project Activities Timeline: 2010- 2012







Previous year activities:

B-TEAM initiative officially started last February 2010. Here are the major activities conducted by the project in the previous year.

Kick-off Meeting in Belfast

The B-Team kick-off meeting was conducted in Belfast City 8-9 February 2010. It was attended by all the partners of the project and procedures, management structures and partner responsibilities were discussed.

1st Brownfield Days: Oulu, Finland

The first Brownfield Days were held in Oulu, Finland 13-16 September 2010. This was the first activity wherein experts/ partners from other regions discussed the actual Brownfield issues and strategies.

BD Oulu programme included the discussion about the approach of Oulu and Toppila Shore II Project Area, Land Use Workshop – Ideas and Policies / Seminar, Sea Centre Seminar Workshop and the presentations of the partners' cultural centres.

On the final day, partners' recommendations both in the strategic and site-level were discussed and drafted for the Oulu Brownfield Pledge. The BP was adopted by the City Board.

2nd Brownfield Days: Torino, Italy

The second Brownfield Days were held in Torino, Italy 8-11 November 2010.

The BD programme focused on the theme 'Introducing of Torino's New Deal From Old Spaces to New Opportunities; Workshop theme "Green Day": From Brownfield to Greenfield Workshop, and "Rainbow Day: From Still-Life to Life Workshop." Brownfield soil remediation techniques were presented by the host and good practice identified by the partners.

1st European Dissemination Event (EDE): Dresden, Germany

The B-Team organised their first European Dissemination Event (EDE) 13-14 December 2010. It was hosted by the City of Dresden, Germany. The European Dissemination Event is part of the overall strategy of the B-Team Project to disseminate the results and experiences in Brownfield regeneration to a broader public.

The results and recommendations from the completed Brownfield Days in City of Oulu/ Finland and City of Torino/Italy were presented. The respective Brownfield issues, updates, reports and recommendations from those cities were discussed with the audience.

Brownfield Days in Ruda Slaska

The Brownfield Days in Ruda Slaska were carried out on 4-7 March 2011. Ruda Slaska is a city in Silesia in southern Poland and part of Silesian Voivodeship, an administrative region and local government unit in Poland.

The coal mining industry is of significant importance for the local economy and vitality of Ruda Slaska and the Silesian region.

The visit to one of the active coal mines was part of the BD activities. In the workshop with the Silesian Technical University, potential uses were discussed and recommendations drafted by the partners.

UPCOMING EVENTS

5-6 September
EDE Ruda Slaska, Poland

3-6 October
BD Vilnius, Lithuania

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Belfast City Council

Report to:	Development Committee
Subject:	Belfast International Airport Consultative Forum
Date:	23 August 2011
Reporting Officer:	John McGrillen, Director of Development, ext 3470
Contact Officer:	Shirley McCay, Head of Economic Initiatives, ext 3459

1	**Relevant Background Information**
1.1	Recent correspondence from Belfast International Airport (BIA) has confirmed that the airport plans to establish an Airport Consultative Forum. A request for officer representation from Belfast City Council on the forum has been received.

2	**Key Issues**
2.1	The Airports (Northern Ireland) Order 1994 includes an article which stipulates that the airport operator shall provide a platform for consultation regarding the management or administration of the airport. There are a number of broad categories of users to be involved in this including: – Consumer Council for Northern Ireland – The district council in whose district the airport is located – Any other organisation representing the interests of those based in the locality in which the airport is situated.
2.2	Belfast International Airport plans to establish a forum. It anticipates that the key functions of the forum will be to: – Help BIA understand and respond to passengers' expectations and needs – Advise BIA on measures to enhance and develop facilities and services to assist BIA in their strategic objective of increasing passenger, airline and destination growth – Review passenger information through the eyes of the public and provide recommendations to BIA – Review the extent to which passenger and airline or service satisfaction surveys are fit for future purpose and provide recommendations to BIA, and to commission research or surveys as appropriate, on behalf of BIA – Identify external gaps that limit the passenger growth and/or experience including infrastructure, aviation strategy, value of money, accessibility, regulation etc.

2.3	An airport forum has been operational at Belfast City Airport for some time. There is both Member and officer representation on the forum. The two BCC members on the forum are Councillors Adam Newton and Tom Haire.
2.4	The following organisations have been invited to nominate representatives to the forum: – Consumer Council for NI – Antrim Borough Council – Belfast City Council – NI Chamber of Commerce – Travel trade representative – NITB – Templepatrick Action Group – Killead residents – Institute of Directors – Tourism Ireland – Department for Regional Development (as an observer) – Department for Enterprise, Trade and Investment (as an observer)
2.5	Councillor Mervyn Rea has been nominated as the Antrim Borough Council representative on the forum. There is no officer representation from Antrim.
2.6	Belfast International Airport has issued an invitation to the Head of Economic Initiatives to be a representative on the new Forum. The first meeting of the forum took place on 9 March 2011. It is expected that meetings will take place on a quarterly basis.

3	**Resource Implications**
3.1	No specific financial resources. The HR implications will include attendance at quarterly meetings.

4	**Equality and Good Relations Considerations**
4.1	Membership of the forum will be equality proofed by the airport.

5	**Recommendations**
5.1	Members are asked to note the request from Belfast International Airport for officer representation on the Airport forum.

6	**Decision Tracking**
Updates on issues raised at forum meetings will be presented at future meetings of the Development Committee, as appropriate.	

7	**Key to Abbreviations**
BIA – Belfast International Airport	

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Agenda Item 11

Belfast City Council

Report to:	Development Committee
Subject:	Cities of the Isles, Cardiff, October 2011
Date:	23 August 2011
Reporting Officer:	John McGrillen, Director of Development, ext 3470
Contact Officer:	Shirley McCay, Head of Economic Initiatives, ext 3459

1	Relevant Background Information
1.1	Members will be aware that the 'Cities of the Isles' (COTI) Partnership is a network of six City Councils in the UK and Ireland (Belfast, Cardiff, Dublin, Edinburgh, Glasgow and Liverpool). Since 2000 these cities have come together annually to share urban regeneration experiences, develop joint projects and establish a co-ordinated approach to issues of strategic importance.
1.2	Each of the member cities takes it in turn to host the annual event in their city. The 2011 COTI meeting will take place in Cardiff on 11-12 October 2011.

2	Key Issues
2.1	The 2010 COTI meeting took place in Belfast. There was senior level member and officer representation from each of the cities involved. The delegates took part in a structured discussion on the challenge of regenerating cities within the context of public sector financial restraints. A site visit of Belfast was also organised and representatives were hosted by the Lord Mayor in his Parlour.
2.2	As the host city for the 2011 event, Cardiff has proposed a programme of discussion, site visits and civic engagement. Delegates will arrive in the city on the morning of 11 October and the session will begin after lunch. The programme will finish in the afternoon of 12 October.
2.3	The topics for discussion at the event will include: • Collaborative work – neighbourhood management and city governance • Universities and the city • Innovative financing models for regeneration.
2.4	The discussion will be facilitated by Andrew Carter, Director of Policy and Research at the Centre for Cities. The Centre has recently undertaken a range of interesting research pieces on topics such as incentives for growth, economic governance for city development and localism for growth.

2.5	These elements of discussion appear relevant to the council, particularly at the current juncture. With the corporate planning process underway at present, there is a need to take account of wider policy discussions and to consider how alternative operating models and processes might translate to the local environment.
2.6	Indeed, given the importance of the topics to be discussed, the opinion of the Democratic Services Section was sought as to the benefits of the participation of a larger number of Members. The Democratic Services Manager has confirmed that attendance at the meeting would be of direct benefit to a wider range of Members, particularly the Party Leaders and/or the newer Members as part of the Council's Member Development Programme.
2.7	It is proposed that the Chair and Deputy Chair of Committee (or nominees) as well as two officers take part in the Cardiff meeting and noted that any other Member who wishes can attend the meeting as part of their agreed Personal Development Plan.

3	**Resource Implications**
3.1	Financial All programme costs to be covered by Cardiff. Travel and accommodation costs estimated at £200 per person.

4	**Equality and Good Relations Considerations**
4.1	No specific equality or good relations considerations.

5	**Recommendations**
5.1	Members are asked to: • Note the COTI event to be held in Cardiff on 11 and 12 October 2011 • Agree to participation by Chair and Deputy Chair of Committee (or nominees) as well as up to two officers at the event at a cost of around £200 per person. • Note that any other Member may attend the event as part of their Personal Development Plan.

6	**Decision Tracking**
A report on outcomes of the visit will be brought back to Development Committee in December 2011.	

7	**Key to Abbreviations**
COTI – Cities of the Isles	

Belfast City Council

Report to:	Development Committee
Subject:	Consultation: Health and Social Care Board and Public Health Agency: Community Development Strategy
Date:	23 August 2011
Reporting Officer:	John McGrillen, Director of Development, ext 3470
Contact Officer:	Catherine Taggart, Community Development Manager, ext 3532 Barbary Cook, Policy & Business Development Manager, ext 3620

	Relevant Background Information
1.1	The Health and Social Care Board (HSC), together with the Public Health Agency, (PHA) have produced a strategy that aims to improve community development approaches across all health and social care organisations in Northern Ireland. Belfast City Council has been asked to respond as part of a twelve week public consultation.
1.2	The HSC and 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. They seek a reduction in inequalities by addressing social factors that affect health and wellbeing. The new strategy is based on the premise that community development activity is a key contributor to these aims.
1.3	The strategy (and its related performance management framework) have been designed to support health organisations to: • take stock of their attitudes, aspirations, and practice in relation to community development; • systematically develop needs and asset based community development approaches in all aspects of their business; • ensure a realistic progress route for community development; • measure progress on mainstreaming community development approaches; and • incorporate community development into overall performance management arrangements.

1.4	Rather than taking a more traditional approach that examines deficits in communities and the interventions required to tackle them, the HSC strategy is focuses on the needs and 'assets' (both physical and social) within communities and the potential of these assets to contribute to positive health outcomes. The consultation presents six broad questions about the strategy. They include questions concerning the clarity of the strategy's intentions; it likely usefulness to the council in the delivery of our own services and a series of questions around the strategy's performance management framework and impact on equality. The draft council response to the consultation is based around the six questions.
1.5	The Full proposal is attached as **Appendix 1**.
1.6	The consultation document was sent to council on the 15th July and comments are required to be returned by the 2nd September.
1.7	The strategy is closely linked to the draft HSCB Personal and Public Involvement strategy which is being consulted on concurrently. Consequently, both documents have been distributed to relevant council officers and a workshop on the two was held for officers. The council's proposed PPI consultation response is also being presented at this Committee.

2	**Key Issues**
2.1	The consultation on the HSC community development strategy is timely as Belfast City Council is beginning a public consultation on its own draft community development strategy. In the pre-consultation stages of the council's strategy, officers engaged with staff from the health sector. This has resulted in a number of connecting and mutually re-enforcing ideas and approaches in both organisations' strategies (e.g. a emphasis on assets, outcomes and the mainstreaming of community development approaches).
2.2	The underlying premise of the council's community development strategy is that by supporting and engaging directly with communities it becomes much easier for the council and its partners to design and deliver effective and appropriate services that make the best use of the city's assets. Likewise the HSC strategy recognises the importance of integrating community development practice within the entire Health Service in Northern Ireland in order to achieve health and well-being outcomes. Their rationale is that community development approaches enable local people to address their own health and social wellbeing needs and develop and improve co-operation with health and social care agencies, leading to better outcomes.
2.3	The council is of course a key health partner in Belfast. Not only are we a joint partner in the inter-agency Belfast Health Development Unit and a key partner in the Belfast Strategic Partnership, but many of our services and activities contribute directly or indirectly to health and wellbeing outcomes. Health and Environmental Services includes work on public health, tackling health inequalities and community safety. Our parks and leisure centres provide venues for a range of programmes to promote fitness. The community development activities of our Community Services section also contributes to improved health and well-being in communities.

2.4	Bearing this is mind there are a number of mutually beneficial opportunities in the joint development and delivery of both HSC and Council strategies and these have been highlighted in the council's draft response. Potential opportunities include: - Supporting skilled community development staff - Developing shared community development outcomes against which partners can design interventions and measure performance and impact. - Enhancing the role of the community and voluntary sectors in the co-design and co-production of local services. - Developing better joint understanding of neighbourhood assets to support integrated approaches to their use. - Developing shared knowledge systems to identify both need and assets. - Sharing best practice in community development work including approaches to community engagement.
2.5	In summary, the HSC strategy aligns well with the council's own stance on community development. Its assets-based approach and ambition to mainstream community development activity fit well with the council model and provides opportunities for future joint working. In addition the strategy's substantial performance management framework may well provide a useful template for the council for any future developments in this area.
2.6	The strategy does not provide details of action plans for implementation although an ambitious timetable for their implementation suggests that these will be in place by the end of January 2012. It will be important for the council to engage with the Belfast Health and Social Care Board on the content of its action plan to ensure that opportunities can be mutually identified and developed.

	Resource Implications
3.1	There are no resource implications.

	Equality and Good Relations Considerations
4.1	There are no Equality and Good Relations implications.

	Recommendations
5.1	Members are asked to approve the draft Council response to the consultation and raise any additional issues, relating to the consultation document, that they would like to be included.

	Decision Tracking
Timeline: August 2011	Reporting Officer: Barbary Cook

	Key to Abbreviations
CD - Community Development HSC - Health and Social Care Board PHA - Public Health Agency PPI - Personal and Public Involvement strategy	

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Health and Social Care Board

Public Health Agency

Community Development Strategy for Health and Wellbeing

Health and Social Care Board

and

Public Health Agency

Northern Ireland, 2011

FULL VERSION

Contents

Introduction

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

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

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

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

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

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

How Community Development Works

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

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

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

The principles of community development are:

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

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

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

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

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

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

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

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

Assets may include:

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

(National Institute for Health and Clinical Excellence, 2009)

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

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

(Foot and Hopkins, 2010)

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

Why Community Development is Needed for Health and Wellbeing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MINI CASE STUDIES

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

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

1. **Southern Area Action with Travellers Partnership Achievements** (2001-2010): (Multisectoral Partnership)
   - Travellers residing in Trust area; 1,200 or 200 families.
   - School attendance increased from 45% to 70%.
   - GP registration from 46% to 100%.
   - HV registration from 92% to 100%.
   - Immunisation rates increased from 45% to 100%.
   - Preschool attendance from (no children) to 70%.
   - After school attendance increased from 25 to 45%
   - Youth club attendance increased to from 10 to-50%.

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

3. **Building Community Pharmacy Partnership**

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

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

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

4. Rural Priority Areas Project / Warm Zone Pilots

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

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

Outcomes include:

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

5. User Engagement and Personal and Public Involvement

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

Outcomes include:

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

6. Social Economy

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

7. Children and Young People's Locality Partnership

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

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

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

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

8. Empowering Travellers in Health and Wellbeing

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

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

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

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

9. Reform of Northern Ireland Wheelchairs Services

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

Aim

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

Objectives

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

Methods of Engagement

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

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

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

10. Newry Neighbourhood Renewal project - Emotional Overeating

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

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

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

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

The launch and the new group will follow after.

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

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

11. The Pathways Project

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

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

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

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

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

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

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

Outcomes include:

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

12. East Belfast Men's Health Clinic

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

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

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

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

13. Children and Young People's Locality Partnership

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

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

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

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

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

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

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

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

Outcomes

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

15. Multi-level Alcohol Harm Reduction

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

Outcomes

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

16. Dove Gardens, Derry – 'Heaven'

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

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

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

International Examples

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

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

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

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

2. Entre Nous Femmes, Vancouver, Canada

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

3. Residents Making a Difference – Whitehorse, Melbourne Australia

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

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

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

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

The Challenge

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

Key Statistics

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

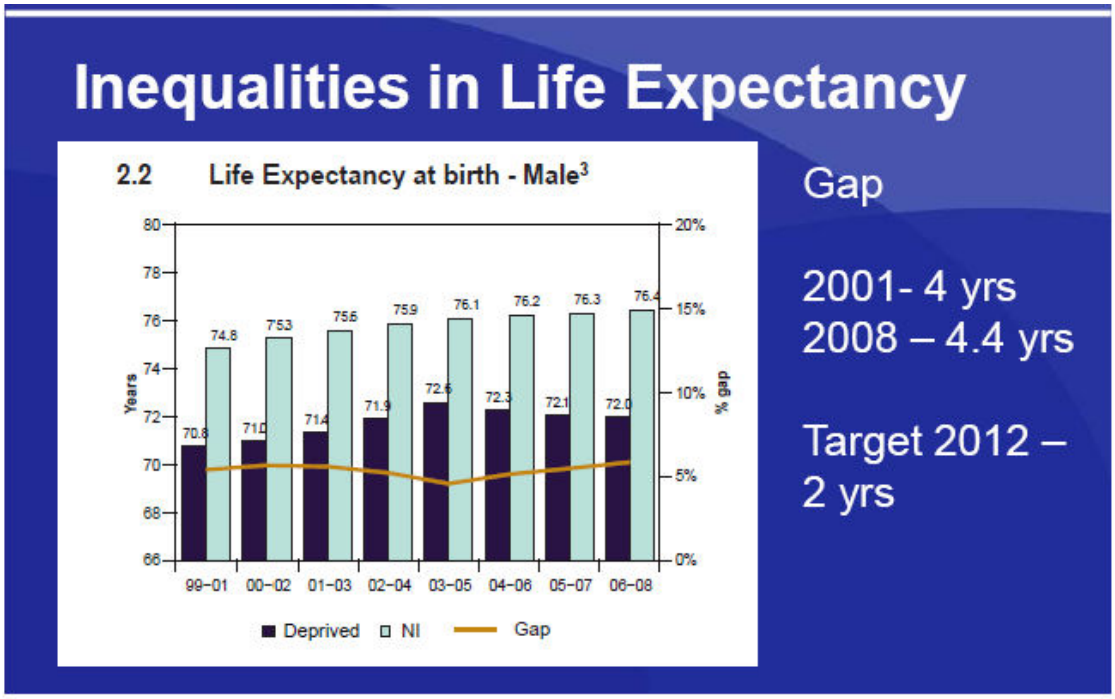
Table 1 Local areas with the highest and lowest male life expectancy at birth, 2006–08

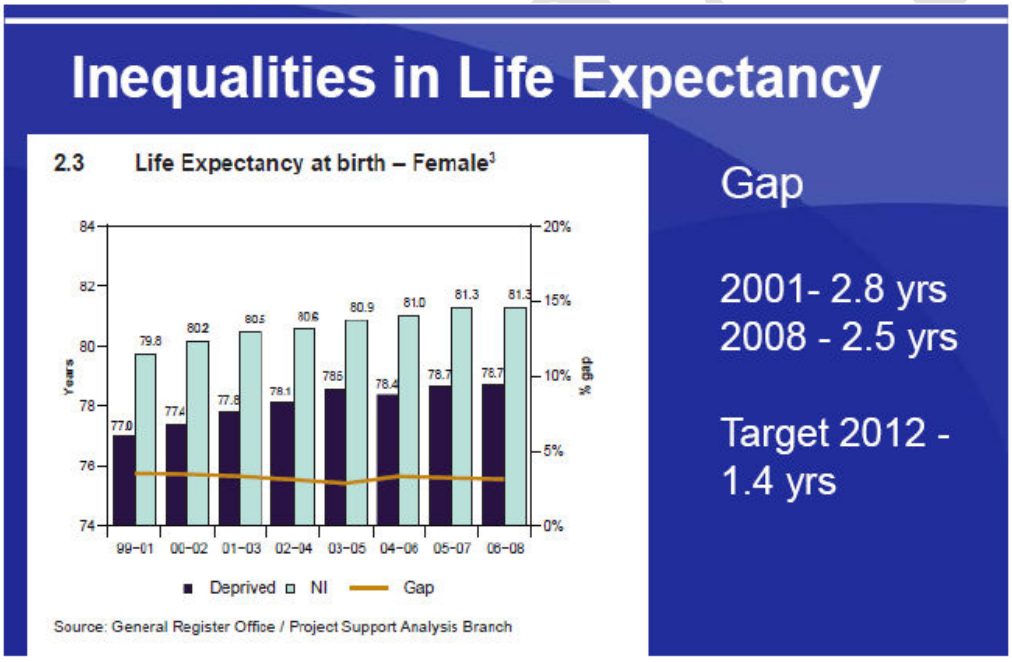
United Kingdom

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

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

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





Source : Health Inequalities Monitoring System DHSSPSNI

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Partnerships

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

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

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

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

Commissioning Plan: Reducing Inequalities and Promoting Health and Social Wellbeing

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

Populations from deprived areas in Northern Ireland experience:-

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

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

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

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

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

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

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

Relevant Targets and Objectives

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

Priority for Action (PFA) Targets:

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

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

Priority 5: Improve children's health and wellbeing.

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

Public Health Agency (PHA) Corporate Objectives

1.0 Addressing health and social wellbeing inequalities.

1.1 Implement programmes to support early childhood development.

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

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

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

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

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

2.3 Reduce alcohol and drug misuse.

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

2.5 Reduce the incidence of births to teenage mothers.

2.6 Reduce the incidence of sexually transmitted infections.

4.7 Build effective public involvement into PHA work.

Public Service Agreement (PSA) Targets

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

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

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

1.3 Halt the rise in obesity.

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

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

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

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

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

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

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

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

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

Conclusion and Recommendations

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

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

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

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

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

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Development Department

Your reference: Consultation: Community Development Strategy for Health and Wellbeing

Our reference: #119352 Being dealt with by: Mark McCann

Date: 16 August 2011 Tel: 028 9027 0579

Mr Martin O'Neill
Community Development Lead
Health and Social Care Board
Southern Office, Tower Hill
Armagh BT61 9DR

Dear Martin,

RE: Consultation: HSC Board and PHA: Community Development Strategy for Health and Wellbeing

Please find below our provisional response to your consultation. Please note that this is still subject to final ratification by full council on 1 September 2011.

Provisional response

Overall comments

Belfast City Council warmly welcomes the HSCB/PHA community development strategy and believes it will play an important contribution in delivering better health and wellbeing outcomes across the Health Service in Northern Ireland.

We support the strategy's case for the mainstream integration of community development approaches within health and social care organisations and the role community development can play in ensuring the needs and views of communities are expressed in public service design and delivery. We are supportive of the needs and assets-based approach that the strategy has adopted and welcome the planned performance management framework.

The development of the strategy is timely as Belfast City Council is beginning a public consultation on its own community development strategy (and would welcome continued input from the health sector). There are a number of connecting and mutually re-enforcing ideas and approaches in both organisations' strategies.

We note that action plans for the HSC strategy are to be developed early in 2012. The council would like to be consulted on the design of the Health and Social Care Board's & the Belfast Trust's action plans as we believe there may well be areas of mutual benefit for both organisations in terms of enhancing our approaches to community development in the city.

The council's own draft community development strategy proposes a broad outcomes-based model for community development activity in Belfast. The model describes four supporting strands of activity and the likely outcomes to which they could contribute.

The strands include support for core community development skills (such as volunteering, group capacity building, etc); support for effective community engagement; effective partnership working; and, ultimately, support for shared service design and delivery with communities.

The purpose of the model is to encourage organisations to adopt mutually re-enforcing community development approaches that jointly contribute to shared outcomes. We wish to work with partner organisations, including the HSC and PHA, to explore how this might be achieved.

Responses to the specific questions

1. Do you think that the strategy will be helpful in your area of interest or work?

There are a number of areas in which the strategy would be helpful to the council and we would welcome further engagement with the HSC and PHA on exploring this. Areas might include:

1.1 Learning from the development of your strategy, and the design and implementation of its actions plan, can inform the council's own strategy and implementation plan. We would wish to share information on this.

1.2 Approaches to community consultation and engagement. The council is currently developing a framework for consultation and engagement and would welcome ideas on developing approaches to engagement.

1.3 Ensuring the council's service contributions to health outcomes have community development approaches embedded with them. This might include activities associated with our corporate Healthier City plan (which includes contributions from Parks and Leisure, Community Services, Health and Environment Services, etc) and our contribution to the Belfast Joint Health Development unit.

1.4 Working with our Community Services team to explore opportunities for joint working on projects that could involve our community centres and community development workers across Belfast's neighbourhoods.

1.5 Contributing to our growing city and neighbourhood evidence base. Our Strategic Neighbourhood Action Programme (SNAP) team have gathered a substantial resource on community assets and needs. There may be opportunities to share learning with the HSC on better utilising this information in community development approaches.

1.6 Measuring impact – the council is keen that its community development strategy has the capacity to measure the impact of our activities. There may be opportunities to develop joint measures with our partners.

1.7 Aspects of your performance management framework might prove useful for the council in measuring the successful implementation of its own strategy.

2. In your opinion is the strategy clear in what it intends to do?

Yes. The underlying premise of Belfast City Council's draft community development strategy is that by supporting and engaging directly with communities it becomes much easier for the council and its partners to design and deliver effective and appropriate services that make the best use of the city's assets.

This chimes well with the HSC premise that community development approaches enable local people to address their own health and social wellbeing needs and develop and improve co-operation with health and social care agencies, leading to better and more sustainable outcomes.

3. Is the Performance Management section clear and understandable?

Yes.

4. Do you agree with the Conclusions and Recommendations in the Summary Document?

Yes.

5. Are you satisfied with the outcomes of the screening exercise?

Yes.

6. Are there any other issues in relation to equality and human rights that you think should be highlighted?

None.

7. In your opinion has any major issue been omitted?

There are three issues which the HSC might want to consider:

1. **Supporting a joint outcomes model for community development**. One of the drivers for the council in developing our CD strategy was the absence of any model in Belfast against which we (and our partners) could shape and measure our own community development activity. We would encourage the HSC to champion its community development work with other partners and highlight the benefits that would accrue for establishing shared community development outcomes across partner organisations.

2. While there is currently no **Community Planning** legislation in Northern Ireland, there is a trend towards utilising Community Planning approaches. Community Planning principles are something that Belfast City Council has endorsed – and we have noted the importance of community development activity in underpinning this approach. This is also likely to be relevant to the health sector over the medium to longer term.

3. The fourth strand of Belfast City Council's community development strategy is about support for the co-design and co-delivery of services with community, mutuals, co-operatives and other social economy partners. We would note that there is a growing national government policy trend in this direction and it may be something which you would wish to address in your strategy, given that community development underpins such approaches.

8. Do you or your organisation want to be involved in taking forward this strategy? If so, please tell us how?

There are a number of mutually beneficial opportunities in the joint development and delivery of both the HSC and Belfast City Council strategies. They might include:

- Supporting the cohort of skilled community development staff in Belfast.
- Developing shared community development outcomes against which partners can design interventions and measure performance and impact.
- Enhancing the role of the community and voluntary sectors in the co-design and co-production of local services.
- Developing better joint understanding of neighbourhood assets to support integrated approaches to their use.
- Developing shared knowledge systems to identify both need and assets.
- Sharing best practice in community development work including approaches to community engagement

9. Please provide any other comments, evidence or information that you wish to share.

We would encourage the HSC and PHA to contribute to the public consultation on Belfast City Council's community development strategy.

Thank you for asking us to respond to the proposals.

Yours sincerely

Mark

Mark McCann
Policy & Business Development Officer
Policy & Business Development Unit, Development Department
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Belfast City Council

Report to:	Development Committee
Subject:	Consultation: HSCNI - Personal and Public Involvement Strategy
Date:	23 August 2011
Reporting Officer:	John McGrillen, Director of Development, ext 3470
Contact Officer:	Catherine Taggart, Community Development Manager, ext 3525 Barbary Cook, Policy & Business Development Manager, ext 3620

	Relevant Background Information
1.1	Council has been asked to respond to the Health and Social Care Board's proposals for a Personal and Public Involvement strategy. The consultation document shows how they plan to improve their way of working with local people and groups to improve health and social care services. In particular its addresses how they intend to encourage users, careers and the general public to influence the planning and delivery of services. The key priorities of the strategy show how they will:
1.2	- integrate this way of working into their organisational culture - raise awareness and understanding about the approach among staff - develop the skills that staff and the public will need - measure the impact of their approach - create and sustain stakeholder support - communicate and coordinate the strategy - develop and structure their action plan.
1.3	There are 8 questions for the Personal and Public Involvement consultation. The first ask for your views on whether the aims of the strategy are clear and if the priorities and recommendations are right. The latter questions ask for examples where personal and public involvement can bring benefits. Finally there are general questions for any other comments and equality issues.
1.4	The full proposal is attached as appendix 1.

1.5	The consultation document was sent to us on the 15th July and comments are required to be returned by the 15th September.
1.6	This strategy is closely linked to the recent HSCNI Community Development Strategy. In fact it could be considered to be part of the implementation plan for that broader strategy. Consequently we sent both documents to relevant officers across council and arranged a workshop to discuss their implications.

	Key Issues
2.1	The Strategy appears to be a sensible outline to produce a more detailed action plan at a later stage.
2.2	There are elements of the strategy that will be of relevance to the Council's Community Development strategy, especially the training of staff and the general public in how to engage with each other and how to contribute to the development of agreed local priorities and improvement actions.
2.3	This HSCNI Personal and Public Involvement strategy makes no reference to their Community Development strategy which is also out for consultation.
2.4	The HSCNI Personal and Public Involvement strategy may benefit from more emphasis to encouraging individual staff to adopt the principles of personal and public involvement. It may also be useful to include a risk assessment and communication plan as part of the final personal and public involvement action plan.

	Resource Implications
3.1	There are no resource implications.

	Equality and Good Relations Considerations
4.1	There are no Equality and Good Relations implications.

	Recommendations
5.1	Members are asked to approve the draft BCC response to the consultation and raise any additional issues, relating to the consultation document, that they would like to be included.

	Decision Tracking
Timeline: August 2011	Reporting Officer: Barbary Cook

	Documents Attached
Appendix 1 "Valuing people, valuing their participation: Consultation document" Health and Social Care Board July 2011. Appendix 2 "Draft HSCNI Personal And Public Involvement"	

Development Department

Your reference: Consultation: HSCNI - Personal and Public Involvement Strategy

Our reference: #119549 Being dealt with by: David Purchase

Date: 2011 Tel: 02890 320202 ext 3792

Martin Quinn
Regional PPI Lead
Public Health Agency
Gransha Park House
15 Gransha Park
Londonderry
BT47 6FN
siobhan.carlin@hscni.net

Dear Martin,

RE: Consultation: HSCNI - Personal and Public Involvement Strategy

Please find attached our provisional response to this consultation document. Please note that this is still subject to final ratification by full council.

Provisional Response

1.1. Overall comments

1.1.1. The Council is supportive of the draft strategy. The Council is developing its own Community Development Strategy and frameworks on consultation and engagement and these will have many areas in common with this strategy and HSCNI's own Community Development Strategy. Consequently we will be watching your progress with interest and would be keen to continue to share learning as the strategies progress.

1.2. Responses to the specific questions

1.2.1. 1. Have we made it clear what Personal and Public Involvement is, what benefits it can bring and why we think it is important?

1.2.2. Generally yes and we think the simplified 'Easy to Read' guide is a useful product that also demonstrates your commitment to some of the principles of public involvement. We do wonder though if some reference to the Community Development strategy you are developing should also be made. We assume that any community development work will also involve personal and public involvement.

1.2.3. 2. We identified six priority areas to take PPI forward. Are there other areas that you think we should consider?

1.2.4. No the list seems to cover all the necessary areas to incorporate the approach.

1.2.5. 3. The detailed recommendations under each key area will form the basis of the actions we need to take to deliver on these areas. Do you think that they will help us do that? Are there other things we need to do?

1.2.6. *Cultural integration* – there does not appear to be anything at the individual level to encourage this other than the inclusion in job descriptions. We are not convinced that including it in the job description will have much effect especially on existing staff. It may be worth considering other mechanisms such as including it in staff personal development reviews (PDR), highlighting good examples internally, or having an award

each year for the person who most embodies the approach. It would also be worth reviewing existing KPIs to make sure they do not discourage PPI behaviour, for example, avoiding the mistake organisations make when they introduce new customer service or quality commitments but still measure staff performance against indicators that demand fast throughput.

1.2.7. *Training* – we would be very keen to hear about your approach to training the general public and wonder if there may be opportunities to share experiences and even offer joint sessions once we are in a position to roll out our Community Development Strategy. We also wonder if there may be opportunities for staff exchanges, job shadowing or similar once both strategies are established. Our only query about this section is whether the strategy needs to spell out the time and resource that will be needed to ensure proper training can be given. A lack of training in a new approach is one of the most common causes of failure.

1.2.8. *Impact Measurement* – see previous comments about including PPI in staff PDRs.

1.2.9. *Stakeholder support and Communications* – see previous comments about sharing experiences in this area.

1.2.10. *Action Plan* – The Action plan appears to be incorporating two stages into one. That is the first implementation stage (2011/12) and then the ongoing cementing of the approach (beyond 2011/12). We wonder if it may be sensible to split these two stages in the plan. The first stage would have specific deliverables list for 2011/12 and target dates. It would not need any other KPIs (the review of progress column) other than these target dates. The resources section of the first stage could also be more detailed with specific budgets allocated.

1.2.11. The plan may also benefit from a communication strategy appended to it. This would identify key audiences, key messages and the methods to be used to ensure the latter are understood by the former. Though we appreciate that, as communications was one of your six themes, it may have been your attention to have these communication actions included in the main part of the Action Plan. Finally an outline risk assessment of what may cause the programme to fail may be considered. Though we would recommend that this only be used to helpfully check the robustness of the plan and not be allowed to become another plan in its own right.

1.2.12. 4. Can you identify any outcomes that will demonstrate how PPI has made a difference in health and social care?

1.2.13. The new Belfast Health and Development Unit, on which the Council partners with the Public Health Agency and the Belfast Trust has a core focus on using community engagement as part of its work. The unit is relatively new, but we would expect that it will soon be able to demonstrate how engagement/PPI has made a difference to the impact of its work.

1.2.14. 5. Have you any examples of good practice in PPI at any level that you would be willing to share with us for possible inclusion in the strategy?

1.2.15. http://www.localinnovation.idea.gov.uk/idk/core/page.do?pageId=17449367

1.2.16. http://www.localinnovation.idea.gov.uk/idk/core/page.do?pageId=17451914

1.2.17. http://www.localinnovation.idea.gov.uk/idk/core/page.do?pageId=17449452

1.2.18. http://www.localinnovation.idea.gov.uk/idk/core/page.do?pageId=17632232

1.2.19. http://www.idea.gov.uk/idk/core/page.do?pageId=16639499

1.2.20. http://www.idea.gov.uk/idk/core/page.do?pageId=11215972

1.2.21. 6. Is there any area of the strategy that could be improved/needs further explanation? If so, please tell us about it.

1.2.22. Nothing other than the points already mentioned.

1.2.23. 7. The PPI strategy has been equality screened. The results of the screening are available for you to consider. We have concluded that the strategy promotes equality and human rights. What do you think? Are there other actions we should consider including?

1.2.24. No comment.

1.2.25. 8. Have you any other comments that you would wish us to consider in relation to the PPI strategy?

1.2.26. Nothing over than the points already mentioned.

Thank you for asking us to respond to the proposals.

Yours sincerely

David

Dr David Purchase
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Belfast City Council
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Belfast. BT2 8BP

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Valuing people, valuing their participation

Consultation document

A strategy for Personal and Public Involvement for the Public Health Agency and Health and Social Care Board

HSC Public Health Agency

HSC Health and Social Care Board

Personal refers to service users, patients, carers, consumers, customers, relations, advocates or any other term used to describe people who use Health and Social Care (HSC) services as individuals or as part of a group, such as a family.

Public refers to the general public and includes community and voluntary groups and other collective organisations. Individuals who use HSC services are also members of the general public.

Involvement means more than consulting and informing. It includes engagement, active participation and partnership working.

What is Personal and Public Involvement?

This strategy is about how we plan to improve our way of working with local people and groups to improve health and social care services.

Health and Social Care (HSC) organisations deliver services to people and communities that make a real difference to quality of life. People's experiences and interactions with the HSC are instrumental in shaping their health and social wellbeing.

Personal and Public Involvement (PPI) is about service users, carers and the public influencing the planning, commissioning and delivery of HSC services in ways that are accessible and meaningful to them. PPI is also about involving local communities and the general population in issues of broad public interest, such as the location or nature of local services.

PPI is not a new concept. The HSC system in Northern Ireland has worked with service users and the wider public for many years. The health improvements to be gained by working in this manner are clear. These include:

- Increased ownership
- Increased self responsibility
- Responsive and appropriate services
- Better priority setting and decision making
- Reduced power imbalances
- Help tackling health and social wellbeing inequalities
- Reduced and transformed complaints
- Patient knowledge and expertise is recognised
- Increased levels of service satisfaction
- Rights are acknowledged
- Increases accountability
- Dignity and self-worth
- Increased staff and patient morale

Find out more about these in **Appendix 1**.

The Department of Health, Social Services and Public Safety (DHSSPS) has outlined a set of PPI core values and principles to which all HSC organisations are expected to adhere.

The core values of PPI are:

- dignity and respect;
- inclusivity, equity and diversity;
- collaboration and partnership;
- transparency and openness.

The 12 principles of PPI are:

1. leadership and accountability;
2. part of the job;
3. supporting involvement;
4. valuing expertise;
5. creating opportunity;
6. clarity of purpose;
7. doing it the right way;
8. information and communication;
9. accessible and responsive;
10. developing understanding and accountability;
11. building capacity;
12. improving safety and quality.

You can find out more about the core values and principles in **Appendix 2**.

Why do we need Personal and Public Involvement?

Under the *Health and Social Services (Reform) Northern Ireland Act 2009*, Health and Social Care organisations have a statutory requirement to deliver on Personal and Public Involvement (PPI).

To meet this requirement, HSC organisations will actively engage with those who use our services, carers and with the general public.

PPI is not, however, a one-off project or exercise; it must be rooted in the culture of our organisations. It must be a part of our everyday working practice, underpinning everything we do.

Many opportunities exist to incorporate PPI practice and principles into the everyday work of the HSC, most of which is focused on the direct provision of services to individual service users.

Adoption of PPI will have the greatest impact where this direct provision takes place: GP surgeries, outpatient clinics and through patient and carer interaction with doctors, nurses, allied health professionals and social services professionals.

This is where through PPI we have the greatest opportunity to make a difference to the experience of service users.

However there are also opportunities for PHA and HSCB staff at all levels to incorporate PPI into our work with service users, carers, the community and voluntary sector and the wider public.

The Boards of Directors of both the PHA and HSCB are committed to making PPI central to how we work. This means talking to those who use our services and the general public about:

- their ideas;
- our plans;
- their experiences;
- our experiences;
- why services need to change;
- what people want from services;
- how to make the best use of resources;
- how to improve the quality and safety of services.

Development of this strategy

The PHA and the HSCB have developed this strategy to provide guidance to our staff on how to incorporate PPI into their work in a way that best benefits service users.

To develop this strategy we reviewed relevant literature and PPI strategies from both current and legacy organisations. We also looked at existing good practice in the HSC.

We consulted with HSC staff, service users, carers and community and voluntary sector representatives by holding workshops and interviewing key people. We especially sought input from marginalised and excluded groups.

A vision for PPI

The Public Health Agency and Health and Social Care Board are committed to embedding Personal and Public Involvement into our culture and practice. Personal and Public Involvement approaches will be adopted to encourage more open, accountable and collaborative commissioning, service planning and delivery, with well-informed service users. Carers and communities supported to actively take part in that process.

How we will implement PPI

Following our review of the available evidence, the PHA and HSCB believe that PPI is central to the effective commissioning, design, delivery and evaluation of services. The best way to implement PPI is to actively seek the views and opinions of service users and the general public. Their views should be listened to and acted upon through an appropriate mechanism or structure.

This approach allows service users, carers and the general public to influence and advise on the commissioning and delivery of services while also considering the professional input of HSC staff, alongside other factors such as our statutory obligations and available resources.

The PHA and HSCB recognise that there are excellent examples of successful PPI approaches already in place throughout the HSC, improving the health and social wellbeing of service users and the general public.

The PHA and HSCB will learn from these, while also supporting, complementing and building upon them.

The PHA and HSCB will look for opportunities for collaborative working within the HSC and outside it.

This strategy sets out six priorities for the incorporation of PPI into our work. These are:

- **Cultural integration of PPI**
- **Awareness and understanding of PPI**
- **Training and skills development**
- **Impact measurement**
- **Stakeholder support**
- **Communication and coordination**

Each of these priorities is explained in greater detail below. We will also prepare an action plan for making each happen.

Priorities

Cultural integration of PPI

The PHA and HSCB will commit to supporting a culture change that leads to full integration of PPI into our work. This will involve:

- formal adoption of this PPI strategy and its recommendations;
- development of an action plan to integrate PPI into our work;
- establishment of a PPI steering group across both organisations;
- identification of PPI leads at senior management level and in each directorate and team;
- inclusion of PPI as a core duty in job descriptions;
- incorporation of PPI objectives into the PHA and HSCB corporate and business plans;
- development of a method of showing compliance with PPI in the commissioning, design and implementation of services.

Awareness and understanding of PPI

The PHA and HSCB will commit to ensuring that staff are aware of and understand the value of PPI. This will involve:

- investing in a systematic and continuous improvement in understanding of PPI theory and practice;
- improving the awareness of staff of our collective and individual responsibility to involve services users and the general public in a meaningful way;
- ensuring that staff understand the core values of PPI and the benefits of PPI;
- ensuring that staff are aware and understand that the involvement processes should happen at a number of levels: individual, service user, carer, community and general public.

Training and skills development

The PHA and HSCB will commit to training staff, service users and the general public in the skills necessary for effective PPI. This will involve:

- working with staff, service users, the general public and key partners such as the Patient and Client Council and the community and voluntary sector to train individuals, service users and the general public;
- developing training for staff and helping service users, carers and the general public access training;
- finding ways to contribute to the training and professional development of future and existing clinicians and HSC professionals and practitioners;
- identifying staff with significant relevant expertise and helping them to act as advisers for others;
- familiarising staff with existing PPI tools and updating these if necessary;
- investigating new ways of involving service users and the general public, such as social networking;

Impact measurement

The PHA and HSCB will commit to developing a robust and consistent system for measuring the impact of PPI. This will involve:

- gathering both quantitative and qualitative evidence of the impact, change, added value, and/or outcomes of PPI;
- developing a set of standards based on the PPI core values that HSC organisations and staff will be expected to comply with;
- measuring the extent of culture change within the PHA and HSCB;
- ensuring that leadership and accountability continues to come from the Board members and senior staff of the PHA and HSCB, with support from the Regional HSC PPI Forum.

Stakeholder support

The PHA and HSCB will commit to supporting stakeholders. This will involve:

- developing and providing ongoing support and training programmes;
- developing a single equitable reimbursement scheme;
- developing a checklist of practical arrangements for staff when working with stakeholders;
- developing partnerships with community and voluntary sector groups to support stakeholders;
- ensuring local people are effectively supported to influence local commissioning.

Communication and coordination

The PHA and HSCB will commit to clear communication and effective coordination regarding PPI. This will involve:

- developing a communication strategy;
- keeping our key messages consistent;
- developing partnerships to share information;
- investigating the potential redesign of the Engage website as a learning platform;
- examining ways in which the PHA and HSCB can coordinate our involvement and engagement exercises.

Action plan

To help incorporate PPI into our work, we will develop an action plan during 2011/12. The action plan will consider opportunities for collective action to deliver on common strategic objectives. Steps will be outlined for joint partnership working. The suggested action plan format is included in **Appendix 3**.

The action plan will include:

- actions to meet the recommendations of this strategy;
- timescale for delivery of actions;
- lead responsibility for implementing each action;
- performance indicators.

External partner organisations may wish to use this framework to demonstrate how their existing PPI plans fit with the aims, priorities and recommendations of this strategy.

It will be important to develop a realistic action plan which reflects and acknowledges its current position and which builds on existing structures, activities and approaches.

The PHA and HSCB Joint PPI Implementation Group will be the vehicle through which the action plan will be developed and progress monitored.

The approach which is suggested is one of effective and structured internal organisational reporting, supported by adoption of and measurement against standards and protocols. This would in turn then be peer reviewed through the Joint PPI Implementation Group, with sharing of and learning from best practice. The Annual PPI Progress Report would also be viewed as a means of demonstrating progress to the DHSSPS and to service users and the general public.

The action plan needs to show that it has a mechanism to accommodate feedback and to demonstrate how feedback will be accounted for and considered in keeping the document up to date and appropriate to the evolving needs of service users, carers, advocates, the wider public and HSC organisations and staff.

Conclusion

We want to hear what you think about this strategy, and your ideas on how we can better meet the needs of service users and the general public.

Key consultation questions

1. Have we made it clear what Personal and Public Involvement is, what benefits it can bring and why we think it is important?

   If yes, have you any further comments?

   If no, where do we need to provide further information?
2. We identified six priority areas to take PPI forward. Are there other areas that you think we should consider?
3. The detailed recommendations under each key area will form the basis of the actions we need to take to deliver on these areas. Do you think that they will help us do that? Are there other things we need to do?
4. Can you identify any outcomes that will demonstrate how PPI has made a difference in health and social care?
5. Have you any examples of good practice in PPI at any level that you would be willing to share with us for possible inclusion in the strategy?
6. Is there any area of the strategy that could be improved/needs further explanation? If so, please tell us about it.
7. The PPI strategy has been equality screened. The results of the screening are available for you to consider. We have concluded that the strategy promotes equality and human rights. What do you think? Are there other actions we should consider including?
8. Have you any other comments that you would wish us to consider in relation to the PPI strategy?

Responses should be sent by 4pm on Thursday 15 September 2011:

By post: Martin Quinn
Regional PPI Lead
Public Health Agency
Gransha Park House
15 Gransha Park
Londonderry
BT47 6FN

By email: siobhan.carlin@hscni.net

By telephone: 028 7186 0086

Appendix 1

Detailed explanation of the difference PPI can make

Increases ownership

By enabling service users and the public to influence the HSC agenda, we can foster ownership of and commitment to HSC services. Decisions regarding changes to services are more likely to be viewed positively and accepted if people have had a role in making those decisions.

Increases self responsibility

PPI promotes and facilitates constructive partnership working. Better informed service users make more informed choices and more appropriate use of services. As their contribution is valued, they more fully appreciate the importance of and benefits to be secured from taking more responsibility for their own health and social wellbeing.

Responsive and appropriate services

If services are to be needs led, then it is vital that service users and the wider community are facilitated in articulating those needs and their views on existing services. Through such involvement, services are more likely to be viewed as being responsive to need and coming from the community. They are more likely to be tailored to specific circumstances and capable of being flexible and responsive to change in need.

Helping priority setting and decision making

Treating service users and the public as partners in the process contributes to consensus, and acceptance of priorities and decisions. It does not always secure this, especially if people perceive that services are being altered in a way that they don't like. Excluding people from important issues which directly affect their lives, however, tends to result in rejection of those decisions, frustration and even resentment.

Reduces power imbalances

A balanced relationship between service provider and recipient creates a more conducive environment for the application, administration, acceptance and implementation of agreed plans, resulting in more effective outcomes. It represents a move towards the concept of joint or communal responsibility.

Helps tackle health and social wellbeing inequalities

PPI is critical in the reduction of health inequalities and social exclusion. Through involvement of service users and the community who are regarded as marginalised and excluded, we will better understand the rationale for the difficulties they face and will be better informed as to how we might work with those individuals, communities and other partners to address some of the root causes of those inequalities that they face.

Reduces and transforms complaints

If PPI principles are applied when specific issues of concern arise and people are listened to and their concerns taken seriously and addressed, complaints, as might be expected, tend to be lower. This allows people to work collectively for service improvement rather than dealing with formal complaints which are time and often resource intensive.

Recognises patient knowledge and expertise

Service users know what it feels like to be ill and have detailed knowledge to enable them to advise on their experience in relation to the progression, regression, and impact of the illness and any treatment. These experiences should be valued and should be sought at all stages of someone's journey through the HSC system. It can provide valuable insights into the illness to help inform the opinion and treatment options being considered by HSC professionals.

Increases levels of service satisfaction

Where PPI values and principles are adopted and are evident in the relationship between the HSC professional and the service user, increased levels of satisfaction are consistently shown.

Acknowledges rights

The Patients Charter back in 1991 gave patients the right to have any proposed treatment including risks involved and any alternatives explained to them before they decided about consent. People are now more willing to question professional views and opinions and have now come to expect policy and service decisions to be formally consulted on. With regards to their own personal health and social care requirements, treatments and so on, people expect these to be discussed and agreed with them. The new statutory requirement for involvement can readily be met, if HSC organisations formally and genuinely adopt and practice PPI values and principles.

Increases accountability

Increased accountability of public services improves public confidence and reduces any sense of "democratic deficit".

Dignity and self-worth

For service users and their carers, being actively and meaningfully involved demonstrates the respect that the HSC has for people. The PPI values and principles if truly embedded and adopted into HSC culture and practice contributes to a sense of dignity and self worth amongst service users, carers and the wider public.

Increases staff and patient morale

If there are less complaints, increased levels of service satisfaction, evidence of a real value placed on genuine involvement and partnership working, this all contributes to increased staff and patient morale.

Appendix 2

Explanation of PPI values

Dignity and respect

Each person is treated with dignity and respect. This includes individual responsibility to respect the views of individuals, communities or HSC staff.

Inclusivity, equity and diversity

The PPI process should facilitate and encourage the inclusion of all those who need to be involved and who chose to do so. It must be sensitive to the needs and abilities of each individual. Each person's background, culture, language, skills, knowledge and experience will be valued, accommodated and respected.

Collaboration and partnership

The PPI process is based on collaboration and partnership working. Each person has a responsibility to build constructive relationships with others involved in the process.

Transparency and openness

The PPI process should be open and transparent. Each person has a responsibility to be open and honest in their interactions and relationships with others.

Explanation of PPI principles

Principle 1: Leadership and accountability

The commitment to PPI will be reflected in the leadership and accountability arrangements in HSC organisations.

The leadership for PPI within organisations will be the key to creating the culture and environment whereby organisations can show they are accountable to the populations they serve.

This requires establishing and maintaining clear lines of responsibility and accountability for the planning, implementation, monitoring and evaluation of PPI activity as part of corporate governance arrangements within the organisation.

Principle 2: Part of the job

PPI is the responsibility of everyone in HSC organisations. PPI needs to be seen as the job of all involved in HSC organisations, integral and not incidental to their daily work. PPI should be part of staff development and appraisal.

PPI has significant implications for the way staff carry out their roles and responsibilities and their attitudes to the people who use the service. Recognising and seeking to minimise the power differential between those who provide the services and those who use the services is the first step.

PPI requires staff to be confident and competent in engaging with individuals and the public in ways that respect them as active partners with a right to be involved and voice their views about services.

Principle 3: Supporting involvement

Appropriate assistance is required to support and sustain effective PPI.

Successful PPI requires building the capacity of people to get involved as well as building the capacity of staff to involve individuals who use the services and the wider public.

The process of PPI needs to be supported by the organisation with dedicated time and resources to make it happen. Resources may include staff time, training and development and practical or financial support.

This requires PPI to be part of organisational planning and management processes including budgets, workloads and training plans to ensure the organisation's commitment to PPI can be sustained.

Principle 4: Valuing expertise

People have expertise whether by experience, by profession or through training which should be valued.

The experiences and views of all participants are valid and should be respected.

It should be recognised that people may have different viewpoints. Understanding different, and at times, competing viewpoints and recognising that decision-making is complex and may involve hard choices is part of involvement.

Decisions should take account of the views and opinions of individuals, the public and professionals.

This requires information sharing and dialogue between individuals, communities, and those planning, commissioning and delivering services including policy makers.

Principle 5: Creating opportunity

Opportunities should be created to enable people to be involved at the level at which they choose.

PPI can occur at different levels:

- **Personal level** – being involved in plans, decisions or giving feedback about the individual care or treatment plan for themselves or for someone they are caring for;
- **Commissioning level** – being involved in the planning and commissioning of services to meet agreed local and/or regional needs;
- **Delivery level** – being involved in plans, decisions and giving feedback about the ways in which the services are run;
- **Monitoring and review level** – being involved in monitoring and review of the quality and effectiveness of services;
- **Policy level** – being involved in developing local regional policies.

The number of people who volunteer to give substantial amounts of time to PPI will always be limited and as such they are a valuable resource. They may not, however, be fully representative of the population profile. Opportunities, therefore, need to be created to enable a wide range of people to be involved who are representative and have a legitimate interest in the work.

Opportunities also need to be created to promote engagement with under-represented or unrepresented groups, including those who do not normally get involved or who may find it hard to give their views, for example because of age or ability. PPI needs to be flexible enough to adapt to the needs of those who need to be and wish to be involved. Some people may choose not to be involved and this choice should be respected.

Principle 6: Clarity of purpose

The purpose and expectations of PPI are clearly understood. Each PPI activity needs to have clear objectives, realistic timeframes and a shared sense of purpose communicated to all participants from the outset. Clear, succinct and understandable information needs to be available at the point of invitation to enable participants to make an informed decision about being involved, to be clear about expectations of involvement and to contribute meaningfully. People's right to confidentiality and/or anonymity should be made explicit from the outset.

The purpose of the PPI activity will inform who should be involved. Decisions about who needs to be involved will depend on what you are asking people to be involved in and why. The aim is to gain the best representative spread of views from those who are affected or may be affected by the service or issue under discussion. Other individuals or groups (or representatives of these) who have a legitimate interest in the work should also be involved.

Decisions about the right time to involve people will depend on the purpose. If people are expected to contribute to planning they need to be involved from the start. However, if the purpose is to consult on proposals for implementation which have already been developed, involvement may come at a later stage. Involvement at an early stage can help prevent misunderstandings or accusations of tokenism at a later stage.

Principle 7: Doing it the right way

Different forms of PPI need to be used to achieve the required outcomes and to meet the needs of the people involved.

No single method or approach can be taken to constitute PPI. There are many different ways and methods of involving people from staff showing respect, listening actively and responding to what people say to more formal and explicit methods such as focus groups, citizen's panels, surveys and community development.

PPI may be a one-off event or a longer term arrangement involving regular dialogue between the organisation and the people involved.

There are a range of targeting methods which can be employed to ensure appropriate representation and a range of voices from self-selection to specific invitation. The choice of method will depend on the earlier decision about who to involve.

Doing it the right way requires practical advice and guidance on the range of methods and approaches including training and development for those responsible for implementing them and learning from good practice both locally and internationally. Partnerships with community groups, voluntary organisation or self-help groups provide an excellent channel to involve a diversity of local voices.

Principle 8: Information and communication

Timely, accurate, user-friendly information and effective two-way communication are key to the success of PPI activities.

People need timely information to be able to be involved meaningfully; information needs to be presented in ways that can be understood by the target audience; people need to know how to make their views known, including how to make a complaint; and they need to be informed of outcomes and decisions.

This requires appropriate systems and mechanisms to be in place to facilitate ongoing dialogue and information exchange between participants before, during and after the PPI process.

Before: The need for advance information which is clear and focused on the purpose and topic for discussion with sufficient background information to support understanding and meaningful involvement.

During: The need for participants to feel they are being actively listened to.

After: The need for timely feedback from the involvement activity and the need for follow-up communication on the impact of the involvement on decisions.

Principle 9: Accessible and responsive

The organisation's commitment to PPI will be demonstrated through its recognition of the right of people to initiate engagement with it.

Traditionally, PPI has been shaped around the organisational priorities, rather than the concerns those in a local community identify as important. Organisations need to be prepared to listen to the issues and concerns of individuals, groups or communities.

This requires a more open culture and a willingness to listen to what is important to people.

Principle 10: Developing understanding and accountability

People's understanding of HSC services and the reasons for decisions are improved through PPI activity.

Making decisions about service provision can involve hard choices. The PPI process itself will not necessarily lead to a consensus about what should happen. However, the opportunity to register a viewpoint in a transparent and open process and to hear other viewpoints can foster a greater appreciation of the issues and competing perspectives involved and clarify the choices policy makers, commissioners and service provider's face.

This in turn can lead to a greater understanding of the reasons for decisions and accountability of the decision-makers to make explicit the reasons for their decisions based on evidence.

Principle 11: Building capacity

People's capacity to get involved is increased and the PPI processes are improved through learning from experience.

The experience and learning from being involved should help build the capacity of individuals, communities and staff to be more confident and effective in engaging with and listening to each other. Being involved should help people to better understand the issues and the business of health and social care and to make an informed contribution.

This requires appropriate mechanisms for reviewing and learning from the involvement process and the outcomes of each PPI activity.

Principle 12: Improving safety and quality

Learning from PPI should lead to improvements in the safety, quality and effectiveness of service provision in HSC organisations.

PPI should support the clinical and social care governance agenda of developing an open culture that promotes and safeguards high standards and improvements in the safety and quality of services delivered to individuals and communities.

This requires a culture of openness, transparency, listening to the views of individuals, communities and staff, learning from feedback, where appropriate learning from an analysis of complaints, sharing information and working in partnership.

Through a partnership approach with people and communities, HSC organisations can improve the safety, quality and effectiveness of services and make them more accountable to the public. The difference PPI makes to the safety and quality of services should be communicated throughout the organisation to share and encourage good practice.

This requires appropriate mechanisms for evaluating the impact of PPI in improving the safety, quality and effectiveness of health and social care services.

Appendix 3 – Suggested action plan format

Recommendation	Action in 2011/12?	Action beyond 2011/12?	Lead responsibility	How will you review progress?	What resources are needed?	Potential Partners?

HSC Public Health Agency

HSC Health and Social Care Board

Public Health Agency
Ormeau Avenue Unit
18 Ormeau Avenue
Belfast BT2 8HS
Tel: 028 9031 1611
Textphone/Text Relay: 18001 028 9031 1611
www.publichealth.hscni.net

06/11

Agenda Item 14

Belfast City Council

Report to:	Development Committee
Subject:	Play Service Play Clubs
Date:	23 August 2011
Reporting Officer:	John McGrillen, Director of Development ext 3459
Contact Officer:	Catherine Taggart, Community Development Manager, ext 3525

1	**Relevant Background Information**
1.1	The purpose of this report is to update Members, as previously agreed, in regard to the evaluation of the 'Play Clubs' which were introduced on a pilot basis in September last year to be provided through to the end of June 2011.
1.2	Members will recall that the Play Clubs were developed as part of the recommendations of the Play Review. This included the recommendation for Service Delivery to be flexible and to involve outreach delivery of the play service making it available in communities where there is limited existing provision for children and young people (up to age 16) and where there are concentrations of children and young people.
1.3	A comprehensive report of the activities undertaken by the Play Service throughout 2010 was provided to Council at their meeting on 3 May 2011. The report included information on the progress of the Play Club project. An end of year report is attached as Appendix 1 to this report.

2	**Key Issues**
2.1	The Play Club model was developed to provide play opportunities for children aged 2-4 years old in areas of need and through a partnership approach, with local volunteers and parents being offered developmental and skills support coupled to a phased increase in their assumption of organisational responsibility and autonomy, in other words, a community development approach through play.

2.2	As agreed by Council, three Play Clubs were to be established in three areas (Ballysillan, Olympia and Whiterock) for four mornings per week. In addition, the Play Service established a Play Club one morning a week in partnership with the Toy Box project for Traveller children.
2.3	The implementation of the model on a trial basis has allowed the identification of key variables that appear critical to the success, or otherwise, of the model. For example, the Play Club based within the Traveller project has been extremely successful and is run in a partnership with the Toy Box project, which works with Traveller families. Assistance has also been provided through the Travellers' Liaison Officer and Community Development Officer. The project has had an average daily attendance of 6.5 (65% of available places).
2.4	The projects were unable to be developed at the Olympia and Whiterock Centres due to insufficient demand and were eventually withdrawn. Staff were re-deployed to other community based projects where demonstrable demand existed coupled to local organisational commitment. The project at Ballysillan has met with minimal success as the demand has been low with an average attendance of 4.7 children (29% of available places). There has also been difficulty in obtaining engagement with the project from within the local community despite the best efforts of the Play Development and Community Development Officers.
2.5	On the basis of the trial experience, the Play Service would seek to develop this model with services based on demonstrable need and an identified partnership with another organisation or local community group. The service would also be restricted to a maximum of two mornings to enable more communities to benefit and to promote longer term sustainability.
2.6	The implications of this would involve discontinuation of the Play Club based at Ballysillan Playcentre. The Traveller Play Club would continue to be provided within the partnership framework and based on there being sufficient demand.

3	**Resource Implications**
3.1	The resources are within existing resources.

4	**Equality and Good Relations Considerations**
4.1	Changes to the Play Service are likely to have made a positive contribution to the principles and practice of Equality and Good Relations through their impact on greater numbers of children from communities experiencing a range of socio-economic disadvantage.

5	Recommendations
5.1	Members are asked: - To note the report of the Play Clubs; - To agree on the future development of the Playclub model based on a partnership approach and targeted at more areas based on identified need.

6	Decision Tracking
Eddie Jackson to implement committee decision. September 2011	

8	Documents Attached
Appendix 1: Play Club Evaluation report.	

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Belfast City Council Community Services

Play Club Evaluation

Purpose of the Play Clubs
The Play Club model was developed to provide play opportunities for children aged 2 – 4 years. The aims are two fold:

1. To adopt a community development based approach to promote play. This involves play staff in the initial stages providing direct support for the play sessions and then withdrawing gradually as the local community take ownership of the project. The play service continue to provide support through programme input, resources, advice and training. The success of this project is based on development in partnership with an existing community group or parent and toddler projects.

2. To provide for a specific target group where there are few play opportunities otherwise available.

The Play Clubs generally are provided one or two mornings per week. The underlying rationale for the model is to enable the local community to acquire the capacity to take ownership of the project and thereby enable the play service to target more areas or groups.

The programme for the Play Club is based on providing a range of play opportunities. Activities in the play club include painting, crafts, games, physical activities, story telling, outdoor and indoor play. The benefits include development of social, physical and creative skills. The Play Club is not to be confused with pre-school playgroups which have a specific curriculum which focuses on specific areas of learning.

Current Position
At the meeting on 1st July 2010, Belfast City Council agreed to run Play Clubs four mornings per week at Whiterock, Olympia and Ballysillan Playcentres.

There was difficulty in establishing the Play Club at Whiterock as there was no physical capacity in the community centre. The Belfast Health and Social Services Trust rent out both the minor and main halls five mornings for a project for adults with learning disabilities.

Endeavours to establish the Playclub at Olympia were unsuccessful. Posters and leaflets were distributed around the area. An information meeting and a registration day were publicised. Both were unattended. There were several phone enquiries but this did not result in any children being registered for the project.

The Play Club at Ballysillan started at the end of September. Nine of the sixteen places were taken up. Several meetings were held where parents were invited to attend to become more actively involved in the Play Club with the aim of taking over the project in the longer term. Ongoing support was offered from both the play and community service units, including a training programme.

Initially, there were several local community members interested in supporting the project through volunteering. Unfortunately due to other commitments, the numbers decreased. Only two volunteers initially took part – although one later withdrew. The main volunteer helps out once a week. The training programme did not take place due to lack of interest.

The main difficulty with this project was the expectation that the play club would be run on the basis of a pre-school playgroup and based on the pre-school curriculum. An information meeting was held before the project started to explain the aims of the Playclub and activities that would take place. The numbers on the enrolment have fluctuated between four and nine, with children leaving and new children joining the project.

Average attendance each month:
Maximum number -16 places

September	5
October	5
November	7
December	6
January	5
February	4
March	4
April	4
May	4
June	3

Average attendance through the year – 4.7 (29% of available places)

There have been six indications of interest for the Play Club if it is to continue for the year 2011-2012.

Traveller Play Club
The Play Service established a Play Club one morning each week in partnership with the ToyBox Project for Traveller children. The project was established from an identified need in that pre-school children in the Traveller Community lack play opportunities in their own home. The Traveller culture historically places little emphasis on play. There is little room in their homes for toys or the provision of creative activities (such as painting). Some have never been away from their family.

The project provides 10 places. Although there is demand for more places, the space available in the portacabin limits the numbers. The project provides

a range of play opportunities – and most have painted pictures for the first time. One four year old child who did not want to leave his mother will now be starting school after attending the Play Club.

Average attendance each month:
Maximum number - 10 places

November	7
December	8
January	2
February	5
March	8
April	8
May	7

Average attendance through the year – 6.5 (65% of available places)

Summary

The Play Club model has had varying success at the three directly managed centres. This is partly attributable to two factors – the perception that the project would be run as a pre-school playgroup and the lack of an identified partner.

The Play Club for the Traveller project works in partnership with the Toybox project and has had consistent attendance (except in January due to poor weather conditions). There is a demand within the local community for the places and this is supported by the worker with the Toybox project who works closely with the families.

The play service has identified at least two other areas where the existing community are interested in working in partnership for the Play Club model to be developed and further exploratory efforts will continue.

Recommendations

To continue to develop the Play Club model in areas of identified need and to target specific groups. The model would be run in each area for a maximum of two mornings per week. This would not be confined to the current six playcentres and would enable support for the voluntary community sector. Through this, the play service will be able to support more areas and increase the potential sustainability of the model within such areas.

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Belfast City Council

Report to:	Development Committee
Subject:	Community and Play Centre Committees – Updated Report
Date:	23rd August 2011
Reporting Officer:	Barry Flynn, Democratic Services Officer, ext 6310
Contact Officer:	Catherine Taggart, Community Development Manager, ext 3525

1	**Relevant Background Information**
1.1	Members will recall that, at its meeting on 15th June, the Committee agreed to re-appoint a number of Elected Members to the Management Committees of the Council's various Community Centres. The Members re-appointed had been nominated previously to serve on the Management Committees in October 2008 and had been re-elected to the Council at the Local Government Elections in May this year.
1.2	At that meeting, it was agreed also that the Democratic Services Section would undertake a further exercise to seek expressions of interest from all Elected Members in order to make additional appointment to the Management Committees. Accordingly, nominations were sought and an updated list is attached for approval as Appendix 1.

2	**Equality and Good Relations Considerations**
2.1	There are no Equality and Good Relations Considerations attached to this report.

3	**Recommendations**
3.1	It is recommended that the Committee approves, for the period of the current Council term, the additional appointments to the Management Committees as set out in Appendix 1.

4	**Decision Tracking**
Timeframe: October 2011	Reporting Officer: Barry Flynn

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Appendix 1

Appointments to Management Committees of Community and Play Centres
(additional appointees are highlighted)

Ardoyne Community Centre
Councillor Lavery
Councillor Mallon
Councillor McCabe

Avoniel Play Centre
Alderman M. Campbell
Alderman R. Newton
Alderman Rodgers
Councillor Hendron
Councillor Hussey
Councillor Kyle

Concorde Community Centre
Councillor McKee

Dee Street Community Centre
Alderman R. Newton
Alderman M. Campbell
Alderman Rodgers
Councillor Jones
Councillor Kyle
Councillor Haire
Councillor Hussey

Donegall Pass Community Centre
Alderman Stalford
Alderman Stoker
Councillor McCarthy
Councillor Patterson

Duncairn Community Centre
Alderman Browne
Councillor Spence

Knocknagoney Community Centre
Alderman R. Newton
Alderman Rodgers
Councillor Jones
Councillor McNamee
Councillor Haire
Councillor Hussey

Ligoniel Community Centre
Councillor Lavery
Councillor Mallon
Councillor McCabe

Morton Community Centre
Alderman Ekin
Alderman Stoker
Councillor Kelly
Councillor Hanna

North Queen St. Community Centre
Councillor Convery
Councillor Lavery
Councillor Maskey
Councillor Mallon

Olympia Community Centre
Alderman Ekin
Alderman R. Patterson
Alderman Stoker

Sandy Row Community Centre
Alderman Stalford
Alderman Stoker
Councillor Kelly
Councillor McCarthy

Appendix 1 (cont.)

Finaghy Community Centre
Alderman Ekin
Alderman R. Patterson
Alderman Stalford
Alderman Stoker
Councillor Kelly
Councillor Hanna

Glen Road Community Centre
Councillor Attwood
Councillor O'Neill

Hammer Community Centre
Alderman Stoker
Councillor Kingston

Highfield Community Centre
Alderman McCoubrey
Alderman Smyth
Councillor Kingston

Horn Drive Community Centre
Councillor Attwood
Councillor O'Neill

Inverary Community Centre
Alderman R. Newton
Alderman Rodgers
Councillor Jones
Councillor Hussey

Suffolk Community Centre
Alderman R. Patterson
Alderman Stoker
Councillor Kingston

Whiterock Community Centre
Councillor Tim Attwood

Woodvale Community Centre
Alderman Humphrey
Alderman Smyth