Evaluation of the Healthy Living Centre programme in Scotland

Report of phase 2

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Contents

	Executive summary	iv
1.	Introduction	1
1.1	The Healthy Living Centre programme	1
1.2	Purpose of phase two of the evaluation	1
2.	Fieldwork and methods	3
2.1	Background	3
2.2	Methods	3
2.3	Managing fieldwork during phase two: continuing with a flexible approach	4
2.4	Fieldwork and data management	5
2.5	Data analysis	6
3.	Findings	7
3.1	Research objective 1: To elicit stakeholder understandings of how HLCs have adapted their approach over time to address issues of social injustice and inequality and to examine what future contributions HLCs will make to this agenda	7
	3.1.1 Introduction	7
	3.1.2 What do HLCs mean when using the term ‘health inequalities’?	7
	3.1.3 Working with realities: HLCs’ ability to change and adapt approaches	9
	3.1.4 Tried and tested methods: benefiting from experience and fine-tuning	10
	3.1.5 Accommodating new groups and enhancing the focus on existing groups	11
	3.1.6 The changing use of premises: the benefit of experience	13
	3.1 7 Holistic approaches: different interpretations and applications	16
3.2	Research objective 2: To describe evolving community development structures in HLCs and their impact on addressing inequalities	18
	3.2.1 Introduction	18
	3.2.2 Changes and adaptations to community involvement	19
	3.2.3 What works in practice: building trust	25
	3.2.4 The importance of the relationships that have developed: personal contacts	27
3.3	Research objective 3: To examine how HLCs meet local health needs while working to address national health priorities	28
	3.3.1 Introduction	28
	3.3.2 Accommodating to priorities and policies	29
	3.3.3 Influences on HLCs’ blending of local needs and emerging policies	30
	3.3.4 Meeting local needs and reflecting national priorities: an increased focus on mental health and well-being	32

3.4 Research objective 4: To explore the involvement of HLCs in wider health economy structures (e.g. community planning, community health partnerships) 35
3.4.1 Introduction 35
3.4.2 Partnership working: at the level of the HLC 35
3.4.3 Levels of HLCs involvement in CHP and CPP structures 38
3.5 Research Objective 5: To examine HLCs' attempts to ensure project sustainability, through taking account of community influences, types of HLC (e.g. voluntary, statutory or community-led), partnership construction and wider inputs at local and national levels 42
3.5.1 Introduction 42
3.5.2 Definitions of 'sustainability' and their application when examining HLCs 42
3.5.3 Aiming for moving targets: the changing landscapes inhabited by HLCs 43
3.5.4 Plans for sustaining services 48
3.5.5 Demonstrating impact 50
3.5.6 Incorporating learning about what works in sustainability plans 53
3.5.7 Funding cutbacks: the HLCs return to the BLF 54
3.5.8 Impacts on HLCs' established practices when seeking sustainability 55

4. Implications and conclusions 62
4.1 Introduction 62
4.2 Drawing together the findings 62
4.2.1 The importance of time and the need to become familiarised with local communities 62
4.2.2 Working with the shifting realities of inequality 64
4.2.3 Spaces, places and cultural acceptability 65
4.2.4 Remaining 'local' while attending to national demands 66
4.2.5 Partnership working is often defined in practice 66
4.2.6 The importance of the manager 67
4.2.7 Building a profile 67
4.2.8 Allowing time to learn the sustainability ropes 68
4.3 Conclusions 69

Appendix 1 Anonymised description of the six sites 71

Appendix 2 Phase two research proposal 75

Boxes

3.1	Clusters of health inequalities (Bridge Consortium)	7
3.2	Community projects implemented/supported by HLCs	25
3.3	Sustainability considerations in site 6	56
3,.4	Sustainability considerations in site 3	57
3.5	Sustainability considerations in site 5	58
3.6	Sustainability considerations in site 4	59
3.7	Sustainability considerations in site 1	60
3.8	Sustainability considerations in site 2	61

1. Executive Summary

This is the second and final report on the evaluation of the Healthy Living Centre (HLC) Programme in Scotland. The Big Lottery Fund (BLF, previously known as the New Opportunities Fund) established the HLC funding programme in 1999. At its inception, this was the largest single investment in community-based health intervention in the UK. The HLC programme was established to address health inequalities by seeking to improve health and well-being among people living in deprived communities. To achieve this aim HLCs were funded to develop solutions which were to be innovative and responsive to local health improvement needs, and complementary to local and national health policies and priorities.

To evaluate the success of the programme, a series of national, regional and local evaluations of HLCs was commissioned. In Scotland, a longitudinal process evaluation of the HLC programme was conducted using a case study design over two phases. In phase one (2002-2005)[1], the pathways between activities, processes, contexts and outcomes were explored in a purposive sample of six Scottish HLC projects. The six case HLCs were selected to reflect the range of target groups, health problems, governance structures, partnerships, anticipated health outcomes and geographical locations of the 46 HLC projects within Scotland. The second phase examined the longer-term development of the HLC programme and its evolving contribution to addressing inequalities, changes to community engagement practices, approaches to meeting local needs and addressing national priorities, involvement in wider health economy structures, and attempts to ensure sustainability.

Methodology

Using an intensive longitudinal case study design, a range of qualitative methods has been applied to the investigation of process and change in six HLCs. Methods included: taped, semi-structured interviews; discussion groups; documentary analysis; participant observation; observation of activities, meetings and events; telephone interviews and ongoing email and telephone contact with key stakeholders. The establishment and maintenance of good relationships between the researcher and HLC gatekeepers (e.g. project managers) were crucial to securing access to people, places, events and documentation. Researcher flexibility and adaptability to accommodate to HLC structures and work patterns was necessary throughout. The number of interviewees participating in each site varied from 8-15 (including project team members, local partners and service users), dependent on the characteristics of each HLC. Individually-tailored topic guides were used for each site to explore often rapidly changing circumstances. An iterative data analysis process has continued throughout the evaluation; themes and findings have been generated using grounded theorising principles and constant comparative methodology.

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[1] Platt, S., Backett-Milburn, K., Petticrew, M., Rankin, D. and Truman, J. (2005) *Evaluation of the Healthy Living Centre Programme in Scotland: Report of phase 1*. RUHBC Working Paper #3. University of Edinburgh: Research Unit in Health, Behaviour and Change.

Findings

To elicit stakeholder understandings of how HLCs have adapted their approach over time to address issues of social injustice and inequality, and to examine what future contributions HLCs will make to this agenda (see section 3.1).

Underpinning the HLC programme was the attention to be given by HLCs to addressing health inequalities. Throughout the evaluation stakeholders were found to use a variety of interpretations when discussing health inequalities, with different (and sometimes overlapping) usage dependent on the type of service being delivered.

HLCs have limited scope to address inequalities at a societal level, with their efforts instead focused on addressing disadvantage within target groups. Notwithstanding this limitation, many HLCs were highly adaptive when seeking to address inequalities within their target communities, responding both to changes in communities and to knowledge gained through working with them. This responsiveness led to the creation of new services, the establishment of new delivery methods and the employment of new staff to meet community needs. Although such adaptability was a feature across sites, this was tempered by certain restrictive models of service delivery and, in some sites, concentration of effort on activities specified in the business plan. There were also multiple instances where tried and tested methods remained in use, with small refinements made as a result of implementing evolving understanding of 'what works'.

Central to the HLC approach to tackling inequalities was enhancement of the appeal of services to local people through relationship building, the establishment of trust, and the 'embedding' of staff/services. HLCs benefited from having time (five years' funding) to become acquainted with host communities. Flexibility and an innovative capacity to make changes and refocus services were required in order to meet new and changing needs. In addition, the often broad application of services across communities was used to gain knowledge which would support a localised and targeted approach to those 'priority' groups most in need. Such universalistic provision was also often used as a way of avoiding stigmatising more marginalised groups/individuals. Stakeholders in one site suggested that the use of wider awareness raising, health promoting activities would help the HLC to engage hard-to-reach groups.

The changing use of physical spaces highlights the way in which approaches toward addressing inequalities/disadvantage developed over time: physical spaces are imbued with meaning. Adjusting to community needs, HLCs adapted their working environments and service delivery spaces better to accommodate services, to overcome barriers to uptake and to promote new methods of work. Several sites developed some form of social meeting space in attempts to address the stigma sometimes associated with attendance. The lack of a local delivery point was a hindrance to promoting social contact for some sites, which expressed an intention to devise or promote social hubs in the future. Nevertheless, HLCs recognised the need to deliver services across

their target communities and the importance of outreach as a method of appealing to, and engaging, local people.

The term ‘holistic’ was often used by HLC stakeholders when referring to the delivery of services. One such usage included person-centred approaches, where HLC services were on offer to address both the physical and mental health and well-being needs of an individual. For example, social opportunities geared towards improving well-being were often promoted in conjunction with more traditional activities, such as exercise- and diet-related services. In one site the food that was provided was eaten at tables to enhance socialisation as well as to deliver a balanced diet. The term holistic was also used to refer to service-centred approaches, for example using referrals and linking existing HLC services, seeking to bolster capacity, and connecting the sometimes disparate partner-provided services that existed across a locale.

Throughout the evaluation, flexibility was central for HLCs which sought to respond to evolving understanding of target communities over time, in order to make appropriate changes to activities/services. Having been charged with developing innovative service capacity, HLCs experienced both successes and failures in their activities. Some models of service delivery were more adaptable to changing circumstances. Learning how to meet the needs of local communities was not a one-off undertaking. Rather, it was a developing process which required up-to-date knowledge of local areas, groups and individuals; an understanding of the history of service provision in the area; knowledge of current services; an ability to remain abreast of wider policy developments; sufficient time to become trusted and embedded within a community; and a supportive local health environment.

To describe evolving community development structures in HLCs and their impact on addressing inequalities (see section 3.2).

Community involvement was a central feature of the HLC programme, with much attention also given to the use of community development approaches when working with local people and responding to their needs. A wide variety of techniques, opportunities and roles were devised for engaging and involving local people within HLC services and structures, with differing levels of success across and within the sample sites. Learning from experience and time, the persistence and dedication of staff were central to engaging, supporting and re-engaging local people at multiple levels across the HLCs. Stakeholders across several sites emphasised how community engagement could decline without the efforts of staff to support community involvement practices.

Involving service users in governance roles remained a challenge for HLCs. In some instances this was attributed to the types of involvement in the HLC that local people sought. While some communities had members who were more willing to become involved in governance, others still were mistrustful of engagement as a result of the curtailment of previous services in the area. Local history therefore also played a part in how HLCs could be implemented. For many HLCs it took a lengthy period of operation for staff to gain the trust

of users, with some sites only considering forming user groups latterly or in any future organisational reconfiguration.

Managerial roles for local people were promoted in two locations and mixed levels of success were again evident. In some instances throughput of management group members was related to the often onerous nature of the responsibilities involved. Some local people sought to be involved for a limited period of time or at a level that was less demanding of time and responsibility than that on offer. Although skills deficits in management group members were addressed through training, new challenges in overseeing large and complex organisations continued to emerge. Having attracted key members of the community to such positions, their throughput led to a declining number interested in assuming such roles. Stakeholders in two sites highlighted their dissatisfaction with community involvement practices that sought to engage users in overly complex managerial functions, suggesting instead that local people be solely and more directly involved in identifying areas of work to address physical and social forms of deprivation.

Local people were also involved in a variety of roles related to service delivery, as volunteers, as sessional workers and as paid members of staff. While the work undertaken by local people was important for the service delivery function, much of this could not have taken place without the considerable support offered by project staff. Building the capacity of local people was a key feature of HLCs' work, although it was suggested that greater attention be given to ensure that community members who engaged with the HLC also had access to additional future opportunities. Having created a throughput of local people in developmental roles, the lack of such wider capacity building opportunities sometimes proved problematic.

While the impact of community development approaches was evident in individual success stories, particularly among local people who had become volunteers and subsequently entered paid employment, HLCs also supported and developed groups that could operate independently. Differences were evident between sites in the emphasis given to such work, in the successes attached to it and in the willingness of people to assume independent control. Features of successful groups that had been established included: developing culturally appropriate responses to local needs/demands; the involvement of HLC staff skilled in community development techniques; and the continuing but gradually reducing support of HLCs over time. Administrative and operational demands of such groups often required professional inputs over time to bolster development and secure their continuation.

In conjunction with time spent building trust, informal approaches used by HLC staff were critical to success when involving members of the local communities. This highlights again the importance of building effective social relationships between communities and HLC staff. Evident throughout the evaluation was the importance local people attached to the provision of personalised contact by HLC staff over the longer term. Five years of funding enabled the HLC and its staff to become 'embedded' within its host community, allowing staff to develop skills in ascertaining and meeting needs

with culturally appropriate services. The precariousness of community development work within disadvantaged communities and the importance of maintaining support over the longer term were often emphasised.

Seeking and obtaining community involvement was an ever-evolving challenge, requiring time, tenacity and adaptability by projects and their staff. One site manager suggested that HLCs' work should not be viewed as an end in itself, rather it might be considered as part of an ongoing process of community involvement and development, first breaking down barriers, then building trust and providing support over time, before gradually withdrawing this support when appropriate. Stakeholders tended to the view that five years of the HLC programme, while highly beneficial, merely marked the starting point in terms of delivering effective community development approaches within target communities.

To examine how HLCs meet local health needs while working to address national health priorities (e.g. mental well-being, diet and physical activity) (see section 3.3).
Devised to respond to local needs while remaining cognisant of national policy developments, HLCs had to meet expectations current at the time of their formation and implementation and address evolving demands as the delivery of their services progressed. While the breadth of HLC work enabled stakeholders to make links with policy-relevant documents, devolution and the emergence of new priorities meant that a continual focus on policy was required of case study sites.

Much of the HLCs' work was considered by stakeholders to link with national health priorities. However, responses to evolving policies differed according to whether HLCs took a proactive or reactive stance. The manner of engagement differed according to the availability of time, interests and strategic involvement of the manager, and the position of the HLC within its local health economy (e.g. proximity to NHS, health improvement functions of local authority, ability to become involved in CHP/CPP structures). In some sites, the types of group targeted and/or resource capacity of management precluded a wider focus on policy, with HLCs remaining focused on their original aims and objectives.

The structure of an HLC and its links with partner organisations influenced the focus on meeting local needs and national priorities. Some sites had more solid links to statutory partners than others (e.g. those hosted by NHS compared with sites operated by community-led management groups). Most HLCs recognised that sustainability would be aided by working closely with local partners who had responsibility for distributing funding. Strategic capacity was in some instances limited by the size of an HLC and by the lack of engagement of some key partners.

An examination of HLCs' increased focus on mental health and well-being draws attention to the manner in which emergent local needs came to be reflected in national priorities, and how holistic service provision became prominent. Increased demands to address mental health and well-being

needs became evident in several sites following periods where the HLC had become embedded within, and gained the trust of, target communities. These demands were then met using traditional approaches, informal methods and attempts to introduce system-wide changes to enhance delivery. The success associated with some social models of care was suggested by one site to be an attempt to redefine and move away from a focus on medical models of mental health care, to take account of 'normal' (social) paths to recovery. In these examples, the non-stigmatising venues and delivery of HLC services were often critical to success.

Throughout, findings reflect the challenges that HLC managers and stakeholders faced in attempting to deliver a programme of work that was established and predated the emergence of new national priorities and policies. Some sites' managers have proved to be adept at managing both operational and strategic roles, while the strategic structure of the HLC and specificity of target groups pursued by others have enabled better positioning to reflect priorities and emergent policy.

To explore the involvement of HLCs in wider health economy structures (e.g. community planning, community health partnerships) (see section 3.4).
The HLCs engaged in partnership working at several levels, including operationally when providing services, strategically to guide in-house and partners' service delivery, and more widely across their local health economy through engaging with community health and community planning partnerships (CHPs and CPPs).

The success in operational partnership working which was evident across sites was often based upon practical experience and diverged from or expanded upon relationships specified in the original funding bids. The flexibility of HLC models and the length of time spent working in partnerships facilitated robust links between statutory and community/voluntary sectors. During a time of flux, HLC partnerships offered some stability to organisations undergoing change, although continual adjustments had to be made to accommodate to changes in partners' personnel. Central to some HLCs partnership work was the promotion of community development practice within statutory agencies, with mixed success across the sample. Several HLC managers considered that attention given to community development work in the statutory sector remained somewhat tokenistic.

The experiences of strategic partnership working by HLC stakeholders were more mixed. Management resources and capacity, the varying interest of partners (particularly when HLCs were considered to be operating successfully) and wider changes affecting the local health economy more broadly combined to have a negative impact on several HLC strategic partnerships. This was less of an issue for HLCs with supportive host organisations or lead partners. However, for others, wider changes and a lack of strategic guidance were considered detrimental to longer-term survival, often necessitating attempts to reinvigorate partners' interest.

Wider developments cross-cutting the HLCs saw the introduction of community health partnerships (CHPs) and community planning partnerships (CPPs). CHPs and CPPs were not implemented in a consistent manner across the country, and there was considerable variation in the relationships between HLCs and these organisational structures. The degree to which key CHP/CPP stakeholders were involved in HLCs differed according to size of the site and its overlap with CHP/CPP boundaries. One site highlighted how partners had appeared to distance themselves following the introduction of CPPs and its moves to focus on an area larger than that targeted by the HLC. HLCs' ability to engage with CPPs was sometimes influenced by local political features which affected the strategic role(s) available for HLC stakeholders. Limits to HLC involvement with CPP/CHPs were also affected by the types and numbers of groups targeted by HLCs and by the rate of development of the wider partnerships.

To examine HLCs' attempts to ensure project sustainability, through taking account of community influences, type of HLC (e.g. voluntary, statutory or community-led), partnership construction and wider inputs at local and national levels (see section 3.5).
Sustainability was mainly discussed by HLC stakeholders in terms of the continuation of the original organisation and its functions, either as a whole or in modified form. Stakeholder views on sustainability have changed over time to incorporate an enhanced understanding of target groups and their needs; to accommodate to the changing wider health economies in which HLCs are located; and to identify new funding opportunities made available by the BLF.

Throughout the evaluation, HLCs have had to consider sustainability in different ways, often as a consequence of wider changes, including the future determination of local services and potential funding by CHP and CPP structures. As a result HLCs have given more consideration to the level of service provision across an area and to their fit within local health economies, including the need to alter HLC service boundaries to incorporate larger areas and, in some instances, new directions for work. The acceptability of proposed changes was also dependent on the actual HLC model in use and strength of ties to local communities. There was seldom an automatic fit and HLC managers attempted to work creatively with CHPs/CPPs to identify opportunities. Managers in several sites highlighted how they had repeatedly sought an indication of the changes to HLCs and service provision that might need to be undertaken. However, the system-wide changes underway often resulted in a lack of guidance or indeterminate responses from CHP/CPP bodies to HLCs seeking to become sustainable over the longer term.

Among their many responsibilities, managers and management groups were tasked with planning the strategic direction of their HLC. However, differences in capacity, ability, time and access to decision-makers were evident across the HLC sample. The strategic significance of such roles was particularly evident when managers left post and where such roles had not been fully developed (often as a result of lack of capacity). Expectations of managers were considerable and varied, sometimes requiring them to be all things to all people. The future plans for continuation of some sites took into account the

need to bolster such roles, should the HLC be sustained. Several managers discussed the need to be able to lobby at wider strategic meetings to generate and sustain interest in the work of the HLC. Not all managers had such opportunities.

Most attention was given to sustaining the organisation, while discussion regarding the sustainability of services centred on the need to continue with the inputs of professionally employed people to support the community. One large site examined how 'backroom' functions of the HLC (e.g. finance and administrative posts) and those of other smaller local organisations might be consolidated under a proposed new funding structure. However, this funding proposal generated suspicion among local community members about the HLC's future target group focus. Meanwhile, some network models were considered likely to be able to sustain independent services, while partners and some host organisations were proposed as possible successors to enable some services to continue in the event of the closure of the HLC. Stakeholders suggested, however, that if services were to continue outside the HLC then they would probably operate at a reduced level. One site which had discussed introducing service charges to improve recovery of service delivery costs considered that this would adversely affect uptake among disadvantaged groups.

When discussing sustainability with potential funders, stakeholders struggled to demonstrate impact or to establish a profile, particularly when work was delivered in partnership with other organisations. HLCs undertook their own local evaluations, with some seeking retrospectively to apply outcomes measures. Some partners also suggested alternative ways of measuring impact, although few were implemented. Several stakeholders reported how they had sought help from CHPs and CPPs about outcome measures, but had received little guidance. Managers were also aware that measuring and demonstrating outcomes would be necessary in any future configuration of the HLC and sustainability plans focused on how relevant data might be gathered.

When sustainability plans were discussed, several sites highlighted the learning that had taken place over the course of BLF funding, including the importance of continuing to work with deprived communities and the need to give particular focus to more vulnerable groups. Many stakeholders discussed how funding arrangements did not provide the core costs which were necessary to sustain organisations and how this might impact on the innovative capacity of HLCs.

With most HLCs requiring large funding packages to continue their organisation and services, it was apparent that options among their partners and within local health economy structures were limited. In addition, uncertainty existed over the eligibility of HLCs, particularly those hosted by statutory agencies, to apply to the new BLF 'Investing in Communities' fund. There was further confusion about the need for matched funding from partners to support bids. Although these concerns were addressed, some HLCs' stakeholders remained uncertain about whether the BLF would fund

organisations to provide services that might be considered a function of statutory organisations. Having worked closely with local statutory providers to gain acceptance during their initial BLF funding, HLCs faced having their sustainability proposals being considered by the BLF (and possibly rejected) if viewed as a more integrated part of statutory provision, even though only limited funding was available from this sector.

All sites highlighted the flexibility that five years of BLF funding had offered in developing services and when seeking the engagement of local communities. Having taken time to gain acceptance among local communities and having had the flexibility to accommodate to local needs, some stakeholders were wary of how new funding packages might impact on both the ethos and content of HLC operations. For example, some stakeholders discussed how a sole reliance on mainstream funding could reduce the capacity for innovation, while others suggested that mainstream monies might influence the ability of an HLC to focus on health. Stakeholders' attention was also given to potential enlargement of geographical areas covered by the HLC, with concerns raised that the ethos of locally-based projects might be eroded if work had to be undertaken across wider areas. By the end of fieldwork several HLCs were awaiting confirmation of bids for funding from the BLF, while others had yet to conclude discussions with CHP/CPP bodies or finalise their sustainability plans.

Implications

The importance of time and the need to become familiarised with local communities
Time-intensive effort is required to develop HLC methods of working and to engage and support disadvantaged groups. Engaging local participation and building relationships and trust within disadvantaged communities was a challenge experienced by all sites, which (typically) could only be addressed through long-term work in target areas. Becoming familiar with the needs of local communities involved the devotion of considerable effort to 'informal' support to local people. Attention given to building health capital often involved considerable time and effort spent building social capital (i.e. social networks and shared norms and values). The length of time that has been spent becoming familiarised with communities and the relationships that many HLCs have established should be viewed as an aid to local planning for future service delivery.

Working with the shifting realities of inequality
HLCs mainly worked in a manner which was restricted to addressing health and social disadvantage among particular target groups, using a variety of approaches, often labelled as 'holistic'. Great value was attached to tried and tested methods of delivery, while it also was commonly recognised that continual innovation was necessary to meet new and existing needs, to maintain interest and involve new people, and to develop informal ways of working and interactions with target users. Decisions made by HLC stakeholders highlighted the continual attention (including when considering sustainability) given to whether successful ways of working will suit new

clients within existing target groups or whether working to address inequalities entails changing practice as new groups are identified or emerge.

Spaces, places and cultural acceptability
The changing use of spaces and places by HLCs both reflected the changing identification of needs/better ways of working and responded to the challenge of removing as many barriers as possible (e.g. stigma) when working with disadvantaged groups. In some instances the services devised and supported by HLCs are inherently non-stigmatising (e.g. community gardens), especially when used to target change in individual lifestyles. In other instances, the value of services with spin-off impact on mental health and well-being (e.g. activities promoting exercise and those offering social opportunities) was paramount. Such services were often both non-stigmatising and culturally appropriate (e.g. walking groups established in urban areas).

Remaining 'local' while attending to national demands
The findings illustrate the contradictions that exist when attempting to reconcile a community-driven focus with attention to the strategic drivers of larger organisations at local levels (e.g. CHPs and CPPs) and national priorities arising from government policy. HLCs had to accommodate to shifting positions at each of these levels, seeking to retain community inputs and the relevance of activities to a variety of groups and to ensure the support of larger partners. Commitment to local need and to continuing work to address such need had to be balanced with attention given to wider local and national circumstances. HLCs are uncertain how to respond to such demands. This highlights the limited amount of central strategic guidance on offer, despite the support structures that were put in place.

Partnership working is often defined in practice
HLCs have had to accommodate to multiple changes in partners and partner organisations both when delivering services and when considering strategy, particularly in relation to sustainability. Some sites have had more success in engaging partners because of favourable strategic resource allocation, shared boundaries and 'fit' with the strategic interest of partners. Partners that are required for winning bids for funding may have little to offer in terms of practical service delivery, whereas other partners' influence and inputs may become more important over time. There was an increased recognition that HLCs, once embedded in the locality and delivering work for shared target groups, were beneficial partners within local health economies.

The importance of the manager
The role of HLC manager was central to each site's development. The manager was typically responsible for guiding service development, positioning in terms of community involvement and user participation, developing links with partners and for leading strategic consideration of sustainability. However, the managerial role and its functions differed between sites as did the level of managerial resources available for operational oversight and strategic command.

Building a profile
Attention given to profile raising differed between HLCs, although all acknowledged its importance. For some sites, the main aim in establishing an identity was to appeal to local people, in other sites profile raising was intended to promote effective partnership working, whereas for yet others it became salient when considering sustainability. In all cases it was found that such activity takes time and often money to develop, with staff members in some sites having greater skills and experience relevant to performing such tasks than staff in other sites.

Allowing time to learn the sustainability ropes
The evaluation highlighted the problems associated with addressing sustainability when confronted with continual changes within operating environments. During key transitional periods, the strategic view of key HLC partners (sometimes those now working as part of a CHP or CPP) was necessarily directed at structures wider than HLCs. However, this lack of focus, together with the HLCs' need to adapt to changes in personnel and structural composition of strategic partners, resulted in the sites being less able to retain the inputs and focus of champions that had been nurtured over time. The funding environment did not appear to favour the award of core costs to HLCs. Although some external support was given, the changes underway to wider structures and the variety of HLC models seemed to mitigate against the provision of general guidance about forms of sustainability. With the attention of funders moving toward a focus on work to address health outcomes and with community planning partnerships assumed to be taking a lead on promoting community engagement, partnership working and connecting local and national priorities, it is worth considering the investment that has been put into programmes such as the HLCs. The groundwork involved in implementing, developing and adapting services and activities to respond to changing local needs and national priorities is substantial and has been undertaken in sites across Scotland. Much learning at local levels has occurred, leading to several diverse models of engagement with local communities in order to address their needs. Sustainability of such initiatives should take into account the relationships, acceptability and work practices within local communities that have been developed over time by HLCs.

Conclusions
The findings highlight the learning and changes made by case study sites between phases of fieldwork and the adaptive manner in which many of the HLCs sought to address their primary aims and objectives. This draws attention to the different ways in which HLC impacts should be considered and of the challenges experienced when working in a dynamic service delivery environment. While there was no 'one-size-fits-all model' for an HLC, each site was faced with similar challenges during their evolution, having to accommodate to changing needs, partners and wider health economy systems. The efforts of managers, staff and partners to shift focus as new local needs and political priorities emerge is a key strength of the programme, enabling HLC stakeholders to adopt positions which should aid sustainability.

Many of the findings reported here are consistent with those contained in the Bridge Consortium Final Report[2], which describes a series of linked evaluations of the HLC programme at a UK-wide level. More broadly, the findings resonate with recommendations made in the report of the Community-led Supporting and Developing Healthy Communities Task Group (CLTG)[3], e.g. the need to set out more clearly the links between objectives, inputs, outputs and outcomes (recommendation 2); the need to make health improvement planning more effective in engaging communities and allowing them to identify their own priorities (recommendation 4); and the need to provide improved infrastructural support and put in place appropriate strategic and operational frameworks for long-term sustainability of community-led health improvement activity (recommendation 11).

The findings highlight the effort required to involve and sustain the involvement of local communities, and of the continuing attempts and successes of HLCs in so doing. This is particularly striking when considering that wider community engagement structures, such as community planning partnerships, were recently advised to ensure that more emphasis be given to sustaining and systematising community engagement structures[4]. In making links with these findings, learning from the HLC programme suggests that more attention be given to longer-term consideration of community needs and to ensuring that there is provision and sufficient capacity to meet these needs, particularly as changes occur over time. Learning from the HLC programme offers a valuable repository of information on engaging with and involving disadvantaged communities in action to improve health.

[2] The Bridge Consortium (2007) *The Evaluation of the Big Lottery Fund Healthy Living Centres Programme: Final Report*.
[3] Community-led Supporting and Developing Healthy Communities Task Group (2006) *Healthy Communities: A Shared Challenge*. Edinburgh: NHS Health Scotland. Available on: http://www.healthscotland.com/uploads/documents/2746-HealthyCommunities%20TaskGroup.pdf
[4] Audit Scotland (2006) *Community Planning: An Initial Review. Edinburgh: Scottish Executive*. Available on: http://www.audit-scotland.gov.uk/publications/pdf/2006/06pf03ag.pdf

1. Introduction

1.1 The Healthy Lining Centre programme

This is the second and final report on the evaluation of the Healthy Living Centre (HLC) Programme in Scotland. The programme was established across the UK in 1999 by the Big Lottery Fund (BLF)[5] using a £300 million fund with the financial split based on the population of each country. Scotland received £34.5 million as its share, which led to the establishment of 46 HLCs being established in communities across the country. Those bidding for funding were informed by the BLF[6] that HLCs should work to promote good health in its broadest sense, to target disadvantaged groups to both improve health and to address health inequalities.

A wide remit was given to successful HLC bidders with organisations being funded for periods of up to five years. The establishment of an HLC was to be guided by efforts to develop and promote partnership working across sectors and to involve the local community in all aspects of design and delivery of services. Great diversity between HLCs was highlighted in our earlier report[7] and multiple forms of HLC model had been implemented. This diversity included: structural variations (operating from a physical base or as a 'virtual' entity); variations in the partnership composition and relationship with the statutory sector; variation in focus (targeting particular groups or working throughout a community); variation in the form of community involvement and engagement; variation in approaches to improving health and health inequalities; and consequentially a wide variation in the types and form of services delivered.

1.2 Purpose of phase two of the evaluation

The first phase of the evaluation was conducted over a three year period (2002-05) and reported on the implementation and development of the HLC programme, exploring the pathways between activities, processes, contexts and outcomes in a purposive sample of HLC projects, using a longitudinal research design. Following this phase, and to examine longer-term development, an extension to the evaluation was sought. The Scottish Executive and NHS Health Scotland commissioned the Research Unit in Health, Behaviour and Change (RUHBC), University of Edinburgh, to continue the evaluation of the Healthy Living Centre Programme in Scotland.

This second phase of research was intended to examine the longer-term development of the HLC programme and to address specific questions that had arisen during the first phase of the evaluation. For example, during phase one, HLC stakeholders had been hesitant when discussing the impact of their work to address health inequalities and longer-term impact on community involvement. Other questions which arose sought to examine the efforts of

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[5] The Big Lottery Fund was previously known as the New Opportunities Fund.

[6] New Opportunities Fund (1999) *Healthy Living Centres: Information for Applicants*. London: NOF.

[7] Platt, S., Backett-Milburn, K., Petticrew, M., Rankin, D. and Truman, J. (2005) *Evaluation of the Healthy Living Centre Programme in Scotland: Report of phase 1*. RUHBC Working Paper #3. University of Edinburgh: Research Unit in Health, Behaviour and Change.

HLCs to address local need and national health priorities and the issues that were faced in so doing. Wider changes to the national and local health economy were also taking effect, leading to questions about how HLCs might engage with newly emerging policy-driven structures (e.g. community planning and community health partnerships). In turn these developments were suggested by several stakeholders to be features which would act as influences and inform the discussion on sustainability, to which greater attention was beginning to be given at the conclusion of phase one fieldwork.

Thus, the second phase of the evaluation posed the following main research objectives to be examined over the longer-term:

- to elicit stakeholder understandings of how HLCs have adapted their approach over time to address issues of social injustice and inequality, and to examine what future contributions HLCs will make to this agenda.
- to describe evolving community development structures in HLCs and their impact on addressing inequalities.
- to examine how HLCs meet local health needs while working to address national health priorities (e.g. mental well-being, diet and physical activity).
- to explore the involvement of HLCs in wider health economy structures (e.g. community planning, community health partnerships).
- to examine HLCs' attempts to ensure project sustainability, through taking account of community influences, type of HLC (e.g. voluntary, statutory or community-led), partnership construction and wider inputs at local and national levels.

In the second phase of the evaluation we successfully gained the consent of the original sample of HLCs to continue to explore developments in their centres over the period 2005-07, using in-depth case studies (as previously). This sample was originally approached and selected in order to represent the diversity of projects funded under the programme, with respect to characteristics such as: geographic location, structure of organisation, target group focus, partnership and host agency configuration, and existing infrastructure. Appendix 1 provides an anonymised description of each case study site.

In the sections which follow, attention is first given to the fieldwork and methods which built upon work undertaken during phase one. The main findings are then introduced under the headings of the original research objectives. The implications of the evaluation for policy, practice and research are discussed in the final section.

2. Fieldwork and methods

2.1 Background

This second phase of the evaluation has retained a broad focus on all aspects of the operations of the six case study HLCs, but moves beyond an examination of implementation and early development. Derived from findings from the phase one report, the origin of these objectives can be found in the funding proposal document (see appendix 2) provided to the Scottish Executive and NHS Health Scotland. Throughout this proposal and during the evaluation, the prime focus has remained on ‘how’ and ‘why’ questions, derived from knowledge gained during the first three years of the evaluation, which seek to chart changes and developments in sample HLCs in their final two years of operation.

Obtaining the participation of the original sample has permitted continuation of the range of interests, structures, health measures and geographic coverage of projects and of many of the methods used previously. As a result of the disparate nature of the sample (and HLC programme in general), the evaluation has had to accommodate to different configurations of sites, partnerships, forms of community involvement, target groups and communities (as previously). A reduction in the size of the evaluation team also informed the way in which the evaluation was adapted to meet the needs and interests of the HLCs. Throughout phases one and two the main challenge of undertaking a multi-site evaluation which took account of the diversity of the HLC programme was to gather comparable data across sites, while at the same time reflecting each site’s unique history, implementation, development and evolution.

2.2 Methods

Similarly to phase one, a range of methods, predominantly qualitative, was used to collect data from various stakeholders, whose job designation and level of involvement differed greatly between HLC. Interviews focused on all research questions, with topic guides adapted to respond to the particular needs of each case study site and to the different stakeholders who participated. Qualitative research methods used in this phase, included: taped semi-structured and individually tailored interviews; discussion groups; documentary analysis; participant observation; formal and informal observation of activities, meetings, events and interactions; telephone interviews; and ongoing email and telephone contact with key stakeholders. The customisation of instruments for each site took into account several sources of information, including data collected and assimilated during the first three years of the evaluation, and new documentation (e.g. minutes and reports) which were sent to the research team on a regular basis.

In phase two one period of intensive fieldwork was conducted at each HLC. This usually took place over approximately one week, except in instances where fieldwork was arranged to coincide with key events or meetings taking place outside of the main bulk of data collection. Data collection during this second phase of fieldwork built on the earlier two periods of intensive fieldwork, permitting further in-depth longitudinal evaluation to be conducted.

Close attention continued to be given to the relationship between evaluator and participants, in particular gatekeepers such as the project manager/coordinator. It was also important that the sole research fellow become acquainted and develop close working relationships with stakeholders in two HLCs which had previously come under the remit of another research fellow. Timing of the evaluation was again crucial, in particular to take account of the different funding arrangements of the HLCs, differences in work patterns, availability of staff and stakeholders.

2.3 Managing fieldwork during phase two: continuing with a flexible approach

At a dissemination event prior to the completion of phase one, HLC gatekeepers were informed of the possibility that funding for further evaluation might be made available. At this stage, verbal agreement of each gatekeeper was sought in order to continue the participation of their HLC and associated stakeholders in the evaluation. Once funding was agreed, a letter was sent to each HLC manager advising them of the continuation of the evaluation. Subsequent telephone calls were made to each manager to advise them of phase two evaluation aims and objectives, and to discuss proposed time-scales and potential dates for the conduct of fieldwork.

As previously, the cooperation of gatekeepers and careful management of the fieldwork by the research fellow was central to the successful implementation of the evaluation. The evaluation team was heavily dependent on the willingness of the HLC gatekeepers to accommodate to the evaluation within a tight timescale, as fieldwork was to be conducted at six sites by one research fellow over the course of fifteen months. Drawing on previous findings and contacts established with a variety of stakeholders, discussion with each HLC gatekeeper enabled a renewed focus on decisions about which participants to contact. Established working relationships facilitated several opportunities for attendance at meetings where key features of the research objectives (e.g. sustainability) were to be discussed. This permitted fieldwork to be scheduled to take account of key decision making processes. The research fellow also benefited from, and continued, the close working relationship with two HLC gatekeepers who had been the responsibility of the second researcher during phase one. An atmosphere of openness continued to pervade the evaluation, with many instances where information was divulged (both in interview and in documentation form) beyond that which had been requested.

Getting the timing right was again crucial, both to minimise the impact on the HLCs, and to ensure that fieldwork was conducted at a time appropriate to collecting adequate and sufficient data. In this phase, fieldwork again differed between sites, with residential visits at three sites and daily visits spread across a block of time at the remainder. In several cases, attendance at meetings outside of the bulk of main fieldwork permitted additional data to be gathered. Several ad hoc fieldwork opportunities arose during attendance at HLC conferences and in other health environment settings, which were helpful in ensuring openness, relationship building, and charting the continual process of development and change which characterised the HLC

programme. The attention given to management of the evaluation and relationship building again meant that fieldwork was completed on schedule.

2.4 Fieldwork and data management

Although fieldwork methods were broadly similar to phase one, the reduced timescale and new set of research objectives led to several changes in data collection during phase two. While evaluation resources necessitated a more limited number of stakeholders being approached overall, there was greater variation in the number of people participating from each location when compared with phase one. The number of interviewees per HLC varied from 8-15, depending on the extent of involvement of the HLC within its local health economy, the type and level of involvement of partners, and of the scale of discussion surrounding topics such as sustainability. The number of observations was also restricted in order to complete fieldwork within a tight timeframe. New objectives guiding the evaluation led to a greater focus being given to meetings involving staff and strategic stakeholders rather than on service delivery. Interviews were conducted with three main groups: project team members (managers, staff, volunteers and board members), key local partners and stakeholders and service users/beneficiaries, with the bulk of fieldwork conducted with respondents from the former two groups. This reflected the content of the research objectives and the difficulties (similarly to phase one) that were sometimes experienced in obtaining the views of service users[8].

Throughout fieldwork, the use of an individually-tailored, detailed topic guide was essential when undertaking interviews. However, as was often the case during phase one, it was vital to remain responsive to changes that had taken place in each site, which were often only divulged during the course of the interview. This was evident throughout the evaluation, up to and including the final series of telephone interviews, when it was often the case that further developments had occurred, even when previous contact had only taken place a few months previously. A feature throughout the course of the entire evaluation has been the capacity of the HLCs and their stakeholders to effect changes in organisation and service delivery between periods of fieldwork.

With regard to data management and confidentiality, the evaluation team decided that it was important to re-obtain informed consent from stakeholders, even in instances where such consent had previously been obtained. This course of action was determined as several years had elapsed between the original provision of informed consent and the second phase of the evaluation. This was also viewed as an attempt to reiterate to participants the issues surrounding confidentiality, in particular following the high degree of openness experienced during phase one and the collection of data during formal and informal contacts both during and outside taped interviews. Echoing the experiences of the research team during phase one, HLC stakeholders remained very open when divulging information and extreme sensitivity was

[8] The emphasis placed on securing interviews with project staff members and key local partners and stakeholders is evident in the selection of quotations used in the 'Findings' section which follows. This also reflects the particular aims and objectives of phase two of the evaluation, many of which were mainly addressed through speaking with such participants.

again exercised when handling data. It should be noted that, although efforts have been made to safeguard anonymity of respondents and HLCs, many stakeholders have acknowledged the participation of their particular site and it is quite commonly known within HLC circles which organisations have participated.

2.5 Data analysis

An iterative data analysis process has continued throughout phase two. Findings have again been generated using grounded theorising principles and constant comparative methodology involving systematic analysis of fieldwork accounts from each of the six sites. Analysis of fieldwork data took into account issues that arose across the sites and, as was often the case, regularly focused on those issues which were happening differently within individual sites or in sub-samples.

Following completion of fieldwork at each site and the compilation of an internal report structured around the research objectives, the data were analysed in various team groupings. Analytical workshops, involving KB-M and DR took place at regular bi-monthly intervals throughout the project. These involved prior reading of selected transcripts and the fieldwork report, before detailed qualitative analysis and discussion of relevant themes took place. Although structured around findings from each of the six sites, it was usual for iterative comparative analyses between sites to take place, both building on phase one findings and drawing on emergent work across sites in phase two. Further whole-team meetings involving SP, KB-M and DR permitted wider analyses based on sharing findings from the previous workshops. Meanwhile, the meetings set aside to discuss data on sustainability gathered for DR's PhD were also a useful source for further discussion, reflection and iterative analysis, drawing on the skills of the principal supervisor KB-M and second supervisor, Dr Wendy Loretto (Management School and Economics, University of Edinburgh). This qualitative process has again formed the basis of the coding and retrieval framework developed using the QSR-N6 software.

3. Findings

3.1 Research objective 1: To elicit stakeholder understandings of how HLCs have adapted their approach over time to address issues of social injustice and inequality and to examine what future contributions HLCs will make to this agenda.

3.1.1 Introduction

One of the main criteria which underpinned the HLC programme was the call by the BLF for HLCs to target the most disadvantaged centres of the population to "[r]educe differences in the quality of health between individuals and improve the health of the worst off in society". In our previous report we examined how HLCs had worked to attract disadvantaged communities, overcome barriers to access, and sought to resolve issues of capacity among staff and suitability of venues for service delivery. This section will examine how the ability to change and adapt has come to characterise the approaches taken by sample HLCs to address inequalities.

3.1.2 What do HLCs mean when using the term 'health inequalities'?

In making links between our earlier report and more recent findings from phase two, HLC stakeholders were found to use a broad range of interpretations when discussing health inequalities. Our earlier findings, where stakeholders discussed inequalities in relation to work to address disadvantage, to change lifestyles, to enhance life-skills, to address life circumstances and to improve service accessibility and uptake, readily link to the seven clusters of explanation of how health inequalities arise, as identified in the Bridge Consortium final report[9] (see Box 3.1).

Box 3.1 Clusters of health inequalities (Bridge Consortium)

As part of the national (UK-wide) evaluation of HLCs, the Bridge Consortium had highlighted differences between centres in the ways they interpreted the concept of health inequalities. After undertaking a review of the literature on health inequalities, the Bridge Consortium identified seven different 'clusters' of explanation about the genesis of health inequalities:

- A behavioural or lifestyle explanation: poor health arises from individual lifestyle factors such as lack of exercise and poor diet.
- A service appropriateness explanation: variations in health arise because of a lack of culturally appropriate services and opportunities in some areas.
- A service accessibility explanation: variations in health arise because no services are available, or people are unable to access the services.
- A community participation/involvement explanation: services are inappropriate or inadequate because of lack of community involvement or consultation.

[9] The Bridge Consortium (2007) *The Evaluation of the Big Lottery Fund Healthy Living Centres Programme: Final Report*.

- A social exclusion/social capital explanation: poor health in parts of the population arise because of structural factors: age, sex, culture, race/ethnicity.
- A poverty and income explanation: poor health is related to poverty and unemployment in key sectors of the population.
- An environmental explanation: poor health arises because of poor environmental quality – housing, available green space, poor air quality etc.

During the present evaluation it has been evident that the majority of our sample of HLCs typically utilise different interpretations dependent on the services they are operating. For example, site 6 designed several services to address lifestyles (e.g. exercise programmes) and in other examples sought to enhance access to primary care services. Several sites also use overlapping inequality interpretations, seeking to bring together partners in service delivery taking both life circumstances (to address poverty) and life-skills approaches:

> "So, it's about kind of tackling [health inequalities] from the kind of core issues that are around, I mean, particularly focused on money because that's where we feel there has been a gap in the city, but also kind of the life-skills in terms of building confidence, self-esteem and we feel that's kind of like core fundamental building blocks that people need to be able to, to make a difference in their own lives but they're not going to change their lifestyles unless any of that is actually built on to start with" (Manager, site 2).

The following quotation highlights the various understandings applied to the term inequalities in relation to work undertaken by HLCs to facilitate and improve choice for disadvantaged individuals and groups throughout Scotland:

> "…inequalities in health are about choice for some people and for some people, even if the choice was there […] because of their social situation, mental situation, any situation, their environment, they can't make that choice to go and access [services]. So for me, inequalities in health […] in relation to the HLC is us enabling people to make a choice in the first place. Now what that choice is, is different for every individual" (Manager, site 5).

As a caveat (and as suggested in our report on phase one) it is important to note that, as services are targeted on populations that experience disadvantage, HLCs are necessarily limited in their scope to address inequalities at a societal level. While the sections which follow highlight how HLC staff have been accepted by target groups, and while emphasis is given to the work that has been undertaken to meet changing needs and groups, the programme is constrained by its focus on particular groups and communities:

> "If you think about the continuum of possibilities, and that isn't helped by that, that gap, the poverty gap widening and widening and widening […] … to that extent we've levelled some of the playing field but it would take a lot more than healthy living centres to level the playing field, to be honest with you" (Chair of the board, site 6).

Findings in this chapter relate mainly to work undertaken to address disadvantage when examining whether, how and why HLCs approaches to social injustice and inequality have changed over the lifecourse of BLF funding.

3.1.3 Working with realities: HLCs' ability to change and adapt approaches

This section illustrates how HLCs adapted and changed their approaches to address inequalities over the course of funding, to meet and better address the needs of their communities, particularly as the communities themselves changed and as the HLCs and their staff become better acquainted with them:

> "People have got to know the service and got to know the people involved in delivering the service" (Project officer, site 3).

The continuing changes that took place, the merits of making such changes and whether such experimentalism has been useful have not been examined in any depth.

Changes to services were sometimes made to curtail the proliferation of activities that were specified on initial business plans (e.g. community allotments and a green gym in site 4). Such changes also allowed for more responsiveness to community needs and for staff skills to be better utilised. For example, site 3 made changes which led to stress management services being provided on an appointment basis, as the original drop-in model was poorly attended and wasteful of staff time:

> "…it's constant, there, there's phone calls every day, whether it's self referrals, organisations, em, people looking for, em, because there isn't another [similar] stress service in the whole of [the area]" (Project worker, site 3).

Several sites (3, 5 and 6) made changes which saw the introduction of more sessional support staff. These changes were made for a variety of reasons, including: to bolster service delivery, to free up staff time to allow for new development work, and to allow for a redesign of service delivery models. As an example of the latter, site 5 created a bank of sessional staff following the departure of their sole project worker. In so doing the HLC boosted local employment opportunities and was found to have created multiple avenues to reach excluded groups:

> "…they've [the sessional staff] managed to get into other parts of the community in a way that they would, were maybe struggling to do previously…" Partner, site 5).

Meanwhile, in other locations, change and adaptation was necessary to overcome problems that had been experienced in attracting target groups (e.g. redesigning a parenting service in site 1 based on transferring good practice from another location). Having the flexibility to make changes, sample sites often responded to features that were unlikely to have been envisaged at the outset of their bids (e.g. new groups moving into the area in site 4, new needs around food and diet emerging following further consultation in a community in site 1, or developing new practices following the provision of seconded posts in site 2). Such changes, evident across the sample, and the greater knowledge gained through four years of work, were found to drain HLC resources:

> "…with demand completely outstripping resources, not just the money but just people and time basically" (Manager, site 1).

However, while change and adaptation were commonplace, the ability to undertake change was sometimes limited by context-specific circumstances. Some sites were constrained in their original choice of model; for example, the design of the community health team operated in site 3 restricted the throughput of trainee staff, and other stakeholders reported that they perceived some push from lottery funders to deliver on specified activities, even if they felt that this was not the best way in which to address need.

The flexibility of the BLF-funded HLCs and ability to change and adapt approaches to address inequalities are discussed in the sections which follow. We outline how HLCs changed to accommodate new groups, how new needs led to changes in service and how the use of premises was altered to meet changing demands. Before describing these changes, it is important to highlight that many HLC services were considered by managers to be successful in appealing to target groups from the outset, often being delivered in the same manner or with modest degrees of fine-tuning. It is these examples that are examined first.

3.1.4 Tried and tested methods: benefiting from experience and fine-tuning

There were multiple instances where HLCs continued to address the needs of target groups in similar ways throughout the evaluation, including:

- improving accessibility to and uptake of primary care services (site 6)
- continuing to run exercise groups (site 3)
- continuing and expanding the delivery of parenting services (site 1).

Acknowledging the continuation of successful exercise services, the manager of site 4, when questioned about changes over the HLC lifetime, stated:

> "…I wouldn't say that there have been major changes since. I think there have been kind of fine-tuning [attempts]" (Manager, site 4).

This manager highlighted how much of the effort in the first three years of the HLC funding had been about finding a focus, developing the services on the business plan through making minor adjustments accommodating to the

knowledge gained over time of what appealed to the target population, and delivering 'evidence-based' services. Having made refinements over time, other comments highlighted how tried and tested services continued to be delivered:

> "It's now kind of in its final year so I suppose kind of again quite samey in that we've kind of picked all the good bits, em, and we're running with them and there definitely is still development stuff going on but I suppose we're kind of working now with the lessons that we've learnt over the last kind of four years" (Manager, site 6).

Acknowledging the time that it had sometimes taken to develop a relationship with certain communities or groups (a point raised across sites), a project worker in a stress-management service discussed how adaptations were made to the way the service was delivered better to meet local needs:

> "At the beginning we were saying, you know, people could have six appointments and, you know, then they would move on and they could be re-referred again, but I think [there's] times we've seen that it's taken that length of time for people to just come to the point and build up that relationship with staff. So, often the first six appointments are, are just about getting to know what's going on for people and its quite surface [level] and, after that, start to get to know the person more…" (Project worker, site 3).

For many of the HLCs, while modifications to services did take place, it was the establishment of a relationship between an HLC and the local community that became more deeply forged as time progressed. Comments from a variety of stakeholders highlighted the trust that had been established between communities, HLCs, the staff and their services. The length of the funding package meant that several HLC staff, often in post throughout the duration of BLF funding, became an integral part of the community in which they were based. This was sometimes referred to as becoming "embedded in the community", enabling close links to be developed between staff and local people and to enhance the appeal to target groups across geographic and social boundaries:

> "I think that there's no substitute for, you know, a well, kind of well-rounded community based organisation which genuinely, you know, is committed to working on a local basis and, and, you know, going to where people are, really and I think there's probably no substitute for that and I think it's the, it's definitely the way because people, people who are living in a really difficult, place, won't relate to, you know officials and officers going in, you know, attempting to change their lives through whatever means, whatever interventions, you know" (Partner, site 4).

3.1.5 Accommodating new groups and enhancing the focus on existing groups

Although each of the HLCs had specified target groups, several stakeholders indicated that their services were adapted to incorporate changes within

communities. As one manager put it, his original business plan might have been “written on a wet Wednesday”. By becoming embedded in communities and through the development of robust partnerships, more attention was given to identifying new target groups and to becoming more focused on existing ‘priority’ groups.

Attempts to accommodate new target groups were a feature of several sites and included the following examples:

- Site 1 established links with another local HLC to provide services for their particular target group, adults with learning disabilities
- Site 3 adapted the style of delivery of parenting groups to meet the needs of communities living in two separate locations
- Staff in site 4 adapted existing services for new target groups, such as asylum seekers who had recently moved into the area.

In this final example, staff had to overcome challenges relating to language, culture and the appropriateness of services, which in this instance involved trialling alternative methods over more traditional forms of counselling. Further enhancements to address unmet need signified a new focus, such as the development of a service targeted at those experiencing chronic ill-health:

> …[while] their focus is very much still on community development and primary preventative sorts of work, I think they’ve realised there's scope to get involved in empowering and supporting the huge amount of people that are in the community that have already got established diseases. (Partner, site 4)

Several HLCs were found to have adapted their approaches to enable them to target their services more widely. In one example, site 2 had adapted its approach better to reflect the changes that were underway within strategic partners, ensuring that, where their target areas had previously been configured with Social Inclusion Partnership (SIP) locations, the change to community planning meant that they were able to deliver services on a city-wide basis. Further work in conjunction with the local community health partnership (CHP) and the use of a ‘traffic light’ tool were being considered for future application, potentially aiding the HLC to identify new groups within communities. In one of its networks, site 2 had developed a new team, created through redirected funding and utilising seconded skills, thus creating a new service and boosting existing services. Obtaining such support led to an increase in capacity, with “a more joint approach to working together” being taken:

> It’s automatic now for us to cross refer. It wasn’t before. […] There’s a great deal more opportunity taken to work together, say […] in a geographic area […] … rather than everybody doing it in a spotting type approach across the city. (Partner, site 2)

In some instances, HLCs’ work became increasingly focused on particular disadvantaged target groups within their wider communities. Such experiences were later reflected in discussion on sustainability and highlight

the learning that has taken place. One stakeholder, managing a single-focus HLC, discussed how attempts to integrate sub-groups had been problematic and how focusing on a particular group proved more productive:

> …I think it was perhaps a bit unrealistic too, and not particularly safe because if you're bringing young people with, say, learning difficulties, who are still at home and are quite settled and they're meeting with [the majority target group of] young people who, em, are really pretty streetwise and are homeless and have nothing, then you're, the other young person is quite vulnerable in that situation. […] …So, I think there's something to be said for picking a group and working very well with that group rather than trying to cover lots of different groups and being seen to be doing lots of different things but not necessarily doing it well. (Manager, site 6)

In another example, an HLC which had been established to work with the entire community had delivered several of its services very broadly in order to provide maximum reach across the population. Subsequently, it was possible to apply a more targeted approach as a result of the knowledge that had been gained of communities most in need:

> So, under a broader banner, where we go out to a health fair of seventy-one people, okay you may only sign up three of the really marginalised ones that you meet there, but you also might get a relative […]. So, under the wider awareness raising stuff, what we've found is that you're actually getting to the hard-to-reach groups. (Manager, site 5)

As suggested by a partner in site 5, and reflecting statements made by stakeholders in other HLCs (e.g. parenting services in site 1 and benefits services in site 2), it was found to be increasingly important for HLCs targeting disadvantaged groups to devise and position their services in a universalistic manner, to avoid stigmatising those more marginalised groups and individuals whom they ideally wished to attract:

> "…there has to be a balance of that because you have to attract in a broad section of the community. It's seen then, it's not stigmatised in any way, […] but the, there's clever marketing in terms of, well, who we really need to be pulling in" (Partner, site 5).

While the necessity to accommodate new target groups varied for each HLC, much learning was evident in how their work was applied. Such knowledge was often attributed to having had five years of funding, which offered flexibility in delivery and some, albeit limited, job security for staff.

3.1.6 The changing use of premises: the benefit of experience

The original call for HLC bids advised prospective bidders that funding was available for both physical centres and/or for programmes of activities. Having originally made reference in our phase one report to centre-based and virtual HLCs, further fieldwork indicates that such a dichotomy may be too simplistic to capture the variation within the sample. While the boundaries between

different types of HLC are more blurred, in particular their use of physical spaces, findings from the present phase of the evaluation reveal that the manner in which HLCs utilise, change and adapt their service delivery spaces has implications for their approach to addressing inequalities, now and in the future.

Findings in this section are broken down into a series of sub-headings which highlight the changing notions of space and place applied by several of the case study sites. Such changes include those occurring during the lifetime of HLC funding and, as stakeholders consider moves from constructions determined by original HLC bids to include new sustainability proposals, incorporating learning from the HLC experience and in response to policy developments.

Changing uses of existing space

In site 6, having earlier laid out proposals for developing their premises to provide for the more basic needs of their target group, stakeholders indicated that further changes to their building were being considered, which by the end of fieldwork had led to the redesign of service delivery spaces. This led to the introduction of a training café both to encourage new service users to come into the building and in enabling a new focus to be given to volunteering and employability. Discussing how this would address inequalities, a stakeholder outlined:

> "A lot of our young people aren't even, they're not ready not able to go […] to go into a New Deal type place or a modern apprenticeship type place. They're just, they're just not there. […] Em, so [the training café is] to be able to provide the bit from where they are at the moment to be able to say, no, I'm really ready" (Chair of the board, site 6).

This approach to addressing inequalities, in particular with regard to employability, reflects previous changes, for example when staff had responded to service user requests and engaged a hairdresser, to enable a better impression to be made when people were applying for jobs. In creating a training environment and through focusing more on employability, site 6 has brought to the fore some of the approaches to addressing inequalities that have been undertaken in other HLCs (e.g. 3, 4 and 5):

> "It'll give us a very clear route from volunteering to qualifications to employment" (Chair of the board, site 6).

Adapting spaces to overcome barriers to service delivery

The provision of new services, such as alternative therapies, led site 5 to seek appropriate space for weekly service delivery. Having struggled to find suitable premises which were open at appropriate times and accessible to the population, the HLC made available and adapted the use of its own public rooms. The success of such services and the appeal of accessible and non-stigmatising premises in promoting uptake has been reflected in the HLC's sustainability proposals, where larger premises are sought and from which future service delivery can take place.

Adapting premises to accommodate to the provision of services was also a feature in site 1. Where HLC services had often been closely linked to leisure service provision, new thinking was applied to overcome barriers to attendance, such as the lack of crèche facilities, which had not been fully considered when the HLC was originally devised:

> "…it's activities in venues that they didn't have them [in] before and I think that bringing, bringing activities to the people instead of expecting them to, to come to the leisure centre, that, that's been a big factor… The town hall has revolutionised the whole, the whole […] project from the point of view of being able to run a crèche alongside it" (Coordinator, site 1).

Changes to the meanings of premises: the broad appeal of social spaces
Although operating mainly as a virtual HLC, delivering services in partnership with other agencies, site 4 underwent an early change in its service plans to develop a community counselling suite within its administrative base. This redevelopment has meant that the building is now viewed as a non-stigmatising location, facilitating uptake and self-referral:

> "I think in some ways that the base where it's actually based is outwith any other statutory agency […]. [People have] a stigma about going along to the social work department and their concern if it's, maybe particularly a parent that [a] child may be taken away from them, and for some [it's a benefit], actually having the, the knowledge that they can maybe pop into a block of flats without anybody knowing why they're coming along" (Project worker, site 4).

Meanwhile, site 5 redesigned its premises to incorporate a community meeting point comprising a health information point and a space for services previously unavailable (e.g. use as a drop-in breast-feeding location). Such changes, also reflected in the redesign of site 6, highlight the increased use of several HLC venues as social hubs, providing opportunities for social contacts to develop and where service users find it acceptable to attend to take up services.

Changes to location and the need to be more local
In this final example, stakeholders in site 3 have often found it challenging to ensure that services are able to reach across geographically spread communities. In response to the adequacy, availability and cost of local service delivery locations, the current administrative premises have undergone several redesigns to provide a location for services to be delivered. However, further consideration was being given to location of premises and accessibility to target populations. While the geographic area in which the HLC is based is large, new proposals seek to place the HLC services closer to the communities that it targets:

> "…my thoughts are, at present, is to negotiate with the Council and, instead of them giving us money, em, to look at peppercorn rents, of free access to shops that are not being used and have them as centres so that

> one day a week, say it's food being delivered, and the stress management workshops or whatever from those central units within localities… So they're right at the heart of the community, avoiding having to go down the likes of Community Centres and the problems that arise from that…" (Manager, site 3).

Throughout all of these examples, changes have only come about through experience, highlighting the time necessary both to establish services and to learn from them. However, in contrast, while the premises out of which HLCs operate are important assets and while several sites are considering changes to them for the future, delivering services on an outreach basis has been and will continue to be vital for many of the case study HLCs. For example, in site 6, staff also discussed how their building and premises might sometimes be seen as stultifying for service users, suggesting a need to focus on delivery in other locations, aiding integration with mainstream services and the wider society.

3.1.7 Holistic approaches: different interpretations and applications

When discussing their programmes, many HLC stakeholders made references to utilising a holistic understanding of health and well-being, which often referred to the provision of services that sought to benefit physical and mental health, along with improving social opportunities and enhancing well-being more generally. Over the course of the evaluation, each HLC in the Scottish sample made increasing reference to delivering their work in a "holistic" manner or to providing a "holistic" range of services. This section examines the uses of the term holistic by the case study sites and provides illustrations of how it was applied in different HLCs.

Increasing awareness of holistic need

Although each of the sample HLCs operated with a social model of health, where health and well-being is influenced by a wide range of social, economic and environmental determinants as well as through medical intervention, it was evident by the second phase of the evaluation that the length of time spent working with particular target groups had led to the consideration of a much wider range of needs. For example, in site 6, some services were developed in response to recurring problems with which the target groups presented and which were not envisaged at the outset:

> "…the other big development is the dawning realisation that while health is still our thing, more and more the young people are back in temporary accommodation or bed and breakfast, you know, or their actual tenancy is teetering really quite badly. So the dawning realisation is that they do need to have a good grounding on issues around housing…" (Chair of the board, site 6).

In the example above, the HLC staff discussed how they had needed to work to provide help to secure the tenancies of several of their client group. Such help was provided in partnership with the Citizens Advice Bureau and it was recognised that without it, moves to improve health more generally were

problematic. In other instances services in site 6 were more explicitly used to improve social opportunities, whereas initially the focus was more on diet:

> "We've shown them that food can be a social thing as well. It's not merely a fuel to keep you going. … [The service users] sit round tables, they're not allowed to take like a bowl of food and wander about and eat it" (Chair, site 6).

Linking up the HLC services
Sites 3, 4, 5 and 6 made increasing references to developing their own sets of services in a more holistic manner, for example linking the services of different branches of their organisations through referrals and advising people of other opportunities on offer, which as staff suggested is "a two-way process". In the quotation below, the manager of site 5 describes how one method of service delivery might bring to the fore opportunities to refer people to other services:

> "Each of the programmes that come about cross-fertilise each other. [So] the lay health workers who have someone include someone who's given somebody a facial, who says there's something going on in their family, dad's drunk or whatever. […] So it's been an evolving thing" (Manager, site 5).

However, in some instances, while links between services had been established, views of some staff suggested that it could be difficult to remain aware of all the types of work that were undertaken in particular HLCs. In site 3 staff suggested they needed more information regarding some of the services that were delivered by parts of the HLC, while it was also the case that some service users presented more difficulty when considering a holistic approach, e.g. people receiving one-to-one counselling. Meanwhile, staff in site 4 highlighted the lack of time they had available to make connections between services, instead often continuing to operate mainly within their own specialism.

Promoting holistic approaches more widely
Holistic approaches to health and well-being were also considered in relation to providing training for other agencies and to building community capacity. In this example, site 4 staff delivered training to community members and other agencies, seeking to raise awareness of wider features that might be likely to impact on community health. Discussing the impact of such training, the manager stated:

> "…some of the people who are sitting round the tables in other committees and other meetings, because we've given them a holistic understanding of what health is, they, they're kind of relating the difference between problems in their flat, not just with the kids urinating in it, but the fact is that […] that's a housing issue, but there's also a health issue and there's also a youth issue…" (Manager, site 4).

Working in partnership to promote holistic approaches
Partnership working and network approaches were also discussed with regard to tackling health inequalities in a holistic manner. For example, site 3 had worked throughout its funding to develop a network of local stress centres, each with its own specialism (e.g. alcohol, drugs and generic), which had recently come to fruition, enabling staff to establish a referral system between services better to meet the needs of service users. More broadly, site 2 had created a new team which enhanced links between several agencies working to maximise benefits take-up. This led to the creation of a new referral mechanism, which illustrates how a holistic approach could also mean being able to direct people to the correct service:

> "…the referral system […] in effect is, you come across somebody who, well in my case, somebody in fuel poverty and you can do a basic benefit check and all this, but you find that their finances are in one hell of a mess because fuel poverty isn't a discrete area: it's part of poverty. […] [Upon referral, a team] will identify with that person, who else they are willing to [meet], so it might be Citizens Advice looking at long-term debt problem[s]. It'll be the Welfare Rights or benefits system or something looking at whether they're getting the benefits they're entitled to. Em, it can be a range of different organisations […] We find a symptom and we're all dealing with symptoms previously. We can find a symptom and then from that refer them in and they will as far as they can, [find] a holistic approach to deal with that person's poverty-related issues" (Partner, site 2).

While the examples of holistic approaches discussed above draw attention to the broadening definitions of health and also of well-being that HLCs use, such references also suggest that HLC stakeholders have improved confidence with regard to identifying a range of features which influence health and in providing services to address local needs. Such features are examined again when discussing sustainability (section 3.5).

3.2 *Research objective 2: To describe evolving community development structures in HLCs and their impact on addressing inequalities*

3.2.1 Introduction
In order to provide appropriate and adaptable responses to meet local needs and to effect change within communities, the HLC programme was to be established with community involvement and development practices built into all spheres of HLC activity, including project planning, development, delivery and management. Throughout the programme, HLCs and their stakeholders were to engage in capacity building to support local communities. In the phase one report, we reported on community involvement, in particular focusing on HLCs' attempts to reach service users and the ways in which local people were involved in service delivery and in governance mechanisms. While the phrase 'community development' is referenced in the title to this section, we discuss findings which more broadly refer to

community involvement, development and capacity building. In terms of community development, each case study HLC adopted a similar focus:

> "…my [understanding of] community development is working with people, not for people or at people… So it's working from the bottom up with a community, enabling them to look at what the issues are for them and in our topic area, it's what would improve their quality of life? What are the health issues for them? So you identify them and then you work with them, not for them and not telling them what to do, but enabling them and empowering them towards addressing what these issues are, inequalities in health, whatever" (Manager, site 5).

The first section examines how community involvement structures have changed and been adapted over time, by examining work undertaken by HLC stakeholders to build community capacity across case study sites. This is followed by a closer exploration of key features suggested to enhance community capacity, focusing in particular on relationship building. The next subsection examines the importance HLCs attach to staff skills, knowledge and approachability. Finally, we look at HLC efforts to achieve a balance between meeting their communities' needs and the consideration given to partner and statutory agency requirements. Throughout this section, the focus remains on how community involvement and development practices impact on addressing disadvantage.

3.2.2 Changes and adaptations to community involvement

It was apparent throughout the evaluation that the sample of Scottish HLCs used a wide variety of methods for engaging with and involving local people. The structures of the case study HLCs meant that there were many different roles that were created for community members (e.g. as management, as volunteers, in paid posts and in consultation roles), within and between HLCs. In the examples below, the focus is on the ways in which HLCs made changes, adapted services and continued to promote the involvement and engagement of local people.

As will become evident, time, effort, persistence and dedication were central characteristics of HLC staff who drove forward efforts to engage and re-engage with people who might have been overlooked and to overcome hurdles to community involvement:

> "…I found that unless you're constantly supporting and running after to, to keep the fires, to keep the embers fanned, etc. it's a community energy, I suppose, [it] will not, will not last too much and then it peters out after a while" (Coordinator, site 1).

The challenges of developing user groups

Throughout the evaluation, several HLCs were engaged in meeting the challenge of establishing user groups. For example, in site 6, staff found that the reasons young people came to the HLC were mainly to receive a service, rather than to become engaged in management/governance structures:

> “…generally when folk are coming in the door of the [HLC] downstairs, they’re there to use the service, they’re not ready to give something back” (Manager, site 6).

While acknowledging that formal structures were off-putting, staff had continued to seek some form of user involvement in guiding service development. Having encouraged a couple of people to have a more active role, staff reported the benefits that this had had in designing more appropriate services, which appealed to the target group. However, such challenges look likely to remain for HLCs such as site 6: the transitional features of the project meant that efforts were first directed at stabilising, assisting and then moving service users through to other opportunities. As a result there was often less continuity of attendance, as people moved on:

> “…we’ve had a couple of young people who have kinds of started […] and have become quite involved in developing groups and doing some volunteering and then they’ve used that to go on into [work for] other services, still quite supported, but other services and volunteering and they’ve ended up in college” (Manager, site 6).

In other locations, HLCs such as sites 1 and 2, which had originally planned for local people to attend partnership meetings, had enjoyed mixed levels of success. Site 1, which consisted of five different projects, experienced large variation in the readiness of members of its communities to become involved:

> “I think the west [coast people] often do gel quite well as a community… (Partner, site 1), whereas other communities displayed: …a lot of mistrust and apathy…” (Coordinator, site 1).

These differences were reflected in the geographical isolation and separation of communities in some project areas, the type of community (e.g. children), some mistrust associated with how other funding streams had been allocated in the past (e.g. one area receiving money while another did not), the interest generated among some communities by the methods of work and by particular members of staff and, as highlighted, the close relationships within one particular set of rural communities.

Gaining the interest of people across small rural communities (even in areas with small geographic boundaries) was felt to be difficult in several HLCs. A stakeholder in site 1 discussed how she had sought the support of key individuals and had made:

> “…better headway working with people from the different communities individually…” (Coordinator, site 1).

Key to seeking such support and involvement was the time taken to build trust (examined in more detail in section 3.2.3 below) and the continuation of an HLC: many local communities had hesitated to become involved since they had been let down when previous initiatives had ended. In site 5, the manager indicated that future effort would be directed at establishing a user group, as

five years of HLC funding had enabled her to build sufficient levels of trust with the community to begin such an undertaking.

Commenting more broadly, a stakeholder in site 2 drew attention to the form of engagement which some HLCs sought from their service users and why some groups might have been put off becoming more involved:

> "…the poorer sections of our community, they've been consulted to death, they are sick of professional people like us coming along, asking them questions and sweet FA changes. There's a lot of anger out there and I think we've got to hone back to the basics of community development approaches. What are the priority issues for these communities? Now the priority issue for these communities is not whether an [HLC] is a company limited by guarantee. They couldn't give a tuppenny toss, frankly and why should they? What they want to do is, is, [to] identify the means by which their physical, social and other deprivations are addressed…" (Partner, site 2).

The challenging demands of user-led management boards

Two of the HLCs had devised and operated throughout with management groups comprising local people. There were several contrasting examples highlighting the experiences of the two community-led boards, drawing attention again to the manner in which community involvement might be pitched. A partner in site 4 considered that its board members were mainly interested in contributing …

> "…more in terms of the project development and the services and the benefit to the local people, em, and probably less […] it's certainly a less attractive proposition getting tied up in the managerial side of it…" (Partner, site 4).

Supporting this finding, in site 3 the larger size of the project and several problems associated with its running had led a partner to comment:

> "I think they're [the board] really caught up with the nuts and bolts of it […], the disciplinary things […], human resources things and the whole. In some ways I don't, I don't think it's a joyful experience for a lot of them" (Partner, site 3).

Reflecting the comments made by this partner, the chair in site 3 drew attention to the initial complexity of managerial discussion at community board level:

> "There was an awful lot of things I didn't understand about [the role of the board] and a lot of things were way over my head and lot of things with the partnerships and the amount of money involved in, and that's quite, initially, I thought, I'm away out of my depth here" (Chair of the board, site 3).

Both sites experienced similar problems in relation to retaining the continuing involvement of community members over time. Although the addition of new members to the board was considered to have "kept it kind of fresh", both HLCs experienced difficulties in recruiting local people to their boards. In site 4, the manager, highlighting how the responsibilities associated with becoming a board member limited the appeal, stated:

> "…people come on and off the board. We're kind of at a stage where we're kind of running out of board members" (Manager, site 4).

Facing its own recruitment issues arising from resignations of board members, site 3 undertook a renewed drive to recruit members of the community with particular skill-sets. While this was found to help overcome the problems related to a skills deficit, it also shifts the emphasis towards appealing to community members with particular skills and away from people with a broad interest in community health and well-being:

> "Their backgrounds are such where we've got a Treasurer who's been a budget manager… […]. We have an, a Councillor that sits on the Board but not as a Councillor, who's an accountant… […]. We also have another person who's a Councillor but there, again, not as a Councillor, sitting on the Board who represents one of the most deprived constituencies in… [the area] …" (Manager, site 3).

Although the community-led HLC boards comprise only a subset of our sample, they represent a sizeable proportion of Scottish HLCs (and other community-based initiatives), particularly in the Greater Glasgow area. This feature was recognised by the local health board which arranged for external organisational support to be provided to initiatives operating with community-led boards. While there are differences between HLCs in terms of size, level of on-site resources (including managerial support), and the unique issues each site faced, the points made above – concerning the level at which community involvement should be pitched – resonate strongly here.

Building community capacity: as delivery agents

There were multiple roles devised by HLCs for community members that focused on elements other than governance. Work to promote and encourage such roles included efforts to devise posts to facilitate service delivery, roles in establishing and operating new independent groups, and wider work that sought to enable local people to influence other services beyond HLC boundaries. While the HLCs have had considerable success in establishing these roles, it was clear that much further support is necessary both to maintain enthusiasm and to replenish turnover as people move on.

Several HLCs had established a variety of services that were facilitated by community members, usually (but not exclusively) on a voluntary basis. These included the running of weight management groups, chronic disease self-management groups, cycling activities, exercise classes, the staffing of fruit barrows and (the major example) walk leaders. Taking the example of walk leaders, several sites (1, 3, 4 and 5), mainly in conjunction with Paths to

Health, had sought to train and support local people to enable them to supervise and lead guided walks in local areas. While walking groups were often well attended and were suggested to have led to some marked changes in ability among those attending, it was often the case that a continued reliance was placed on HLC staff to provide leadership and support, even where local people had volunteered for training:

> "…there's about eight walk leaders that have actually done the course from the [HLC area] but people don't really want to do the leading which is weird" (Project worker, site 4).

In other examples, local people were involved in paid positions as lay health workers on a full-time basis (site 3) and on a sessional basis (site 5). In addition, site 5 provided several local people with supported employment and structured training opportunities within the HLC and in some partner organisations. Working with local employment organisations, the HLC was said to have:

> "…put a lot of effort into trying to include those people that have felt excluded for different reasons and I think that they do that by employing volunteers that you wouldn't normally expect to see in those roles and they've taken a lot of stick for doing that, but they've done it and they've held their head up and supported those people…" (Partner, site 5).

In site 3, while the work of the lay health workers was considered successful and while many staff had received substantial amounts of training, the original expectation had been for a higher throughput of local people taking up such roles, so that capacity building would have a wider impact:

> "The supported employment programme with the lay health workers is a very good programme. […] …it's been highly successful in our case. We've only had to, we've only lost one lay health worker in a sort of four year period and we've replaced that person. So, we've had very little turnover of staff. The downside of that is that we've had very little turnover of staff" (Project manager, site 3).

In a further example of work to build community capacity, site 4 sought to train local people in 'participatory appraisal' techniques to enable them better to seek and understand the needs of their community. As a corollary, the manager also identified the need, and sought to provide training, to assist other local agencies to apply similar techniques in order that the newly created community capacity did not hit a "glass ceiling". As result of such capacity-building and training it was envisaged that work to identify and address inequalities would become increasingly focused on the community:

> "What we would then have is a, a range of interlocking voluntary and statutory sector organisations all using roughly the same kind of methodology… [enabling them to] … recognise that at the heart of this is a standard input from the community […] … we get the community

> placed at the centre because we can use a very holistic model of what we're doing…" (Manager, site 4).

Building community capacity: helping establish new groups
One of the key elements of the work undertaken by staff across several sites (1, 3, 4 and 5) was the effort given to building capacity through developing independent groups, as shown in the examples in box 3.2 below. In some instances this manner of working was a main feature of the HLC (e.g. site 3), whereas in others such work emerged during the course of HLC activities (site 4) or was a facet of how some members of staff preferred to work (site 1).

Differences were evident in how staff viewed work and in their ease and ability to work to establish independent projects. For instance, a coordinator in site 1, working in a community considered to "gel quite well", suggested that working to assist and build the skills of the community was quite natural to her:

> "Community development's really, really big in my persona, you know it always has been for me and because I'm not very strong on controlling, I tend to always refer things back to the [community] and prefer group discussion and group decision anyway" (Project coordinator, site 1).

In contrast, in site 3, there was a debate between staff regarding the merits of such community development work and one staff member stated that she did not believe that such forms of service delivery were effective:

> "I've got a problem with that [developing local independent groups]. … The committee stuff and I think it's a whole culture, […] like you get a group and you form a committee and you've got your funds, like blah blah blah. They've lost all the stuff these people actually came together to do in the first place, it gets lost. People [who] actually really want to do stuff [for the communities] drop out because they're too busy…" (Project worker, site 3).

However, the majority of HLCs believed such methods to be beneficial. Stakeholders in site 4 expressed how work to develop new groups using community development approaches had been given a boost by the employment of a member of staff with particular skills in this area. In addition several HLCs stakeholders reported success in developing a range of groups. Features of successful groups included: developing culturally appropriate responses (e.g. growing projects in rural areas to improve food access; support projects to improve breast-feeding rates and reduce social isolation in built-up housing areas); and the continuing provision of some form of support by HLC staff, albeit with attempts gradually to reduce inputs over a suitable length of time. Where successful, several projects which have received support from HLCs have now formed their own committees and successfully applied for funding to enable their activities to continue. Box 3.2 contains examples from several sites of key features that have facilitated success:

Box 3.2 Community projects implemented/supported by HLCs

Site 1: A community growing project emerged from the findings of a new consultation with people in the local area. Under the auspices of the HLC, the coordinator brought together local people and business people to form a committee. Support from the coordinator enabled the project to secure funding for a building from which to operate and materials to use when working in the garden. The project was operated by a paid worker along with help from volunteers. This allowed allotment-style plots to be rented by local people. The HLC has now withdrawn its support and the project continues to operate independently through applying for its own funds and with volunteer inputs. The project was also discussing the establishment of a social enterprise where produce might be sold to local people and businesses.

Site 3: A parenting support project originated following the identification of a need in another group and which was acknowledged by staff from statutory agencies. After conceiving the idea, statutory agencies sought to develop a local group of interested people. The project utilises a space in a local community centre which offers crèche facilities and often runs to capacity. Through the encouragement of the HLC, service users have formed a committee, which has been successful in raising funds to provide equipment for relaxation, training and social opportunities. HLC support has been gradually withdrawn although periodic contact is maintained and available on request.

Site 5: Pre-dating the HLC, a large community garden project was supported over a nine-year period by the HLC manager. Commitment of the HLC and local people had been vital as the process involved has been lengthy. Gaining access to the land and determining the scope of the project have taken much time. Continued effort is needed to ensure the provision of willing volunteers. A local committee has now been formed to apply for project funding, as the group previously operated by drawing on HLC funds and through the provision of fundraising support by the HLC manager. HLC support is being phased out and no further funding is to be made available. Similar to the support offered by the HLC to other projects, the manager intended to utilise the garden as a supporting partner in the future, e.g. through providing volunteering and employment opportunities for service users.

3.2.3 What works in practice: building trust

Different structures, different geographies, disparate communities and variability in the approaches taken by staff blur the picture regarding 'what works' in terms of community involvement. This is particularly the case when looking at HLCs that operate and deliver a large number of services to several communities and for those which work predominantly with partners. While differences were found in the involvement of communities in identical activities, further blurring was evident when one HLC stakeholder discussed how their methods sought to reduce any sense of 'out-group' community within their target group:

> “…because of the very small homelessness circuit in [the area], I’m trying to break young people out of that circuit and into kind of the mainstream. There’s a big bit of our work which is about not making them a community and actually trying to break the community that’s already there. And sometimes, that’s a worry downstairs in that we’re contributing to that” (Manager, site 6).

However, throughout the evaluation and regardless of the type of group that was targeted, the persistence required by staff and the amount of time taken to get to know local people draw further attention to the necessity of building trust between HLCs and local communities:

> “Well it has taken time. […] …, it takes times for, to get into the locals because they need to get to know you and to get to know who you are and what you do […] and know that you’re safe and you’re trustworthy and all the rest of it. It’s, it just take time, takes a long time to into the [local] psyche” (Sessional staff member, site 5).

Such trust was often related to the individual staff members employed, with a new member of staff in site 1 highlighting the time-consuming business of building relationships with different communities. Taking time to build trust was often aided by the informality of the approach adopted by the HLCs, which is something that appears to be crucial when engaging local communities. This point is best made by first highlighting the difficulties a coordinator faced when formally advertising to attract local people from separate and isolated communities to join a partnership meeting:

> “whenever I’ve run something just for the general public, completely free, you know, advertised all over the place, [there’s] virtually no response” Coordinator, site 1).

In contrast, informal approaches were usually expressed through having staff located close to communities and of having knowledge of target groups gained through repeated exposure and learning about communities over time. Much of this informality came down to simple measures such as engaging in ‘chat’ with key community stakeholders:

> “ and also just things like, kind of informal chats with people who are maybe attending a course or who enquire through the telephone, and I think it’s just staying in touch with people”(Project worker, site 4).

While such informality was evident in HLCs that had staff embedded to work within a particular community (e.g. sites 1, 3, 4 and 5) and which operated within a bounded geographical area, similar approaches were applied by HLCs that operated using a network model, with fewer geographical ties, through the use of existing community groups. Highlighting how a thematic partnership took a “bottom-up, grass-roots approach”, a stakeholder commented:

> "…we work in different geographic areas. We take in areas of multiple deprivation in the city, work with the community council, the local groups, well it can be anything from the mother and toddlers group into the, you know, the senior citizens, through to the Church… […] We had a month long blitz of the area and folks got information in the pub, they got information in libraries, in the GP surgery. We had folks on the community council going round and, in a way, identifying people, talking to people who are in poverty and trying to link them in…"(Partner, site 2).

Such success in using informal approaches to appeal to the community suggests that one of the most important features of encouraging community involvement would be the need to build effective social relationships, something which requires perseverance, commitment and time.

3.2.4 The importance of the relationships that have developed: personal contacts

In drawing attention to the importance of building effective social relationships, several HLCs considered the need to continue providing support for communities in the longer-term. The following quotes highlight the reluctance of several HLC target groups to go without some form of support and illustrates the difficulty that HLCs might face if no sustainable funding were to be found and staff withdrawn:

> "…you can't just walk away at all; you've a total relationship with people that you don't want to, to abandon" (Project coordinator, site 1).

Later, in discussing her attendance at an independently run dance class supported by the HLC, the same coordinator indicated that her arrival after an absence of several months had elicited a cheer. She suggested that this indicated how the community group:

> "…notice my absence and so because of the way that the project has worked with building relationships with people em they, they do notice and so you're, you feel like you should be showing your face every so often in, in most activities" (Project coordinator, site 1).

Such embedding with "healthy living coordinators, just being part of the community" was evident across multiple sites, with key staff, both those local to and from outside the area, becoming a prime locus of support for community members and groups. In some sites, the knowledge of local communities gained by a staff member who had been in post over a considerable length of time was shown to be an important feature in ascertaining needs:

> "…I mean, I think that we all realise this [that the manager] always seems to have a knack for being able to sort of, just put her finger on, when she talks to you and when she gets to know you and what you actually need" (Service user, site 5).

In other instances, the appeal of staff who lived locally and who were known within the communities was an attraction for local people to become involved in the first place (e.g. sites, 1, 3 and 4):

> "…it's that engagement with the community which she's […] able to, through previous experience, she will know a number of the families, parents…" (Partner, site 1).

Although the time required to develop relationships was viewed as essential in most instances, stakeholders in site 3 suggested that the amount of time that community health staff spent with particular groups might have hindered the development of new groups. Instead they suggested that staff should have: "back[ed off] and move[d] to a different group". Yet experiences of other sites suggest that many of the target communities presented challenges that were only overcome through gaining experience of the local people, something which only came about over time:

> "…I think a lot of it is in the experience and where I've seen some of the new sessional staff coming in, struggling maybe with the initial training […] … and then going out and doing pieces of work and seeing that themselves, actually kind of working with clients […] … seeing the difference that just that kind of contact can make" (Partner, site 5).

The importance of the relationships that have developed is revisited in section 3.5. For many HLCs, stakeholders suggested that target groups require support for longer than that so far provided by the HLCs. Coupling this with the views of a manager in site 1, who suggested "when you cut loose and you don't have a coordinator, within a month or so it would all fall", work to engage and involve disadvantaged communities should be considered over the longer-term.

3.3 Research objective 3: To examine how HLCs meet local health needs while working to address national health priorities

3.3.1 Introduction

When the programme was established, HLCs were asked to develop projects that responded to community-determined health and well-being needs while seeking to work with and complement relevant local and national strategies and health priorities. While the previous section examined efforts undertaken by HLCs to involve their communities, to gauge local needs and to devise appropriate services, this section explores HLC stakeholder views about responding to national health priorities and relevant policies which have emerged since they began to operate. It is suggested that the structural features of an HLC influence this fit, in particular the relationship with the health sector. A specific example is then examined, which looks at the changes and adaptations that have been made by HLCs to address emerging mental health and well-being needs and how such work fits with national priorities. This example was chosen because of the importance of mental health and well-being as an underpinning theme for health improvement actions.

3.3.2 Accommodating to priorities and policies

In several HLCs, the size of the target area, the large number of communities involved and the scale of the original business plan proposals had meant that sites were tackling a very broad array of health and well-being problems. This readily facilitated work to address both local need and national priorities. In several HLCs, which were addressing the needs of a wide range of target groups, work to address national priorities was reflected throughout service delivery, albeit with an HLC often putting “its own slant on situations”:

> “…the national priorities give us enough scope. They’re broad and we haven’t had a difficulty in terms of reflecting those in, in the local health work” (Partner, site 4).

Even when focusing on a single target group, an HLC was able to fit its work into the breadth of priorities such as those addressing diet, exercise and smoking:

> “We are aware of what they [the national priorities] are, and I suppose if you look at health in its wider aspect and all those things fit into it and that’s what we’re looking at, it’s health in its wider aspect, so I guess by default, because we’re looking at holistic health… […] … but generally it’s by default because we’re doing it anyway” (Project manager, site 6).

While national priorities were reflected in HLC work according to the needs of local communities, several differences did emerge between sites in terms of how HLC management and strategic stakeholders developed their work as the policy environment evolved. Since the construction of bids which mediated proposed work through policies in place around 1998/1999, many changes have taken place, including devolution in Scotland and the emergence of new policies.

Several sites (2, 3, 4 and 5) were found to be seeking to position their work within emerging policy frameworks. Differences were evident between managers and the strategic focus they adopted. For instance, when discussing how the whole-community focus of the HLC fitted within the framework of the policy document ‘Improving Health: the Challenge’, the manager of site 5, drawing on personal interest and earlier involvement in the HLC bid, outlined that the way the HLC had been established and its focus on the whole community meant that work related to policy developments had been underway for some time:

> “The priorities we are working to are the priorities of the White Paper which are the priorities of the JHIP. The four pillars […] the Improving Health, a Challenge. […]. Right, the four pillars, there’s, aye the four pillars, community, I can’t remember what they all, but the priorities of the four pillars are alcohol, tobacco, physical activity these are all in our Business Plan. They were in our Business Plan in 1999. We’re way ahead of JHIPs and Public Health Networks. We’ve been doing it” (Manager, site 5).

In another site (3), there was a perceived strategic need by the manager to attempt to locate the work of the HLC within the Improving Health framework. At the same time, overlapping boundaries (see section 3.4) with newly emerging structures such as community planning partnerships provided opportunities for the HLC manager to become involved in developing new plans to address its priorities, to which the HLCs workplan was then to be related. Such attempts to incorporate newly emerging policies and priorities were evident when the manager of site 3, who had not been involved in the original bid, stated:

> "…I suppose, first of all we were set up without looking at National priorities particularly […]. The JHIP's [Joint Health Improvement Plan] finished now so we're trying to look at what our work, how does it fit under the JHIP which has a hundred and thirty-six aims, it's just ridiculous. Em, and the ROAs [Regeneration Outcome Agreements], so the ROA for Health, how does it fit with what we're doing, em, and now, we've got the Performance Assessment Framework as well, you know, how does that fit with the local priorities?" (Manager, site 3).

Sites 2 and 4 were considered by partners to have developed services in response to local needs that could be placed within newly emerging policies. Acknowledging the policy document 'Delivering for Health' and an increased focus on anticipatory forms of care, stakeholders in site 4 discussed the merits of a chronic disease self-management programme, while in site 2 the network model used was itself viewed positively in relation to this policy agenda:

> "…the structures that are put in place, the infrastructure of the [HLC] will deliver, will help primary care deliver in a proactive preventative, anticipatory way and that, for me, just bangs every button that, em, is possible on this" (Partner, site 2).

In contrast, other HLCs did not seek to draw such overt links between services and emerging policies. Some operated for particular target groups which were not highlighted in policy documents, while for others, the resource capacity of management and involvement of partners sometimes precluded such discussion from taking place:

> "…we've talked about it at the strategic partnership but not in any really seriously focused way. I think I'd be lying to say [we had]" (Manager, site 1).

3.3.3 Influences on HLCs' blending of local needs and emerging policies

While managerial interest and resources had some impact, the way in which an HLC was structured and its relationship with, and involvement of, statutory partners (in particular the NHS) influenced the attention given to wider priorities. As will be discussed in sections 3.4 and 3.5, several sites sought closer alignment with new community planning and community health partnership structures and gave greater prominence to national priorities when considering sustainability. Yet, throughout the lifespan of the

programme, the links between an HLC and statutory partner organisations influenced the ways in which national priorities were discussed and addressed.

Developing close links with statutory bodies
While each of the HLCs sought to develop their work in partnership, there were differences in the closeness of links with statutory organisations such as the NHS. In one site there were explicit references to aligning a model of working with wider structures, in attempts to position the organisation with sustainability in mind. In a strategic planning group operated by site 2, several key personnel had overlapping posts in the HLC and in statutory bodies and partnerships, including community planning and community health partnerships. These overlaps meant that the HLC stakeholders were keenly aware of changing statutory services and in considering the fit of the HLC within these structures.

In another HLC (site 5), close links were formed where the NHS was the lead partner and host organisation for the HLC. In this HLC, the manager described how "…the NHS badge, although it's a stricture, also gives you cred…" The breadth of services delivered and the strategic interests of the manager had enabled the HLC to link work to national priorities, which also strengthened links to the NHS and CHP. However, while stakeholders considered that delivering an appropriate service to the local community was crucial, the close links to statutory organisations such as the NHS might be questioned:

> "…she wants to be able to run with everything [to do with the NHS] because she's relying on a, on a budget for it, and I think that if [the manager] was left to making decisions about what was best for the [area], some of the things I don't think she would do" (Partner, site 5).

Community-led sites establishment of links to national priorities
Other HLCs, although not having the extent of strategic links that sites 2 and 5 had established, still sought to develop their work to meet local needs and national priorities. Both community-led sites sought to involve statutory partners in advisory and management functions. When discussing the distribution of power within a community-led management group, a manager highlighted the use of a management tool to facilitate discussion between community board governance structures and local funding bodies:

> "…one of the reasons why we use Big Picture […] …I suppose one side's from the local funders' point of view is that we don't, we didn't actually become a project that just spiralled off and did exactly what the community wants…" (Manager, site 4).

In site 3, the size of the HLC and the managerial resources that it required was suggested to have impacted on its ability to accommodate local needs and national priorities. Some stakeholders indicated that less emphasis had been given in a community health service to ascertaining local needs than might have originally been envisaged. Another partner suggested that the size

of the HLC, and the way in which it had “mushroomed too quickly”, resulted in the organisation having to “fire-fight … so they spend a lot of their time on the here and now”, which made it more difficult to focus on both local needs and national priorities. A staff member commented:

> “I would like them actually to go out and [do] a wee bit of real research to see what the […] community needs… […] I don’t think it was, like everyone wanted to be all-singing, all-dancing […] stretching yourself too thinly, but not actually looking at, what can we actually do…” (Project worker, site 3).

Developing independently with a narrower strategic focus

In site 1, hosted by a local authority, the devolved responsibility for local service development taken by its five projects (and its coordinators) led to a variety of different approaches to service delivery. Staff in each of the projects indicated that they worked closely with communities “…finding out what the people are saying is important to them and targeting that…” Although adhering to principles of community development, and while the work could be linked to policies to address physical activity and diet, the way in which the HLC’s services had been constructed, mainly guided by local authority partners, was suggested by another partner to make it difficult to link with national priorities:

> “The difficulty we probably have is the activity level, the projects that are promoting activity, which are hugely important, don't actually fall into any kind of target category that we, we in the NHS have” (Partner, site 1).

3.3.4 Meeting local needs and reflecting national priorities: an increased focus on mental health and well-being

In this example, findings illustrate how the HLCs were able to respond to emergent local needs that reflected national priorities. During the evaluation and across the sample, stakeholders highlighted that they had responded to local needs through applying a greater focus to services targeted at mental health and well-being. This change in emphasis often developed as HLCs and their stakeholders began to consider holistic approaches to service delivery and the range of benefits that might be derived from some of their activities. For example, in walking group activities promoted by several case study sites, multiple benefits were observed and services were positioned accordingly:

> “…it’s taking a different angle on dealing with stress, although they’re getting physical activity, they’re getting peer support and they’re getting, you know, relaxation [from stress]” (Project officer, site 3).

Several sites found that their initial level of service provision did not adequately cater for the level of mental health and well-being needs that were being expressed, which were often only revealed when staff became acquainted with service users in services which did not overtly specify a mental health element:

> "[I've] just been thinking that with the massages that I do, it's all more, they've got something behind it, d'you know what I mean, like there's ones with ME or there's ones with this, that, that and the next thing…" (Sessional staff member, site 5).

In other sites, where mental health service provision was a key feature of the original HLC model, stakeholders discussed how their initial work had led them to consider the need to increase the availability and scope of services, in particular as several staff found that it took some time for service users to fully engage with HLC work:

> "… they're more trusting so, they open more and there is some people who's been coming back again and again with different issues. I think, you know, they are, what they were here for in the first place. It's just taking them a long time to get to the point and to deal with it" (Project officer, site 3).

Informal approaches to meeting mental health and well-being needs
The increased awareness among HLC staff regarding mental health and well-being needs led to several changes in services. In some instances this brought to the fore the informality which characterised community involvement and development practices for many of the HLCs. For example, site 6 acknowledged the increase in mental health needs of its users by arranging for a seconded mental health post to be attached to the HLC for two days a week in order to provide more focused work:

> "…I think the one-to-one work is actually really tackling problems that young people have with their mental health, em, and in really informal ways rather than going to a psychiatrist or a CPN…" (Project manager, site 6).

In another site, while the main focus was on promoting models of best practice, an interesting counter-example emerged of an instance where staff discussed the use of informal approaches that had been adopted with some mental health groups, providing a form of support that contrasted with more clinical approaches:

> "I think there was an expectation because of my psychiatric nursing background that I would be going in as a professional nurse or stroke therapist and when I met with the group that's just not what they need, that's not where they were, that's not what they wanted in terms of recovery and I'm really enjoying the freedom of actually bringing resources to the group and being with them in a more relaxed way" (Project worker, site 4).

Later, the same project worker gave more consideration to the method that she employed and to the various ensuing benefits for service users:

> "…it's just to get people out of the mindset that, when it comes to mental health and well-being, it has to be therapy or it has to be nurses […]

…it's about looking a wee bit more normally at what people do to recover, rather than assuming if you've come through mental health services, that's how recovery will always be defined, the medical way. It's much more social, it's much more [a] normalising kind of path of recovery" (Project worker, site 4).

Attempts to make changes to the wider system

Sites 3 and 4, which delivered mental health services more directly e.g. counselling, had also engaged in the provision of training, including mental health first aid training, to a variety of community groups. Furthermore, site 3 had undertaken moves to create a network between existing organisations delivering mental health services (e.g. different forms of counselling), to improve referrals between agencies and to encourage sharing of best practice at monthly inter-organisational meetings. Within its own service, site 3 found that levels of demand outstripped supply and more people were presenting for support and treatment than staff capacity would allow. In order to reduce waiting times, relaxation groups were set up to provide help to those waiting for more specialised support. These were found to have several benefits:

> "It's really grown, we've developed, we have waiting lists so we've developed relaxation groups, you know, people can go for support while they're waiting for the one-to-one support and we felt it was important that people weren't kept hanging around, you know, like happens in the statutory bodies, you know, you wait forever for an appointment and we felt that it was important to have them engaged as quickly as possible and what's happened with that is that some people are now saying they don't need one-to-one support, the relaxation groups are enough to give them the skills to cope on their own with peer support" (Project officer, site 3).

Identifying and seeking to fill gaps in provision

In another site the HLC had begun its operations through delivering a broad range of services. Having spent time gaining the trust of service users, the manager, reflecting the views of an NHS partner, and responding to changes in how statutory mental health services are to be delivered, highlighted the increased demands that had arisen in the area:

> "This should be a mental health project, but if it was a mental health project nobody would come in the door, it would be labelled. But the majority of what comes in the door, is people who are somewhere on the four tiers of mental health and mental ill-health if you like, and tier one is getting bigger all the time because of the lack of resources here. […] But that's what comes through the door. These are the people that are on the treadmill who end up at the doctor's" (Manager, site 5).

Drawing attention to the benefits of the HLC location for delivery of mental health services, the manager also discussed how the venue provided a non-stigmatising location for potential users to attend. Similar efforts to address stigma associated with seeking help for mental health problems was also a

feature of site 4, which had changed its programme to provide a counselling service both to fill a void and to eliminate duplication with other local agencies.

3.4 *Research objective 4: To explore the involvement of HLCs in wider health economy structures (e.g. community planning, community health partnerships)*

3.4.1 Introduction

This section explores the development of HLC partnership working during phase 2 of the evaluation. We begin by looking at findings concerning operational and strategic partnership developments within the HLCs. This is followed by an examination of the differing and sometimes challenging experiences of HLCs in establishing, developing and maintaining strategic relationships across the wider health economy, in particular during a period of significant change. Findings are presented which explore how HLCs have become involved with community planning and community health partnerships and the different types of involvement that they have with such structures. Further findings related to the involvement of HLCs to the wider health economy are presented in section 3.5.

3.4.2 Partnership working: at the level of the HLC

The implementation and diversity of different forms of partnership and partnership working were explored in the phase one report. In this section, findings are presented which look at the various meanings that are given to operational partnership working. Later, consideration is given to strategic developments within HLC partnerships.

Operational partnership working: what does it mean in practice?

In the second phase of the evaluation, HLC stakeholders discussed many successful forms of operational partnership working that had been developed. In several instances much of the success was attributed to the creation of productive relationships leading to enhanced acceptance of the HLC by partner organisations. These relationships often took time to develop. In a statement that has resonance across the sample, a partner in site 2 commented on the relationship-enhancing effects of time spent working in partnership and resulting benefits when delivering services:

> "…it's the making connections with other organisations based on an increased awareness of what each other, a number of organisations are doing and the connections that happen [from] that. It's a simple level of being able to refer X to another place, of being able to find the right door to put somebody through in a holistic [sense]" (Partner, site 2).

Across the sample HLC stakeholders indicated that there were many instances where partnership working had achieved links between sectors:

> "What people can actually see is something that we struggle with sometimes, which is actually to get the community and voluntary sector organisations to work together" (Chair of the board, site 2).

Several sites highlighted how continual adjustments were made to services and partnership delivery mechanisms according to the 'ebb and flow' of personnel in existing partner organisations. In another instance, HLC operational partnership working was viewed as a collective way in which to accommodate to wider structural change:

> "I think there's been so much change in the Council, there's been so much change in the Health Boards, there's been so much change in terms of how and whether the Council and Health Board fund voluntary organisations, there's been so much uncertainty there. Now, in [our partnership] … that has caused us to, well, like a tribe, we've all come together in order to support each other in a time of change" (Partner, site 2).

The variety of different partners with which HLCs were involved and the continued expansion of operational partnerships were key features. While the following example refers to a virtual model of service delivery, the breadth of organisations involved is characteristic of the types of operational partnership work in which the wider sample engaged during phase two:

> "We deliver services in the [area] out of anything like nineteen to twenty-one different agencies, […] anything like from the local development company through to […] three or four youth provider organisations, you know, pre-five organisations, mental health groups, […] mother and toddlers groups, […] asylum seekers support organisation and […] the churches. So, what we would do with them is we've got a relationship with them where, you know, we actually deliver services with them to their clients […]. So, therefore, what we see is mechanisms engaging with a wider population and because we're a virtual centre, that's really the only model that really makes any kind of sense" (Manager, site 4).

It was claimed that partnership working across sectors influenced how other organisations delivered their services. Community development approaches used by HLCs were also suggested to have had an impact on statutory partners' work. However, reflecting the scepticism of several HLC stakeholders, a manager commented:

> "… they [health professionals] think they're doing community development work and it's very tokenistic" (Manager, site 3).

Later, the same stakeholder conjectured, that while statutory partners sometimes appeared to consider HLC staff in a more junior role, working with the HLC, which was using community development practices, had "…maybe opened their [partner's] eyes…" Commenting on how an HLC had established local partnerships comprising agencies, community groups and local people, a statutory partner from another site commented:

> "…one of the things that I think [the HLC] did try and promote was this community development approach and it's something that we're, you know, an interest I have and I think we should be using it far more multi-

agency wide and that's involving local communities and actually asking them what the issues are for them" (Partner, site 1).

Strategic HLC partnerships

In contrast to the successes of operational partnerships, the experiences associated with strategic partnership working were more mixed. Sites 1 and 6 indicated that the strategic relevance of their partnerships had lessened. In site 1, this arose through pressures of time on managerial resources to oversee partnerships and the difficulty in retaining a breadth of organisations to guide strategic development. Meanwhile, in site 6, strategic responsibility increasingly fell to the host organisation as a result of operational successes and the location of the HLC within a larger host body, coupled with time pressures on partners. However, changes that had led to a reduced number of partnership meetings were viewed positively as the involvement of partners had been retained:

> "I think we might have developed a pattern of how it's going to be. Em, and if that is the pattern and people can put, commit to that, I would rather have the commitment to meet a couple of times a year to review and plan than pretending that it's going to be anything different, do you know what I mean and then folk don't just come to the meeting" (Chair, site 6).

Despite its use of tools such as the Big Picture (see section 3.3.3), maintaining strategic links in site 4 was found to be challenging: changes in personnel and the development of new CPP and CHP structures led to declining participation and a need to refocus on building relationships with new partner representatives. Meanwhile, in site 3, the strategic relevance of the managing board was questioned when changes to the wider system (such as conjoining health board services and the introduction of CHP/CPPs), coupled with the financial difficulties faced by the board, led the manager to ask:

> "I have to be sure that what we're doing has still got the principles behind Healthy Living Centres there. Is this a response to the communities' needs or is this a response to what funders think we should be doing […]?" (Project manager, site 3).

The remaining sites indicated that they had had to work to reinvigorate strategic partnerships. In site 2, the departure of the project coordinator meant that a strategic group, which had been a "bit dormant", was coaxed into a more active position, moving from an "overseeing role" to one based on "ensuring that there is long-term viability". As a result of changes linked to the community planning process (see section 3.4.3), site 5 had been able to develop new remits for its strategic partnership which were thought likely to aid the HLC in the future.

Yet, for many of the HLCs, the strategic relevance of their own partnerships was only one aspect of their efforts to engage in, and position themselves within, their local health economy. Wider system changes meant that HLC

managers and key stakeholders often sought to become involved with new partners, structures and strategic groups. The quotation below draws attention to the various organisations with which site 3 was strategically involved, while the sections which follow examine HLC involvement in structures such as community planning partnerships and community health partnerships:

> "The actual partners, as far as strategic partners in working are, obviously, the Health Improvement Teams within the CHP, the Health Improvement Officer at the Council […], [Community Planning Partners] on the Worklessness [theme]. The Education Department, […], then Health Co-ordinators for the Schools… […] [We then] sit with the, in the Joint Health Improvement Plan Writers Group which is now finished […] and the Older Persons […] Group and the JHIP Youth Health Group. So, they, we do quite a lot of strategic [work] …" (Manager, site 3).

3.4.3 Levels of HLC involvement in CHP and CPP structures

All UK HLCs have had to attempt to keep pace with substantial amounts of change in the wider policy environment in which they are operating and, as shown in section 3.3, HLCs have been giving consideration to changes in public health policy agendas. Changes that are pertinent for many of the Scottish sample include the introduction of community planning partnerships (CPPs) and community health partnerships (CHPs). CPPs were established to bring local authority and key agencies together to seek to improve and deliver better public services at a local level. Meanwhile, CHPs are considered key building blocks in modernising the NHS, through seeking to develop joint working, to integrate services and by remaining responsive to local circumstances. Both these partnerships include a move to work across communities rather than the past focus on area-based initiatives.

Partnership working and the previous links of the HLCs to health boards and SIP structures meant that several of our sample found their partners organisational status changed, as did the relationships that they had previously established:

> "…some of the partners have totally, very distanced themselves from us. […] Now they phone me up and they, when we hand in our application [for funding], they'll say we, we're not on your board. […] Because we're community planning […] …they're no longer on our board […] …they don't engage on that level […] because we're a project, not an umbrella organisation" (Manager, site 4).

As discussed in more detail in section 3.5, these new partnerships were also to have an impact on HLC sustainability. Through recognising the need to develop new relationships, many (but not all) HLC managers sought to enhance involvement with their local CPP/CHP structures. In site 4, the manager discussed how his HLC operated within a part of larger CPP and CHP areas and how he needed to ensure that he was involved in the new structures, commenting that:

> "…if we stand alone as a project then we've failed. We need to have major buy-in from the community health […] partnership, we need to have major buy-ins with the community planning partnership" (Manager, site 4).

There were several features that impacted on the level of involvement of HLCs with CPP/CHP partnerships, several of which are explored below. These included:

- the differential manner and rate at which these new partnerships were implemented
- differences between HLCs in terms of the overlap of their operational boundaries and those of the new partnerships
- the strategic involvement of key personnel
- the availability of strategic resources and foresight of the HLC, in particular its manager
- the types of target group addressed by the HLC and whether these were also groups that were of interest to CPP/CHPs.

The following discussion examines these features across three different forms of HLC involvement with such structures. These include those sites that are interwoven, those which have overlaps and those which have more limited involvement in CPP/CHP structures.

Interwoven forms of involvement with CPP/CHPs
Two sites (2 and 3) operated with boundaries that matched the new CPP/CHP structures and partners from both were involved in strategic and operational matters relating to each HLC. In site 2, there were several key individuals who attended both the HLC strategic planning group and who attended CPP/CHP meetings. The joint roles of partners and the way in which the CHP had originated from the health improvement body of the CPP were suggested to have led to some "really robust connections" between the HLC and new partnerships. Having such overlaps in representation readily facilitated opportunities for the HLC to present its work to the CHP, enabling a wider understanding of its services:

> "I would see that the CHP's relationship with the [HLC] is quite important […] …it seems to be the beginning of a relationship-building that the CHP recognises that the [HLC] can actually engage with the voluntary sector and the community sectors effectively […] … so there is a role for the [HLC] in terms of that engagement at that level […] … and that's more effective than the CHP trying to deliver that for itself" (Chair of the board, site 2).

In a contrasting example, site 3 also operated across similar boundaries to its local CPP and CHP and had involved partners from both structures (and health board and SIP predecessors) in advisory roles in the strategic management of the HLC. However, because of complex funding arrangements, site 3 was not permitted the same extent of opportunity to be represented at strategic CPP and CHP meetings. On the other hand, these

same funding arrangements also led to both sets of partners retaining a close involvement in HLC business, in particular in relation to sustainability(see section 3.5).

Involvement through overlapping but smaller boundaries

In sites 4 and 5, where HLC target communities formed a small part of the larger partnerships' boundaries, there were major differences in the way the two HLCs have sought to become involved with the CHP/CPP structures. For example, site 4, established to deliver services to a geographically bound and defined community located within a larger CHP boundary, sought to promote its services by developing a role where it was able to influence the CHP and its views on community involvement:

> "…when the new community health […] partnerships are developing their programmes, obviously there's a community engagement part to it, …[so] we're working with them [the CHP] to develop PA [participatory appraisal] as a mechanism to engage with that, but what we're actually sort of saying, as an organisation who want to place the individual in the community at the centre of the process, one of the things we have to do is make sure that our partners, the statutory partners, structurally and strategically, have the same kind of remit" (Manager, site 4).

The manager later discussed how undertaking such work (including promoting the Learning, Evaluation and Planning framework [LEAP] to the CHP) was an attempt to develop a strategic role for the HLC, where political complexity ("bickering and fiefdoms") had ruled out such an overt option. Instead, the strategic work of the HLC had to be undertaken "in the background". As noted in the introduction to this section, the manager of site 4 also found that it had been difficult to develop relations between the HLC and the CPP due, in his view, to changed consideration given to projects that were tied to particular areas.

In site 5, which similarly covers only part of the boundary of the local CHP/CPP structures, the strategic positioning and interests of the manager and the hosting of the project by the NHS created more opportunities for wider involvement. This led to the establishment of close contacts on the CHP and overlaps in personnel attending HLC strategic meetings and CHP management meetings. Additionally, the HLC partnership had recently been reinvigorated, having evolved to become one of several local public health networks set up to cover the CPP geographic area. Although reticent about the set-up of the current health improvement functions of the CPP, several partners enthused about the role the HLC had played in leading and informing this sub-group, the way that such moves had led to a reduction in the proliferation of local partnerships and the way in which this "makes a better use of everybody's time". Following the CPP intention to establish public health networks across its rural communities, it was found that:

> "…what's happened in the [HLC location], is where there are healthy living initiatives, they've taken a lead in that [process] and where there

aren't healthy living initiatives, there's been more of a struggle [to develop public health networks]" (Partner, site 5).

Limited involvement

The third category of involvement is in marked contrast to the previous two. Partnership work at sites 1 and 6 was mainly focused at more local levels, engaging partners to work together operationally. Working as part of a larger host voluntary organisation, site 6 had less direct involvement in newly developed structures, with representation instead being obtained via the wider voluntary sector. The host organisation took the strategic lead, leaving the HLC to develop operational partnerships. Discussing the operational focus of the project, a stakeholder commented:

> "Here's what we're looking at, you know. Do you think there are other strategic partners who would also be interested in engaging in this at a strategic but operational level, because having somebody there on paper, which might tick boxes for them and their funders, isn't any good unless we're able to, to do some operational work…" (Chair of the board, site 6).

Meanwhile, in site 1, the main drive of the geographically dispersed HLC was to engage local people and organisations to develop responses to local needs, with strategic powers residing in a central coordinating body. Having little historical involvement in SIP structures, there was a hesitance in seeking involvement in the local CPP, especially as it was considered to be "not dynamic". Future changes to council wards meant that reconstruction was likely to take place within the larger CPP structure, which had resulted in uncertainty about how it might relate to the HLC. Meanwhile, the HLC's predominant focus on exercise had resulted in more tenuous links with CHP partners. Although a CHP partner was now attending strategic meetings, it was indicated that, with the exception of key parenting services, it was more difficult to establish links between the NHS and the HLC:

> "…the topics that they're focusing on, or had been focusing on in other areas, probably, had not been key targets, more sort of general targets from a health service point of view" (Partner, site1).

However, although it was considered problematic to link HLC activity with CHP targets, the HLC was still involved in developing the local health improvement plan and further moves were envisaged for the HLC to have representation on a local health improvement group.

Despite these differences in involvement of HLCs in CPP and CHP structures, attention should also be given to the different emphasis required in developing such wider involvement between community- and statutory-led HLCs. While site 3 retained close links throughout, comments from site 4 suggested that the partnership involvement declined as strategic structures changed. In contrast, statutory-led sites (2 and 5) appeared to retain a closer relationship during this period of change. Discussing the importance attached to their statutory links, a stakeholder in site 2 commented:

> "…[the time taken in] building up that recognition and kind of, em, support for the network, if we'd been maybe in the voluntary sector completely would we have had the same influence, well?" (Line manager, site 2).

3.5 Research objective 5: To examine HLCs' attempts to ensure project sustainability, through taking account of community influences, types of HLC (e.g. voluntary, statutory or community-led), partnership construction and wider inputs at local and national levels.

3.5.1 Introduction

Although the BLF required that HLC applicants indicate their plans for continuation after the end of lottery funding, limited emphasis was given to such matters in the original application forms and when decisions about funding were made. Reflected in the national HLC report and in the recent Community-led Supporting and Developing Healthy Communities Task Group[10] report, the findings of this evaluation again draw attention to the magnitude of the challenge and to the cross-cutting nature of the problems when considering sustainability for HLCs, in particular, and short-term funded community initiatives, more generally.

This section will begin by examining different definitions of sustainability and how these relate to the work undertaken by HLCs. Themes which have emerged from the data are then introduced, including: an examination of the changing organisational landscapes inhabited by community initiatives such as HLCs; the focus given to sustainability of services; the ability to demonstrate impacts of HLC work; the responses to learning from the first phase of funding; the approaches made to the BLF; and the consideration given to HLC 'ethos' when seeking sustainability.

3.5.2 Definitions of 'sustainability' and their application when examining HLCs

A review of the literature indicates that there are multiple referents for the term 'sustainability' and a lack of consensus regarding conceptual and operational definitions[11]. Much research on sustainability refers to 'programmes', or the work and activities provided by organisations which target particular areas, groups or communities. In these instances, definitions of sustainability include: the continuation of an entire programme or parts of a programme within the original or other host organisation; the continuation of benefits or effects from a programme; and the development of community capacity to allow a programme to continue and to permit new work to be developed. Such

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[10] Community-led Supporting and Developing Healthy Communities Task Group (2006) *Healthy Communities: A Shared Challenge. Edinburgh: Health Scotland*. Available on: http://www.healthscotland.com/uploads/documents/2746-HealthyCommunities%20TaskGroup.pdf

[11] Shediac-Rizkallah, M.C. and Bone, L.R. (1998) Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. *Health Education Research*, **13**, 87-108.

definitions also reflect several of the ways in which sustainability was considered in the original HLC applications for BLF funding.

However, while literature on sustainability makes many references to programme sustainability *within* organisations, less focus is given to sustaining organisations per se. In the case of the HLCs, the programmes of work (or services) *and* the organisational capacity to support delivery and to innovate were established through the BLF (and partner) funding. Sustainability in this instance refers to whether, and how, funded community-based initiatives such as HLCs – set up to ascertain, coordinate and deliver activities based on need – are maintained over time. Such a distinction draws attention to the organisational model and the view of HLCs as 'platforms for innovation' introduced in the Bridge Consortium final report, and whether and how HLC models are sustainable.

Thus, the sustainability of HLCs in this report is primarily considered in relation to the approaches taken to sustain the model or organisation that provided the original activities and whether and how this might occur either as a whole or in a modified form. Throughout this analysis, consideration is also given to the sustainability of HLC activities and to the legacy of the work that has been delivered. The longitudinal design of this evaluation permits the exploration of HLC processes, in particular an examination of the way in which stakeholders' views on sustainability change and evolve as the HLCs adjust and adapt to the contingencies of the wider health economy structures in which they operate. This examination of process needs to take into account: the gain in knowledge and enhanced understanding of target group(s) needs; changes within host partners; changes underway in the wider health sector (introduced in section 3.4.3); reductions in funding available from statutory agencies; the new funding criteria of CPPs and CHPs; and new funding streams made available by the BLF.

Adapting the broad definition applied by Shediac-Rizkallah and Bone, sustainability is the global term that is used to refer to organisational and programme continuation. Such a definition will enable a broad focus to be applied to sustainability, allowing the examination of the HLC models in relation to the wider health economy in which they operate. In addition this definition permits an examination of the sustainability of the HLCs ethos and allows for a focus to be given to changes to individual, organisational and broader societal processes[12].

3.5.3 Aiming for moving targets: the changing landscapes inhabited by HLCs

There were several different considerations given to sustainability by case study HLCs over time. Across the sample, it was evident that each HLC had had to respond to unique circumstances to ascertain levels of partner support, and the funding options that were available. Initial fieldwork identified a variety of possible options to sustain HLC work, including those brought to the fore by changes to host organisation management boundaries (e.g. site 1) and

[12] Swerrisen, H., and Crisp, B.R. (2004) The sustainability of health promotion interventions for different levels of social organisation. *Health Promotion International,* **19**, 123-130.

through interactions with newly emerging partnerships such as CHP/CPPs (e.g. sites 2, 3, 4 and 5), with much attention across sites given to seeking to "…create proposals that we know will have the support of the CHP, or other community planning partners."

Multiple considerations during a period of change

In common with other community health projects, HLCs were informed by the Scottish Executive that future funding for health improvement programmes was to be distributed by local organisations such as CPPs and CHPs. Stakeholders at several sites highlighted attempts to understand and adapt to new structures, although the scope of change was suggested to have caused problems:

> "… it's a very difficult time, I think for every Healthy Living Centre, with CRF [community regeneration fund] monies, and, and community planning partners coming into place, and the CHPs. It doesn't help that we're ending our funding programme and we've got all this and then BLF's just announced this bit of money…" (Manager, site 3).

System-wide changes meant having to develop relationships with the newly developing partnerships and often having to adapt to changes in their own lead partners. Two sites (3 and 5) faced upheaval as partner representatives and lead organisations changed following the dissolution of a health board. Consideration also had to be given to a redesign of services as these changes took effect. More broadly, HLC stakeholders expressed problems they had experienced when seeking guidance on which course of action to follow:

> "… what we have been doing, is kind of trying to say to our local partners, the health board or community planning, is like, we know we have to change, but you have to give us an idea of the areas you want us to work [in]…" (Manager, site 4).

In another site, changes to the operational management boundaries of the local council and lead HLC partner were thought likely to affect the boundaries of local CPP structures, making it difficult to engage in discussion about future services and funding provision:

> "…there's so many 'if's' up in the air and it would be very easy for me to do a presentation to [say] Community Planning and to get them to rubber stamp, yes they will support us, but, at the moment, I don't think it's, it might help us in a bid for money, but nobody around the table seems to be in a position to commit anything" (Project manager, site 1).

Redrawing some of the boundaries

Several HLCs were engaged in discussions about potential changes to the geographic and community group boundaries within which HLCs delivered services. These discussions were initially and predominantly concerned with the need to provide services across the areas encompassed by larger partnerships, sometimes termed "equity of service provision" by CHPs. It was

indicated that some HLCs were having to consider working outside their original target communities and were concerned about the potential impact on resources, forms of service provision, willingness of staff to work across wider areas and local community involvement and governance mechanisms:

> "…the need for what we're doing hasn't gone away 'cause we've not solved the problems that we were set up to do and is that then about us turning round to, sort of say […], well to save the staff, right, what we're going to do is, we're going to move out of [this area] and cover the whole of the CHP, so instead of a hundred percent being delivered in [this area] only twenty percent is going to be delivered [here] and what does that then say to our [local] Board? Does it say to them that that was fine but, because, you know, expediency says that we have to cover the other areas. You know, instead of getting, you know, eight members of staff delivering for your community, you're actually only going to get about an eighth of that" (Manager, Site 4).

In other instances, CHP partners were concerned about setting a precedent by providing funding to a geographically bounded HLC, which might then lead to claims for financial resources from other community health initiatives. In addition, seeking to maximise any funding contribution, a CHP partner in site 5 highlighted:

> "… I suppose if I was being completely honest what I would like to do is a, less of a Healthy Living Centre, but [more] a healthy living service that covered the area that I've got management responsibility for" (Partner, site 5).

As a result of changes to the boundary of the local authority, site 1 was examining options to meet the needs of a larger number of communities and assessing the possible impact on resources. Wider change in the area targeted by site 3 meant that changes to health boards and the implementation of the CHP had to be taken into consideration and were affecting discussion on HLC sustainability:

> "…I suppose I do see it in the context of what's the system need in terms of health improvement in [the area] ..." (Partner, site 3).

How are HLC organisational models viewed in light of wider system changes?
For several of the sites the suggestions put forward by CHPs were anathema to their model of working and the way in which they had developed their services. Stakeholders in two sites (3 and 5) highlighted the sometimes negative views held by some CHP representatives of community health initiatives such as HLCs. Responding to suggestions that the CHP might seek to develop an area-wide team to deliver health improvement services, a stakeholder in site 4 questioned the value attached by CHPs to community-owned projects and whether such a model would be used in the future.

However, in contrast to the sometimes protracted negotiations with CHP/CPPs regarding the HLC model, stakeholders in site 2 were, for a time,

very positive about how their model might be supported and directed by the local CHP. In this site, the HLC had worked closely with the newly implemented CHP and was considered to "[sit] well alongside or within something like a community health partnership…". Viewing the CHP as the primary source of funding for its managerial and administrative functions, site 2 worked to align its work with CHP priorities, bringing to the fore its anticipatory and preventive focus. Discussing how it was "…important that we don't get hidebound by the nature of one of the projects in the [HLC]" and seeking to promote a model of work rather than a set of services, a stakeholder commented on how the HLC had already begun to reconfigure its partnership groups and how it might adapt its focus in future:

> "…if there is continued investment, and what they [the CHP] might do is start giving us a steer about the new themed groups, so… [we]… might more clearly follow some of the top priorities within that" (Chair, site 2).

In site 3 the funders' attention was initially focused on consolidating HLC services with newly emerging funding streams. However, in contrast to site 2, the community board in site 3 were reluctant to consider a new funding package that would have led to a split in their organisation, which some also considered might limit its generic appeal (see, also, section 3.5.6):

> "…it became obvious that [the CPP] has determined that [this team] go away, [be] taken under their wing […] and this seems to have been discussed with other partners, eh, em [the manager] in the community health partnership, em, and it's been presented to us almost as a fait accompli" (Director, site 3).

Highlighting the agency of the HLC sample, in particular, but not limited to community-led sites, the rejection of one set of funders' proposals by the board of site 3 illustrates the manner in which communities themselves engaged with the wider partnership structures when determining options for future funding.

A lack of strategic guidance

Despite much discussion, the strategic involvement of HLCs with their CPP/CHP partners often resulted in uncertainty, with few decisions regarding sustainability having been reached by the end of fieldwork. In several examples, HLCs were considered "one item on a big agenda", with a manager highlighting how an item on HLC sustainability appeared at the bottom of a newly established CHP management agenda. Such uncertainty was a feature both in determining future structures for service provision and for obtaining any funding commitment:

> "I think back to Dunfermline [venue for the first HLC conference], October 2005, David you were there, forty-seven or forty-six HLCs were there and you had these people on the plenary panel, up on the thing going, "you have to knock on the door of your CHP" and that woman, very ably, from the Borders, down the front said, "But we're through the door…" …[so] you know, we're not just knocking the door of the CHP,

> we've battered it down… Even though we're so far ahead and we know the structure […] and we know where we fit in and we've battered the door down, are we in there? Is it going to make any difference?" (Project manager, site 5).

In another site, the line manager was critical of what she perceived to be a lack of guidance from the Executive regarding any further form of political directive to CHPs:

> "…you've got the lottery setting up programmes of funding […] and it's what's the interconnection between that and the Scottish Exec […] in terms of me maintaining any of that or how, how, you know, encouraging CHPs to take up good practice. What is the directive from the Scottish Executive to the CHPs to look at that? There is none" (Line manager, site 2).

Some attempts to overcome this lack of strategic guidance were put in place through funding made available by the Big Lottery Fund, which led to the creation of the HLC Support Project, responsible for the HLC conference highlighted in the quotation above. This project has operated to provide guidance to HLCs across a number of domains, including sustainability, and is discussed in several places in the remainder of this report. However, as highlighted above, strategic guidance appeared limited.

The strategic importance of the HLC managers

The various governance mechanisms of the HLCs meant that the decision-making functions differed for each site. However, across all sites, the manager's role was vital as they provided one of the main links between wider partnerships and HLC strategic functions. In some sites opportunities to influence CHPs were limited because of the size of the HLC in relation to larger external partnerships and because of the limited strategic functions of the HLC (e.g. site 4). In other sites, managers had actively sought and been able to attend health improvement groups and partnerships (e.g. sites 1, 2, 3 and 5). However, in some instances limited resources affected the time available to concentrate on strategic matters:

> "…I would prefer to be released from other things to concentrate on [the HLC] now to see us through to the end because I think that's the only chance we've got [to achieve sustainability]" (Manager, site 1).

The importance attached to the managerial role in ascertaining strategic developments was evident when needing to synthesise information for local people on community-led HLC boards (site 3 and 4):

> "…if you're a community person who's a plumber, you come in here and learn, telling the difference between, eh, a community planning partnership, a CHCP, Glasgow City Council, for us, eh, […] …it's taken us five years to get some of our board up to the difference that they recognise that there's no such thing as an LHCC and even then they weren't a hundred percent [sure] what an LHCC was" (Manager, site 4).

In addition, managers were responsible for presenting the work of the HLC to key decision-makers (site 2) and in undertaking policy appraisal while maintaining close links with both the CPP and CHP (site 5). While the manner in which these roles are enacted differs according to the interests/resources/skills of the manager, the overlap of HLC boundaries and local politics, the manager of site 5 highlighted the value attached to such access and how a more formalised strategic role was sought in future:

> "…[there's] this other thing of giving, which would allow me to attend these meetings. If I'm not able to lobby at these meetings how are we going to, how are they going to recognise us, we would just go away, you know" (Manager, site 5).

The strategic significance of the managerial role was also highlighted where an individual had left post and no replacement had been sought. Although site 2 sought to operate with a minimum of bureaucracy, the departure of the manager drew attention to the importance of the role:

> "… unfortunately the coordinator left and that's not to say that in any way, em, you know, [the HLC] depended on an individual, but it did mean that a number of us [on the managerial group] then had to review what we were doing 'cause previously, I think, a lot of that kind of pushing and directing came from her" (Partner, site 2).

3.5.4 Plans for sustaining services

When examining wider change and how this might affect the organisation, HLC stakeholders also had to take into account sustainability of services. For several sites, this was discussed in terms of continued provision, dependent on the outcome of discussion to sustain the organisation. In others, effort was directed towards sustaining services in the community and among partners.

Discussion on the sustainability of services illustrated the importance attached to continuation funding. In site 1, stakeholders highlighted how some services such as walking groups might continue to operate independently, while others such as dance classes where professionals were employed were thought likely to operate at a different level since, without funding, classes might not be at "…the same level as, as professional inputs". Although attempting to reduce funding subsidies, HLC stakeholders had found that increasing charges for groups was sometimes off-putting to new members. In other instances, highlighting the value attached to paid staff, a coordinator stated:

> "…sustainability to me, means another fifteen or so years in terms of making a real, real impact. […] You can implement, you know, initiatives but in terms of making a real impact from the sustainability point of view, we [the coordinators] need to carry on…" (Project coordinator, site 1).

In site 3, sustainability of a set of services was first discussed through considering how new funding criteria might be met. Discussing the potential cost-savings of a new trust funding structure (for consolidating several existing services, including those of the HLC), a partner drew attention to how

such a model would centralise service delivery and reduce the "backroom" administrative operations and costs. However, while such an option was considered as a way to overcome a shortfall in funding, it was viewed negatively as a "wind-down of the [HLC]" and later rejected by the community board. As this example highlights, much emphasis was given to sustaining the HLC organisations over and above the services that had been established.

In site 2, work to support future service delivery was a key feature of sustainability plans, as funding was only sought for administrative and managerial roles to oversee the network functions. Having provided part-funding for seven local projects, the HLC was helping guide action to sustain their work:

> "…we're not cutting them adrift, we're saying like, what kind of dialogue do we need to go into and it might be that the projects themselves secure support from mainstream funds, from one of the partners already in the [HLC]…" (Chair, site 2).

Latterly the HLC above had employed a consultant to assist the projects and a variety of different forms of sustainability were being sought, including: self-sufficiency through revenue generation, mainstream funding, and lottery funding. Despite having been successful in encouraging partners to develop new methods of service delivery without supplying additional funding, the line manager was uncertain if this would be the case for all projects in the future:

> "If they're either funded elsewhere or not funded, what's their tie to the [HLC]? Will they still continue to be members of the [HLC] and what I'm hoping is that the [HLC] would very much become more, more focused on that kind of joint work without additional resources" (Line manager, site 2).

For site 6, the unique nature of the focus applied to the target group meant that the host organisation had discussed continuing to provide some form of reduced service should funding not be found, as it was not likely that partners would be able to take on the work and meet the needs of the target group provided for by the HLC. Similarly, the service delivery functions of another HLC were considered vital to a statutory partner which did not consider that there were alternatives for all the services it provided:

> "I don't think that there's anything that they've [the HLC] been tackling that we wouldn't say was a priority for our services and, realistically, core services just on their own can't tackle these kind of long-term issues, kind of healthy lifestyles, em, particularly maybe stuff round about, eh, behaviours…" (Partner, site 5).

With a proposed shift in focus to concentrate on more vulnerable groups, stakeholders in site 5 suggested that more general forms of health promotion work (e.g. exercise programmes) might be taken up by partners, such as GPs. In addition, stakeholders had also considered how work to support and bolster the work of some partner organisations had been successful. As a

result, partners were able to deliver their work independently, enabling a future focus on referrals between organisations to be given precedence. As this example illustrates, work to sustain services was heavily contingent on work to sustain the HLC organisation.

3.5.5 Demonstrating impact

Among the challenges noted by several HLC stakeholders as they sought further funding was the ability to identify strengths and to demonstrate the impacts of the work. After receiving criticism during phase one of the evaluation, the BLF were praised by HLC stakeholders for the changes introduced to annual monitoring forms and in the attention that was given to local HLC circumstances and contexts following the transfer of operational responsibility for HLC grants from London to Glasgow (May 2005). Following on from the examination of monitoring and evaluation during phase one, this section looks at the ways in which the impact of the HLCs' work was considered when seeking sustainability. A central challenge involved demonstrating the added value of the work of the HLC when a range of other factors (including partners' work) might also be influencing health:

> "What is it that has actually impacted on the ground on these people's health? It's very difficult to tease out which bits of it is. Is it mainstream services have had a shift, is it the [HLC], is the national policy? What is it that has actually done that? So, all you can do is show what you've delivered and how you believe that's contributed to that" (Line manager, site 2).

The HLC profile

Stakeholders in several sites expressed the need to build a profile that enabled HLCs to gain recognition for their work when approaching potential funders. For example, a stakeholder in site 1 considered it important that the HLC be widely noticed by its lead partner, the local authority:

> "I think [that] if you don't have a brand that's recognisable, nobody knows that you've been there…" (Project manager, site 1).

However, for some HLCs, identifying the impacts of their work, much of which was done in partnership, was considered difficult. Site 4 stakeholders suggested that they had a "poor public profile", arising through a focus on partnership working "…where it's very difficult to actually see the work we do as an entity…" Overcoming similar problems in site 3, a partner highlighted how it had been necessary for the HLC to develop a profile among partners to aid future decision making:

> "What I think they haven't been good at is, is describing and telling their story, so we have now got a marketing group, which […] is really around, you know, em, you know, if you haven't actually told anybody what you're doing…" (Partner, site 3).

Beyond outputs
While there were differing views regarding the timing of evaluations, several stakeholders had been able to use some output data to promote the HLC work. Discussing the monitoring and evaluation systems used by site 2, a partner highlighted that evaluation tools such as LEAP, combined with output data, could be used to gain the interest of funders:

> "Well, we've got a lot of evaluation material, which is all sort of clogged up in the way that [BLF], you know, do it and that can be, as I say, pulled out and presented in different ways. Em, I think that's very persuasive actually, at the quantitative level and it's pretty persuasive at the qualitative level" (Partner, site 2).

Stakeholders in several sites highlighted that they drew on both their own local evaluations and the UK-wide and Scottish evaluations when approaching funders. For some, the longitudinal focus of their evaluations meant that interviews and focus groups with service users, along with feedback from health professionals, had produced data from which health outcomes were inferred:

> "[The external evaluator has] been doing one-to-one and group evaluation. The coordinators do one-to-ones … […] and just ad hoc comments they write down, you know things people say without being prompted. Em, we've had feedback from GPs and some people feedback, say, "oh, I thought it was a load of rubbish when it all started, but now I can see the difference", and there's people whose health has definitely been proved to be taking a turn for the better. You know, there's health improvements, either from their own word of mouth of from doctors, whether it had been taken off medication, or whatever" (Manager, site 1).

Overcoming challenges when outcome measures are sought by funders
For many HLCs, funders' new emphasis on outcomes marked a contrast to the predominantly output oriented monitoring and data collection that had been expected in the past (see phase one report). HLCs used a number of techniques to overcome problems associated with demonstrating impact on health measures (e.g. because of short time-scales, a lack of baseline measures, or because work was undertaken in partnership). Latterly, site 3 had devised outcome measures to track groups of its service users over a one-year period. In another example, stakeholders in site 4 had developed "evidenced-based, best practice models of service delivery", which were suggested by the manager to enable HLC services to be benchmarked against other providers.

At partner level, reconciling funding streams with HLC work was a challenge for NHS (and CHP) partners because of the length of time required to determine outcomes. Several suggestions for overcoming these problems were mooted, including one partner in site 2 who had suggested undertaking:

> "… [a] cost benefit analysis of some of our other activities to say if we did this, how much would that cost in terms of hospital bed days if we didn't do it. So, what we might be able to do is translate hospital bed days into investment in the network to 'up' the capacity within the voluntary and community sector to take that, an anticipatory care approach which would reduce the number of bed days…" (Chair, site 2).

Meanwhile, stakeholders suggested that the approach taken by a network established by site 2 toward addressing financial inclusion permitted presentation of quantitative data on benefits take-up to funders. While the collection of 'hard' outcome data was supported by most stakeholders, there were some concerns that the ability to collect such data in one set of services might blur the attention given to 'softer indicators' or to less immediately quantifiable services.

What to measure in the future?

While the need to use outcome-related data with future funders was discussed, sites which had received multiple forms of funding highlighted the need to obtain information from partners regarding which measurement techniques and tools they might use in the future. This was a particular problem where funders had introduced different forms of measurement during the course of the original programme:

> "…I don't want to go into a second phase of funding with that problem. I want to have clear guidelines of what tools we're using, what we're measuring, how we're measuring them" (Manager, site 3).

In another example, a potential funder discussed the difficulty associated with demonstrating outcomes, in particular for young homeless people, but of the necessity that funded organisations attempt to do so:

> "You know, it's [difficult], and you know, a lot of young people like that drifting in and out of services and drifting in and out of different types of accommodation and staying here and staying there. So, it is difficult [to measure outcomes] but we need something to show that the money that's being used is, is being effectively used in the best way" (Member of the local Council, site 6).

In other instances, HLCs such as site 5 had devised a new business plan using outcome-focused logic models, while the manager of site 4 highlighted the strategic work that the HLC was undertaking in order better to position the HLC when seeking sustainability:

> "…I think if part of our long-term sustainability is that if we're very clear about what our outcomes are, how we can then measure them then when we go to other funders or other agencies or we're bidding for other work that we're quite clear on that (Manager, site 4).

3.5.6 Incorporating learning about what works in sustainability plans

When discussing sustainability several stakeholders drew attention to the way in which plans were being developed based on learning from previous work. Linked to the 'platform for innovation' function discussed above, this section draws attention to two features that relate to this role. These are: the learning from the HLC experience that has led to better informed understandings of target group(s) and their needs; and the recognition of a need to continue with a facilitation/coordination role to deliver services.

Learning about target groups and their needs

Sites 1, 5 and 6 highlighted proposals for refining their future focus on particular target groups based on the knowledge gained during their first five years of operation. For example, site 5 had begun by operating a broad array of services targeting a large number of groups throughout its community. Stakeholders discussed how sustainability proposals concentrated on vulnerable groups while also, as noted in section 3.3, seeking to avoid stigmatising potential users. As the manager outlined:

> "So the bid will be very [much] focusing down on these people because that is the needy people, that is the target group and the stuff that we are doing is complementary and additional to statutory services" (Manager, site 5).

Stakeholders in site 6 also discussed refining their focus to concentrate on the needs of young people experiencing, or at risk of, homelessness, as this was the group that the HLC had had most success in reaching. Having delivered services to a wider range of excluded young people in the past, the manager highlighted how links with partners enabled them to refer if necessary, leaving the HLC to focus more on its core group:

> "So I think there's something to be said for picking a group and working very well with that group rather than trying to cover lots of different groups and being seen to be doing lots of different things but not necessarily doing it well" (Manager, site 6).

In other examples (sites 3 and 4), stakeholders sought to retain a focus on the communities that their original programme had targeted, as it was suggested that the needs of these communities had not "gone away". Having become better acquainted with their target groups, staff in site 3 were critical of attempts to secure funding for a service that would narrow its focus and limit its reach across a deprived community:

> "I just think the service needs to be generic, needs to be entirely generic otherwise you've got stigma attached to it and you've got people thinking that you've got an aim for them, an overall aim that's your agenda rather than it just being at the health [level]…" (Project workers, site 3).

The "catalyst" and "WD40" roles of staff

In a broader example, findings illustrate the importance attached to the continued need to employ staff. While this may seem like an obvious point,

sustainability definitions highlight community capacity building as one method by which services might continue, which was supported by findings from phase one. However, the importance of having paid staff in post was highlighted in site 1 when the manager discussed how “the cracks are beginning to show” after a member of staff had left post and before a replacement could be appointed.

Similar to the role ascribed by the manager of site 5, who considered her position to operate as the “hub, or the catalyst or the glue, can I say WD40…”, strategic stakeholders in site 1, having initially considered that community capacity-building might aid sustainability, more latterly acknowledged the need to continue with “the catalyst” role offered by staff:

> “…you’ve got your facilitators […] you need somebody who can keep driving things forward and then you need to have that type of person in, in a community, in order to drive the health and well-being [agenda]” (Partner, site 1).

Such attention to staffing highlights the developmental role many had in working with communities. Emphasising the developmental function of HLCs and the necessity of employing staff on a long-term basis, the manager of site 4 stated:

> “…if we can claim any kind of success [it] is that it has been that five years of funding that has allowed a) to get the staff in who have come in for five years and, b) to actually allow us to develop programmes which didn’t have a, a, the challenge of looking over your shoulder each year…” (Manager, site 4).

3.5.7 Funding cutbacks: the HLCs return to the BLF

With each of the six HLCs seeking funding to continue their organisation and many of their services, partners were unable to meet the prospective shortfall after the termination of lottery funds. Over the course of fieldwork, it became evident that four of the six sites had few options but to return to the BLF to apply for new funding packages. Exceptions (discussed in section 3.5.8) included site 2, which sought to continue its network approach without seeking further funding for existing services, while site 6 had successfully applied to several funders (including the BLF). This section examines the remainder of the HLCs and stakeholder discussion surrounding BLF funding.

HLC eligibility for BLF ‘Investing in Communities’ funds

Fieldwork across the sample suggests that the understanding about eligibility to apply for particular BLF funds varied between HLCs and over time. In advance of the launch of the BLF ‘Investing in Communities’ package information given at the inaugural national HLC conference in October 2005 indicated that the fund would not provide continuation funding for HLCs. There was also some confusion regarding the opportunities for HLCs hosted by statutory sector partners to apply to this fund. Some uncertainty also existed over whether statutory sector match funding was required to support bids to the BLF. Clarification was provided in a series of emails sent out by the HLC

Support Programme in April 2006, although some stakeholders were still unclear about the ability of HLCs to apply for Investing in Communities funding.

For several of the sample HLCs, the position of the BLF was only made clear through personal contact, including discussion among site 5 stakeholders and BLF personnel at an HLC stakeholders event in July 2006. Toward the end of the evaluation fieldwork, sites 1, 3, 4 and 5 were all at various stages in compiling and submitting applications for BLF funding (see section 3.5.8).

The HLC 'fit' within BLF funding streams
Concerns raised by stakeholders in sites 4 and 5, but later dispelled by representatives of the HLC Support Programme, highlighted a perceived need among stakeholders to have a sizeable proportion of match funding in place from partners in order to bolster bids to the BLF, "because if we don't get much funding from them, that really affects the bid". Other concerns were raised in site 4, where discussing efforts to broaden service delivery to satisfy CHP priorities, the manager highlighted his desire not to appear to be developing a service that was a function of statutory services that might then be rejected by the BLF:

> "...[at] one level what we're doing is, we're turning round and sort of saying, you know, to the Big Lottery, we're delivering within the [HLC area and wider] … […] we're working across the area, but we also have the issue about, if we, if we turn round and try and make it too […] wide, the Big Lottery might see us as just a funding mechanism for the health board…" (Manager, site 4).

Local politics and funding structures were also being considered at site 3, where discussion with the BLF suggested that the HLC should consider submitting two separate applications for funding its services. With a focus being given to worklessness and employability by local CPP/CHP structures, the HLC was, in common with site 4, having to consider:

> "…the wording of this, it's going to be quite, not tricky, but it has to be, it has to be quite politically well done so that Big Lottery Fund accept, because they are not going to accept employability to fund" (Manager, site 3).

3.5.8 Impacts on HLCs' established practices when seeking sustainability
This section concludes the examination of efforts to attain sustainability by looking at how funding streams and wider health economy features might affect an HLC's ethos. Short vignettes encapsulate the ways in which sustainability was being discussed at each site at the conclusion of fieldwork.

Seeking to retain flexibility
Throughout phase two fieldwork, HLC stakeholders discussed the need to retain the flexibility that their initial BLF funding packages had offered them. Flexibility was an often-used term both in relation to developing appropriate services to tackle health inequalities (see section 3.1) and in involving the

community (see section 3.2). For many, it was the flexibility offered by BLF funding that allowed "a reasonably free rein to develop things" and which was considered at risk when mainstream funding was discussed:

> "…I would say that the flexibility we have to work with young people is our biggest strength. […] In that [BLF] don't actually set that kind of set targets or restrictions. I'm just aware that there's lots of other funders that are very narrow in what you can do and I think one of our, our big advantages is we can actually try things out and we can, as we have done, kind of learnt from what actually works with the young people rather than a funder kind of saying, this is what we think works, you go out and do it" (Manager, site 6).

Stakeholders in site 6 discussed how they actively sought multiple sources of funding to retain flexibility. For example, when applying to the local council HLC they attempted to retain a focus on health through seeking several external sources of funding. This multiplicity of funding was suggested to increase flexibility and help overcome any future political expediency if funding shortfalls came about in the future:

> "…you jump through hoops for any funder but I think the reality is that once you've got, like, a hundred percent statutory funding, I think you, kind of, lose your edge in the voluntary sector. […] I think it's nice to have a solid base but to be able to then add the value, to have the flexibility of other sources of funding coming in…" (Chair of the board, site 6).

Box 3.3 Sustainability considerations in site 6

Operating as part of a larger charitable organisation and characterised by attempts to retain flexibility, site 6 had been successful in obtaining several different funding packages, which allowed for both the continuation and expansion of its services. Of the six HLCs, site 6 was the only one to have obtained continuation funding at the conclusion of fieldwork, although this was in part because its original funding drawdown had begun earlier than at the other sites.

Following protracted discussion, the HLC had obtained money from the local authority (which had a remit to work to assist the same target group). Stakeholders were also successful in obtaining two separate BLF funding streams, one to permit a new partnership approach to be taken toward exercise (BLF Active Futures), and the second to permit the development of the HLC and to allow it to continue to target the health needs of young people (BLF Young People's Fund). Key to these efforts to attract funding were the HLC manager and Chair of the host organisation. Although originally employing a fundraiser, it was found that completion of relevant documentation required specialised knowledge held by these staff.

As a result of this funding success, stakeholders envisaged that services would expand to be available seven days a week. This funding package was suggested to increase flexibility of service delivery, with mainstream monies

only accounting for around one third of the overall funding allocation. A further capital grant from the Scottish Executive had enabled the redevelopment of the HLC, which increased the provision of basic amenities and allowed for the creation of a training café.

Ensuring acceptability of the HLC model to local communities

In site 3 concerns had been raised about potential changes to HLC services on the basis of having to apply for new funding streams. As a consequence, stakeholders had considered how such change might impact on the future appeal and acceptability of HLCs to local communities. For example, in site 3, the funding proposals mooted by the local CPP were rejected in an attempt to avoid limiting the generic appeal of a particular service. Relating the concerns of staff about how some types of funding might limit a service's reach, an officer stated:

> "…they were concerned that […] we were not reaching everybody that we should already, and [that] there's loads of development work that can be done with what we've got just now [and] that if it was a government scheme, then it could put up barriers for people who might see us as part of the system, if you like, rather than as a, an independent support agency" (Project officer, site 3).

Similarly, stakeholders in site 5 discussed how five years of BLF funding had led to the development of a profile within the local community whereby the HLC was "accepted and understood". At the same time, the perceived need to obtain some form of statutory funding was acknowledged, but stakeholders were wary of how such funding could also create "shackles" and stressed that it was important to retain independence:

> "…it's important in the fact that it's not a statutory service, that people feel that they can go to, that it's friendlier, that it's more approachable" (Partner, site 5).

Box 3.4 Sustainability considerations in site 3

While the HLC had operated as an independent organisation developing multiple services using its BLF and partners funding packages, the restricted funding environment had (as discussed in section 3.5.3) led to attention being given to consolidating services, in this instance under a 'worklessness' funding stream. However, this proposal was rejected as it was considered a limiting factor in the generic appeal and acceptability of the HLC to its local community. Such a proposal would also have split the HLCs' services, which stakeholders suggested might have brought about the end of the community-led organisation.

Having engaged in much discussion between board members and local funders, management in site 3 had approached the BLF (Investing in Communities) to enquire about further funding for the organisation. Discussion with the BLF indicated that the HLC would need to apply to two funding streams to provide for the different services that had been established. Work to develop such a bid was underway at the conclusion of

fieldwork. When working on the bid several features were taken into account in considering how the organisation might be structured in future. These included moves to reduce the size of the organisation, a redesign of the approaches taken by a community health team, an as-yet-to-be-determined move toward service level agreements by local funding partners, an option to bring services closer to the community through a move to new premises, and the development of proposals to implement a social enterprise to deliver services that could be provided on a commercial basis.

Box 3.5 Sustainability considerations in site 5

Seeking to retain its links to the NHS, but acknowledging that funding from local partners would be insufficient to sustain the HLC, the manager of site 5 had approached the BLF in mid-2006. After submitting a stage one bid to the BLF Investing in Communities Fund, the HLC was advised to apply through the Life Transitions stream. As fieldwork was coming to a close, the HLC was working with a consultant to put together the finishing stages to their BLF bid. Limited matching funding had been agreed, although some funds were secured through a continuation of health improvement funds that the HLC had already received. Although CHP stakeholders had discussed bridging monies while decisions were pending at the BLF, no guarantee of CHP matching funding had been made at the close of fieldwork.

While several stakeholders were critical of the CHP and its protracted decision-making process, the support and credibility offered by the NHS were considered important when proceeding with the bid. Awaiting the sign-off of the BLF bid from the local health board and lead partner, the manager highlighted how the new funding bid sought to build on the acceptability of the HLC within the local community, enabling a greater focus to be applied to the most vulnerable groups. Considering a wider role for the manager, the bid sought to establish an enhanced strategic role to allow closer work with statutory agencies to explore future sustainability, including service level agreements and the examination of models of social enterprise.

Having to consider enlarging the size of areas covered

While several sites were faced with changes to the size of their target communities, stakeholders in site 4 were particularly concerned about how working across a wider area might impact on the ethos and appeal of their HLC. For example, the suggestion that the HLC might deliver services across the larger CHP area was viewed negatively in terms of how local people perceived and engaged with the project, such that a move away from strictly local provision:

> "…would be a bit damaging… [as]… that's where you get the added value, that's where you get the trust and the credibility and the local relationships" (Partner, site 4).

In addition, the manager of site 4 was concerned about how the HLC might be perceived by neighbouring communities, if the organisation were seen to be "parachuting in" and appropriating funding that could have been used by existing local community groups. When considering delivery across a wider

area, further changes to the developmental ('platform for innovation') role for HLCs were mooted if partners were to stipulate commissioning for work using service level agreements:

Box 3.6 Sustainability considerations in site 4

Seeking to continue its role as an independent community-led organisation, but also attempting to broaden service delivery to work within wider boundaries, the HLC had extended the provision of services to neighbouring communities using existing funding "as a loss leader". These services enabled the HLC to accommodate to CHP priorities (e.g. preventive work) and its boundaries, and were undertaken to enable site 4 to seek to attract some form of match funding from local CPP and CHP partnerships. Caution was being exercised in attempting to limit the spread of services in order that a focus on the original target community be broadly retained. While no final decision had been reached, it was suggested that the local CPP would provide some limited funding for at least one year, while a decision about the provision of CHP monies was still to be reached. Consideration had also to take into account neighbouring community health initiatives that were seeking new funding in a restricted funding environment.

Upon conclusion of fieldwork the HLC had employed a consultant (through BLF Investing in Ideas funding) and was in the process of compiling a bid to the BLF (Investing in Communities funding), which sought to enable the continued provision of services and the ability to respond to new needs. Further discussion was still underway in relation to whether and how any newly funded model might operate within the expanded CPP and CHP boundaries and the extent to which the new BLF bid should reflect this.

Change across multiple levels

In site 1, HLC stakeholders were contemplating wider change to their model. Change was being influenced by expanded partner operational boundaries, having to consider a joint BLF bid with two other HLCs linked via the local authority, and the threat of one project attempting to secure separate funding. For the project manager, such changes brought about a "fear… of dilution" of future services. In this example, highlighting the differing views on what might constitute sustainability, a partner in site 1 commented:

> "…I mean, when I originally thought about sustainability, I thought, oh, ok, right, [the HLC] is going to finish, let's see which parts of the project we need to maintain and, and, how we can then find funding to maintain them. That's really how I saw [the HLC] being sustained as opposed to let's just find more money to keep the whole thing going" (Partner, site 1).

Seeking to develop a bid for future funding, the manager of site 1 had sought agreement from NHS partners that the five projects which comprised the HLC would work together towards attaining sustainability. Highlighting the flexibility of the model, the manager illustrated that:

> "… we think there's a lot of cross-fertilisation going on that might be lost if we were to set up as small little groups" (Manager, site 1).

Box 3.7 Sustainability considerations in site 1

Having rejected attempts to fund some of the HLC services separately, the manager had recently been prompted to work with two other local HLCs to be able to bid for a set amount of local authority funding. This was intended to secure a base from which the HLC might attract other funding and which would enable the retention of the additional benefits and "unseen support" gained from being located within the local authority.

In addition, changes to the operational management boundaries of the local authority meant that the HLC was considering developing a service that would work across a much enlarged geographical area. At the close of fieldwork the intention of the HLC was to seek funding to allow existing work to continue, with the aim that best practice might continue to be transferred across locations. To assist, a consultant was working with the manager to determine the future operational boundaries of the HLC. A bid to the BLF (Investing in Communities) fund was likely to follow, although it was suggested that further work was necessary to ascertain the needs of the wider communities that might now be targeted and the level of resources required to meet those needs. Further work was also required to develop clarity regarding the fit of the HLC within the wider NHS boundaries and of the relationship with the two other local HLCs which had been part of the bid for local authority funding.

Moving away from a 'health' focus

Having invested much effort in aligning and seeking funding for administrative support from the local CHP, stakeholders in site 2 subsequently discovered that no funding was available. However, the CHP did seek to continue its partnership with the HLC at CHP committee level, which was suggested to allow HLC stakeholders to continue to have an influence at policy level. Instead, the location of the HLC within the local authority allowed for a new funding stream to be drawn upon to enable continuation of managerial and administrative support to the organisation. This funding stream was linked to the financial inclusion agenda, leading the line manager to query:

> "…what the local priority around health inequalities actually is if this is to remain supported because, to me, I don't see other initiatives and whatever's happening locally that has an inroad into the communities of need" (Line manager, site 2).

Later, the manager commented on how the change in funding criteria was likely to lead to the focus of the HLC shifting:

> "…away from health and health inequalities, it's becoming more narrow. It maybe is more going to a remit of the social inclusion agenda" (Line manager, site 2).

Box 3.8 Sustainability in site 2

The network model developed by site 2 was a contrast to the organisational status of the remaining HLCs, which meant that sustainability had to take account of several different features. Having provided funding to seven local projects and having distributed funding to a large number of smaller organisations and projects, the HLC stakeholders sought to sustain both projects and the network model. A consultant was employed to ascertain the sustainability needs of the projects and several positions were discussed. These included: social enterprise, mainstream funding provision, revenue generation and lottery funding. Discussion was still underway at the close of fieldwork regarding these positions and about any future funding that might be distributed by the HLC to support smaller organisations.

Having successfully secured funding from the BLF Active Futures fund, the HLC had already developed an exercise-themed network. Centrally, having been informed that no CHP funds were to be made available, funding for the administrative and managerial posts to the HLC network was secured through the Working for Families initiative. It was suggested that this linked well with work on financial inclusion that was already undertaken by the HLC but limited its focus on health. Work was due to be undertaken to redesign the HLC, devising new networks, taking account of these changed funding arrangements.

4. Implications and conclusions

4.1 Introduction

The aims of this phase of the evaluation were to examine the evolving contribution of the HLC programme to addressing social injustice and inequality in disadvantaged communities, and to investigate the strategies adopted by HLCs and their partnerships to ensure sustainability in the longer term. Connected to these aims, the evaluation sought to examine the development of HLC approaches to community involvement, the attention given to meeting local needs and national priorities, and the ways in which HLCs adapted to changes underway within the wider health economy. This section of the report begins by discussing the findings from phase two (making links, where appropriate, with material from phase one) and highlighting a number of specific implications to have arisen. This is followed by a final concluding section which draws together findings from the present evaluation with those of the UK-wide Bridge Consortium evaluation of HLCs, along with findings examining community health initiatives more widely and presented in the report delivered recently by the Community-led Supporting and Developing Healthy Communities Task Group.

4.2 Drawing together the findings

The discussion and implications that arise from findings related to phase two are presented within a single section and introduced using separate headings. This is intended to convey the interconnected links between the findings and the overlapping content of the research objectives, while retaining a focus on their relevance as a series of individual points. This format was chosen as it allows for the implications to be considered that both relate to and reach beyond the HLC programme to include other existing and future complex community initiatives.

4.2.1 The importance of time and the need to become familiarised with local communities

Linked to earlier findings (see phase one report, page 15), which highlighted the time necessary to implement an HLC, findings from phase two illustrate the time-intensive effort required to develop HLC methods of working and to engage and support disadvantaged groups. Neither 'knowing' about a community nor 'being known' by a community develops overnight, hence there is a need to allow for an adequate time-span to embed initiatives such as HLCs within communities.

- Throughout both phases of the evaluation, the emphasis placed on the time taken to become established and trusted by local communities has highlighted the difficulties faced by short-term funded initiatives, particularly when success might be followed by the termination of funding. The negative impact of short-term funding for such organisations is a well-known but neglected issue and remains a barrier to full realisation of the potential of community health initiatives. It is worth reiterating a point highlighted in the phase one report (page 62), that more consideration should be given by funding bodies to providing continuation funding for successful projects where need remains unmet.

Engaging local participation and building relationships and trust within disadvantaged communities was a challenge experienced by all sites, which (typically) could only be addressed through long-term work in target areas.

- HLCs have spent several years engaging local people through promoting various forms of user involvement employing flexible models of participation. Such hard-won connections can be easily lost if an HLC is discontinued. The time invested by HLCs in local capacity building and the length of time taken to gain trust and 'win over' local people should be recognised and built upon.

- Attention should be given to the appropriateness of user-involvement models employed by HLCs, with scope to change those that do not work. In some instances user involvement might be more productively sought through user groups rather than management boards, while skills- and capacity-building is vital for all models.

Becoming familiar with the needs of local communities involved the devotion of considerable effort to 'informal' support to local people. Face-to-face contacts were vitally important and culturally appropriate in most HLC groupings, where high value was often placed on personal contacts. This was particularly evident where past initiatives had been curtailed. As a consequence, attention given to building health capital often involved considerable time and effort spent building social capital (i.e. social networks and shared norms and values).

- The 'informal' and developmental methods of work used by many HLC staff should be given greater recognition on the grounds that they promote rapport-building and opportunities for improving understanding of local communities.

- Funding that concentrates primarily on service delivery does not always permit such developmental time. The provision of core funding would allow for such developmental work to take place over the longer term.

The length of time that has been spent becoming familiarised with communities and the relationships that many HLCs have established should be viewed as an aid to local planning for future service delivery.

- Locally responsive organisations such as HLCs are well placed to 'be there' and to identify the 'right time' for an initiative to be developed within a particular community. For example, growing projects were devised when circumstances, interested people (and businesses), appropriate wider supports and community volunteer energy were in place. In addition, such structures permit attention to be given to 'fashionable trends' (e.g. the increased national focus on healthy eating and locally produced/sourced food) while also being able to respond to national policies (e.g. providing a greater focus on preventive health care). Greater recognition should be given to such responsiveness, particularly when planning local service delivery across organisations.

- As a corollary to the above, HLCs are also well placed to ascertain when initiatives might not work or might be failing within a community. Having in place sufficient resources to maintain oversight and make necessary changes to services is vital, as is having the ability to curtail activities when required.

4.2.2 Working with the shifting realities of inequality

Across the sample of HLCs there were several different definitions and understandings of health inequalities. While this was evident from the outset of our evaluation (see phase one report, page 39), over time it was increasingly observed as a feature within HLCs. However, through their inception and establishment in deprived areas, HLCs were mainly working in a manner which was restricted to addressing health and social disadvantage among particular target groups. Working to address disadvantage, it is appropriate that a variety of approaches, often labelled as ‘holistic’, were used.

- If similar community-based initiatives are to be assessed by funders and evaluators, then attention should be given to the variety of ways in which impacts on disadvantage might be shown. As discussed in the phase one report (page 60), theory-based evaluations may help in understanding what effects projects have had. Drawing on the HLCs’ experience, this might include: demonstrating changes in attitude or behaviour; changes to structural factors (e.g. changes in food provisioning or social circumstances); or through reference to ‘holistic’ elements (e.g. well-being, confidence). The impacts on disadvantage of such varied work and service delivery formats should be given greater consideration when considering outcome evaluation.

Great value was attached to tried and tested methods of delivery, while it also was commonly recognised that continual innovation was necessary to meet new and existing needs, to maintain interest and involve new people, and to develop informal ways of working and interactions with target users. Decisions made by HLC stakeholders highlighted the continual attention (including when considering sustainability) given to whether successful ways of working will suit new clients within existing target groups or whether working to address inequalities entails changing practice as new groups are identified or emerge.

- There may only be a limited amount of activities/services that can be defined in advance following assessment of local needs, especially if the HLC is a completely new venture. Theory-based approaches could be used to make links between ‘new’ activities and health outcomes.

- Adaptation and flexibility are key attributes of HLCs, which facilitate a wide variety of work with multiple target groups. These should be recognised when work is devised to meet local health outcomes.

- In some instances, targeting whole communities (or area populations) may be the only way to ensure that those most in need also become involved/take up services and do not feel stigmatised.

- Community involvement should be recognised as an evolving and continual challenge requiring adaptive responses towards a range of groups.

- Enabling an organisation to accommodate to changes in the community requires substantial and broad-based managerial support within the project. This can only happen if sufficient skills are in place, if partners are focused, if partnerships can be expanded, or if budgets can be adapted to buy in skills. Host organisations and lead partners need to recognise that such adaptation may be necessary to meet changing community needs.

Across the HLCs there are multiple examples which illustrate how years of operational experience enhanced staff efforts to obtain knowledge of target groups and communities and to understand and respond to their changing needs. Accommodating to such change, HLCs placed emphasis on the need to embed over the longer term both services and the members of staff who were delivering them, in order to promote interest and increase uptake.

- It is vital that attention is given to levels of staffing, skills and training of staff, the time that is needed to become familiarised with communities, and of the recognition that needs might be met through a variety of configurations of staff, including both dedicated project workers and sessional staff.

- While the use of volunteers is crucial, continuing to employ paid staff is vital in order to ensure provision of a high quality service and the longer-term availability of professional support.

4.2.3 Spaces, places and cultural acceptability

Places are imbued with meaning. Previously (phase one report, page 21) we examined distinctions in HLCs' use of space. During phase two our evaluation has shown how the changing use of spaces and places by HLCs both reflected the changing identification of needs/better ways of working, and responded to the challenge of removing as many barriers as possible (e.g. stigma) when working with disadvantaged groups. In some instances the services devised and supported by HLCs are inherently non-stigmatising (e.g. community gardens), especially when used to target change in individual lifestyles. In other instances, the value of services with spin-off impact on mental health and well-being (e.g. activities promoting exercise and those offering social opportunities) was paramount. Such services were often both non-stigmatising and culturally appropriate (e.g. walking groups established in urban areas).

- The changing use of spaces was important when HLCs sought to maximise the voluntary uptake of services. It is perhaps easier for

community initiatives such as HLCs (than for statutory agencies and initiatives) to adapt spaces and places so that they are responsive to the social, cultural or localised needs of their target groups. HLCs use of a wide variety of spaces and their appeal to local people should be considered when planning future services.

4.2.4 Remaining 'local' while attending to national demands

The findings highlight some of the contradictions that exist when attempting to reconcile a community-driven focus with attention to the strategic drivers of larger organisations at local levels (e.g. CHPs and CPPs) and national priorities arising from government policy. HLCs had to accommodate to shifting positions at each of these levels, seeking to retain community inputs and the relevance of activities to a variety of groups and to ensure the support of larger partners. Commitment to local need and to continuing work to address such need had to be balanced with attention given to wider local and national circumstances. The findings illustrate an uncertainty that exists within HLCs regarding how to respond to such demands. This highlights the limited amount of central strategic guidance on offer, despite the support structures that were put in place.

- The ability of HLCs to reflect local needs and national priorities, along with changes to the wider health economy, required robust engagement with local health economy partners. The provision of sufficient strategic support and guidance is vital to ensure that those involved in the planning and delivery of services in an area are aware of opportunities and responsibilities, particularly during periods of change. Greater attention should be given to the local and national levels at which strategic support might prove useful.

4.2.5 Partnership working is often defined in practice

HLCs have had to accommodate to multiple changes in partners and partner organisations both when delivering services and when considering strategy, particularly in relation to sustainability. Some sites have had more success in engaging partners because of favourable strategic resource allocation, shared boundaries and 'fit' with the strategic interest of partners. Partners that are required for winning bids for funding may have little to offer in terms of practical service delivery, whereas other partners' influence and inputs may become more important over time. There was an increased recognition that HLCs, once embedded in the locality and delivering work for shared target groups, were beneficial partners within local health economies.

- Some of the most productive relationships emerged from the informal ways in which HLCs developed partnership working with a variety of agencies. Partnership working was often defined in practice. Building on and refining an earlier recommendation (phase one report, page 31), future initiatives would benefit from using some form of partnership agreement to provide guidance and to outline agreed responsibilities, particularly during the implementation phase. However, sufficient scope should also be given to exploring emergent opportunities for partnership working with existing and new partners.

- The operational and strategic relationships with partners underwent significant change during the time of the HLC programme. Greater recognition needs to be given to the external changes (e.g. in personnel and boundaries) faced by community-based organisations such as HLCs as partners' working remits evolve.

- A breadth of partners, along with attention given to retaining interest and focus among partners over time, encourages a wider worldview when developing strategy and seeking forms of sustainability.

4.2.6 The importance of the manager

The role of HLC manager was central to each site's development. The HLC manager was typically responsible for guiding service development, positioning in terms of community involvement and user participation, developing links with partners and for leading strategic consideration of sustainability. However, the managerial role and its functions differed between sites as did the level of managerial resources available for operational oversight and strategic command.

- Greater attention should be given to delineating the role(s) of the project managers, who often are required to perform operational, strategic, fundraising, monitoring and evaluation tasks. There is a need to ensure that appropriate time, resource commitment and training are available to enhance the capacity to perform these roles.

- It may be necessary to re-appraise the roles performed by managers of initiatives such as HLCs following the implementation phase and a period of development. Managerial roles in practice may differ from those that were originally envisaged.

- The strategic role in guiding the future of the HLC was not always fully considered when developing managerial positions. Future initiatives should consider the opportunities available to enable managers to develop strategic plans to facilitate the 'fit' of their organisation to its local environment.

4.2.7 Building a profile

Attention given to profile raising (a feature discussed during both phases of the evaluation) differed between HLCs, although all acknowledged its importance. For some sites, the main aim in establishing an identity was to appeal to local people, in other sites profile raising was intended to promote effective partnership working, whereas for yet others it became salient when considering sustainability. In all cases it was found that such activity takes time and often money to develop, with staff members in some sites having greater skills and experience relevant to performing such tasks than staff in other sites.

- Similar initiatives should investigate carefully the objectives they hope to achieve through profile-raising activities, and where best to direct their efforts (e.g. towards local communities, partners or both).

- Profile raising was often discussed in relation to sustainability. In conjunction with investigating sustainability objectives, attention to profile raising should be undertaken at an early stage during the development of organisations such as HLCs.

4.2.8 Allowing time to learn the sustainability ropes

The evaluation highlighted the problems associated with addressing sustainability when confronted with continual changes within operating environments. During key transitional periods, the strategic view of key HLC partners (sometimes those now working as part of a CHP or CPP) was necessarily directed at structures wider than HLCs. However, this lack of focus, together with the HLCs' need to adapt to changes in personnel and structural composition of strategic partners, resulted in the sites being less able to retain the inputs and focus of champions that had been nurtured over time.

- Although the full ramifications of changes to partners' organisations/structures cannot be known in advance, the end date of funding for time limited initiatives such as HLCs is known. Larger organisations and statutory agencies should give more attention at earlier points in time to the strategic future of initiatives such as the HLC programme.

- At the same time, it is important to recognise that HLCs have engaged in efforts to influence their partners and to promote change within their local health economies. Such efforts were often determined locally. Acknowledgement should be given to the strategic capability of HLC stakeholders (usually managers) and their willingness to work with existing structures and partners to find common solutions.

The funding environment did not appear to favour the award of core costs to HLCs. This marked a change from earlier fieldwork, where discussion about sustainability examined the potential provision of mainstream funding (phase one report, pages 43-44). While such options were still being considered during the second phase of evaluation, there was much uncertainty regarding eventual availability of sufficient funds. Although some external support was given, the changes underway to wider structures and the variety of HLC models seemed to mitigate against the provision of general guidance about forms of sustainability.

- The demands of ensuring that sustainability actions keep pace with wider system changes implies that more resources be devoted to providing support to organisations such as HLCs. Such support would take account of fund-raising, evaluation and strategic planning. Government and funding bodies should send out clearer and more

coherent messages about measuring the impact of complex initiatives and future options for funding.

With the attention of funders moving toward a focus on work to address health outcomes and with community planning partnerships assumed to be taking a lead on promoting community engagement, partnership working and connecting local and national priorities, it is worth considering the investment that has been put into programmes such as the HLCs. The groundwork involved in implementing, developing and adapting services and activities to respond to changing local needs and national priorities is substantial and has been undertaken in sites across Scotland. Much learning at local levels has occurred, leading to several diverse models of engagement with local communities in order to address their needs. Sustainability of such initiatives should take into account the relationships, acceptability and work practices within local communities that have been developed over time by HLCs.

- Efforts to sustain initiatives such as the HLC programme should take into account the intrinsic values that have been developed over time and which have led to achievements in working with disadvantaged communities. The potential negative impact of radical change or the curtailment of some models on local communities should be assessed.
- The HLC programme was established to demonstrate not only what works (and to build upon this), but also to test out different ways to respond to changing health and well-being needs within target communities. The continuation of such flexibility was what many HLC organisations sought when sustainability was discussed. The benefits of flexibility, linked to a focus on the achievement of intended outcomes, should be recognised when community-based initiatives are considering sustainability.

4.3 Conclusions

The discussion above, which focuses on implications from the second phase of the evaluation, highlights the learning and changes made by case study sites between phases of fieldwork and the adaptive manner in which many of the HLCs sought to address their primary aims and objectives. This draws attention to the different ways in which HLC impacts should be considered and of the challenges experienced when working in a dynamic service delivery environment. While there was no ‘one-size-fits-all model’ for an HLC, each site was faced with similar challenges during their evolution, having to accommodate to changing needs, partners and wider health economy systems. The efforts of managers, staff and partners to shift focus as new local needs and political priorities emerge is a key strength of the programme, enabling HLC stakeholders to adopt positions which should aid sustainability.

Many of the findings reported here are consistent with those contained in the Bridge Consortium Final Report[13], which describes a series of linked evaluations of the HLC programme at a UK-wide level. More broadly, the

[13] The Bridge Consortium (2007) *The Evaluation of the Big Lottery Fund Healthy Living Centres Programme: Final Report*.

findings resonate with recommendations made in the report of the Community-led Supporting and Developing Healthy Communities Task Group (CLTG)[14]. Delivered in late 2006, this report addresses the community-led 'pillar' of the policy document 'Improving Health: The Challenge' and health inequalities in the policy document 'Closing the Opportunity Gap'. There are clear links between the recommendations contained in the CLTG report and the findings of the present evaluation. For example, three recommendations based on findings contained in the CLTG report are as follows:

- Identify and set out more clearly the links between objectives, inputs, outputs and outcomes, defining success in ways that reflect a broad view of health and its determinants. (Recommendation 2)
- Make health improvement planning more effective in engaging communities at all levels and more flexible in allowing them to identify their own priorities. (Recommendation 4)
- Build on the lessons from existing practice to provide improved infrastructural support and put in place appropriate strategic and operational frameworks for the long-term sustainability of community-led health improvement activity. (Recommendation 11)

As suggested in section 4.2, the findings of the second phase of the HLC evaluation reiterate the wider messages resonating from examinations of community-based health improvement activity in general and highlight the specific issues faced and processes undertaken by a particular national programme.

In drawing further links across the communities agenda, the findings of phase two of the HLC evaluation highlight the effort required to involve and sustain the involvement of local communities, and of the continuing attempts and successes of HLCs in so doing. This is particularly striking when considering that wider community engagement structures, such as community planning partnerships, were recently advised to ensure that more emphasis be given to sustaining and systematising community engagement structures[15].

In making links with these findings, learning from the HLC programme suggests that more attention be given to longer-term consideration of community needs and to ensuring that there is provision and sufficient capacity to meet these needs, particularly as changes occur over time. Learning from the HLC programme offers a valuable repository of information on engaging with and involving disadvantaged communities in action to improve health.

[14] Community-led Supporting and Developing Healthy Communities Task Group (2006) *Healthy Communities: A Shared Challenge*. Edinburgh: NHS Health Scotland. Available on: http://www.healthscotland.com/uploads/documents/2746-HealthyCommunities%20TaskGroup.pdf

[15] Audit Scotland (2006) *Community Planning: An Initial Review. Edinburgh: Scottish Executive*. Available on: http://www.audit-scotland.gov.uk/publications/pdf/2006/06pf03ag.pdf

Appendix 1 Anonymised description of the six sites

Site 1

This HLC was established as a new venture, led by a local authority, to deliver activities and services through five inter-linked projects, based in different locations, across a large geographical area in the north of Scotland. A central, strategic partnership was devised to oversee the work of the five projects, which each devised local partnerships (comprising statutory, community, voluntary and private organisations) to co-ordinate and deliver work within each area and for particular communities. A management group consisting of central and local project co-ordinators, line managers and key partner representatives was established to oversee the development of the daily operations of each project. The HLC operates in both urban and sparsely populated rural locations, and transport to counter isolation is a key feature across all of the sites. Target groups include dependent mothers, young children, elderly people, school children, people with mental health problems and middle aged people. Service delivery has developed to be delivered from a series of community venues and locations using partner inputs and sessional staff under the guidance of project co-ordinators. Services are predominantly oriented towards exercise and include led-walks, cycling and exercise classes. Other services focus on healthy eating, food growing and a series of parenting classes and courses. One project delivers most of its services from a central location and provides assistance with transport to attract target groups. Although each project has a different target group, team working has been established to disseminate best practice so that transference of activities across locations can take place. A local consultant has been employed to assist the development process. The HLC employs four locally-based project co-ordinators, several part-time project workers and administrative staff. The lead partner has provided managerial support and assisted with sourcing additional funding for posts across the HLC.

Site 2

This HLC was established to develop a network of existing organisations. It is situated in the most polarised local authority in Britain with 33% of the population living in poverty and 5% in the top economic stratum. Its overarching aim was to enhance partnership working at a practitioner level in order to ensure that clients were referred to all agencies which were able to provide support and advice. This was achieved by working through three themed action groups: cash in your pockets (which included a benefits and energy efficiency awareness campaign, extension of the neighbourhood money advice services, development of a food co-op, introduction of low income savings scheme and an expansion of the credit union); parenting skills (which included child development, promoting positive child behaviours and the development of a volunteer mentoring scheme); and life-skills (which supported the development of personal competencies and core life-skills through a range of differing approaches, including a community arts scheme and a peer led training and development initiative).

The HLC aimed to be a low bureaucracy organisation. This was achieved by capitalising on the existing voluntary and community-based agencies in the area. Eight new posts were funded in the voluntary sector, including credit union workers, benefits advisers, travellers outreach worker and ethnic minority worker. In addition seed corn grants (less than £1000) were distributed through the themed action groups to small community-based ventures. The grants funded a wide range of work from parents pampering days to new musical instruments for a group of mental health service users.

The HLC expected to see tangible benefits from its work, including 50% of project participants reporting increased feelings of well being, a 10% reduction of prescription for mental health problems amongst the target population, 70 families reporting that they have been supported by the project and 80 participants moving from unemployment to training or employment.

Site 3

This HLC was established as a new organisation. Operating as a company limited by guarantee with charitable status, it is led by a group of elected, local community members. The HLC had primarily developed two sets of services, addressing stress management and community health, but also acted as an umbrella or host organisation for a number of inter-linked services and activities (e.g. targeting youths and food/diet). Services were delivered across a widespread urban and rural location covering two towns and their outlying rural housing areas. The targeted locality originally comprised an archipelago of sixteen Social Inclusion Partnership (SIP) areas, although the focus often included wider communities. A large number of partner organisations work with the HLC to deliver services, while core funding partners provided advisory support to the management committee. Additional funding from key partner organisations had facilitated the addition of a number of new services and employment of new staff to run in conjunction with the original BLF-funded remit. The HLC operates from one set of premises in which all staff are based, delivering several services from this base. However, due to the large geographical coverage required, the majority of services are delivered in community-accessible locations throughout the area. A large number of full and part-time staff work for the HLC, including a project manager, project officers, finance officer, community health officer, project workers, lay health workers and administrative support staff.

Site 4

This HLC was established as a new organisation which operated as a company limited by guarantee with charitable status. It was led by a management board comprising of local community members, which was assisted by professional partners who acted as advisers. It operated in a small but densely populated urban area which was characterised by entrenched poverty and poor quality social housing. Much of the area was due for demolition which limited the availability of locations from which the HLC could operate. In order to overcome the lack of community venues, the HLC undertook extensive local partnership working and was able to add a

new health dimension and address some of the training needs of existing community-based projects. The overarching aim of the HLC was to promote health and tackle health inequalities in the area through three work streams: lifestyle and culture (which included the development of health fairs, cooking classes, encouraging local cafes to offer healthy options and offering taster sessions of healthy food in local supermarkets); sport and exercise (which included the development of safe walking routes through the area, developing a cycling club (including free cycling lessons and free cycle hire), badminton sessions, line dancing and sports coaching); and a mental health workstream (which included mental health first aid training and counselling sessions).

Site 5

The HLC is based on a Scottish island and comes under the auspices of the local NHS board which has responsibility for the area. A management group consisting of key partner organisations, including the NHS, oversee the operational and strategic development of the project while wider partnership meetings were devised to promote new working arrangements and to obtain wider inputs to strategy development. The HLC was built upon the foundations of an earlier, smaller project targeting health improvement within the local community. The HLC operates from a central location (within the main town on the island) to provide a user-accessible resource and information point from which several services and activities (e.g. counselling, alternative therapies) are delivered. Further activities, such as exercise courses, are delivered in a number of outreach locations. There are a large number of partners involved, including statutory and voluntary organisations based both on the island and on the mainland. The HLC, with partner involvement, operates a large number of inter-related programmes which seek to enable the community to achieve long-term health gains in CHD, stroke, cancer, mental health and a reduction in health inequalities. As the availability of premises on the island is limited, the centre base facilities are used by partners to deliver services and to host meetings. Following changes to staffing the HLC employs a project manager and a number of sessional staff who deliver projects independently and in conjunction with partner organisations.

Site 6

This HLC is based in a large Scottish city and is led and managed by a voluntary organisation which delivers a series of linked services to the target group. The HLC operates from a centrally located, user-accessible base from which many of its activities and services are delivered. The single-focus target group is comprised of socially excluded young people (16-25yrs) who live in a number of locations throughout the city. Around six partner organisations were involved in providing a strategic overview, while services were developed in partnership with these and multiple other local groups/organisations. The project sought to improve the sexual, mental and general health of its target users by attempting to overcome the barriers to mainstream service access that they experienced. The centre base serves as an information point and location where users are able to casually drop in to

activities, where specific services are advertised and run (e.g. parenting courses, healthy eating activities), where partner organisations work on joint projects or deliver satellite versions of their own services, and where one-off health promoting events can be staged. Services are also delivered on an outreach basis, either independently or in joint working arrangements with partners. Three staff, including a project manager and two project workers delivered services. Several sessional staff have also been employed in order to free up the time of project workers, thus allowing more developmental work to be undertaken.

Appendix 2 Phase two research proposal

Evaluating the Healthy Living Centre programme in Scotland: contribution to the Scottish Executive health policy agenda and routes to sustainability

Applicants
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Introduction

The process evaluation of the Healthy Living Centre (HLC) programme in Scotland[1], funded by the Scottish Executive, has been underway since June 2002 and two rounds of fieldwork visits have been conducted, as planned. Analysis of fieldwork data is in progress and interim findings[2] have been disseminated. A report will be submitted in April 2005. Although the current phase of data collection is complete and according to schedule after the first two years of operational activity, this timeframe has provided limited scope to examine longer-term development, responses to the changing policy environment and issues of sustainability and continuation in the six participating HLCs (which will continue to receive funding for varying periods up to 2007). Opportunities for dissemination of findings are also extremely limited.

An extension of the study for a further two years (to mid-2007) would permit an in-depth assessment of the potential and achievements of HLCs with respect to supporting the Executive's drive to tackle social injustice and inequality[3]. More specifically, this work would focus on: actions to foster community learning and development skills to enhance social capital in disadvantaged communities[4]; progress of actions to improve health and reduce health inequalities, through addressing priorities such as mental health and well-being (at community, as well as individual, level)[5], diet and physical activity[6]; involvement and integration in community planning structures and community health partnerships (CHPs), and quality of linkages to statutory health improvement functions (health boards and local authorities); and strategic and operational activities among stakeholders to sustain their HLC beyond time-limited lottery funding[7,8] in light of early considerations to mainstream[9] activities and projects. An extension would also permit a sustained effort to promote learning from the original study among relevant audiences at national and local levels.

Preliminary findings from ongoing research

On the basis of data already collected, it is apparent that HLCs, in conjunction with the communities in which they operate, have devised a number of

innovative services to improve health, including physical, social and mental well-being, and reduce health inequalities. Service delivery mechanisms and techniques, such as 'drop-in' and the multiple uses of food within a number of HLC settings, have been widely examined[10-15]. While HLC staff were keen to discuss success stories of individual users in improving health and reducing inequalities, they were more hesitant when looking at wider target groups, noting the longer time-scales involved in assessing the outcomes of their work to address health inequalities. HLC staff raised concerns over their ability to reach the most deprived groups, and services and methods of targeting inequalities were continuing to evolve, in order to overcome barriers, at the end of the evaluation.

During the current evaluation, the pace of establishing community learning and development structures has been mixed across the sample. Many HLCs discussed the need to avoid tokenism in creating opportunities and roles for community members within each site. The need to be seen to establish and deliver activities and services was felt to be a priority; building community learning and development capacity was viewed as a longer-term objective (related to objectives to reduce health inequalities).

Several stakeholders discussed the need to deliver on outcomes agreed with the Big Lottery Fund (BLF), while also addressing local and national health priorities that had emerged after funding had been secured. Findings suggest that HLCs were seeking to balance health planning for the future with encouragement of local community participation. The position taken by the HLCs appeared to be related to different structural arrangements (e.g. links to statutory or voluntary organisations) and likely options for future funding. Several HLCs were becoming increasingly involved with a number of local planning structures, to develop future joint visions for health improvement at the community level. As well as addressing health needs, this strategic and often time-consuming work was considered to play a vital role for many sites seeking sustainability beyond BLF funding. Attempts to re-invigorate central partnerships were underway and intended to broaden strategic thinking for a sustainable future.

Aims and objectives

The proposed study will have two major aims:

1. to understand the evolving contribution of the Scottish HLC programme to tackling social injustice and inequality, especially through health improvement in disadvantaged communities
2. to identify and investigate the strategies adopted by HLC partnerships and lead organisations to ensure sustainability in the longer term (i.e. beyond initial five-year, BLF funding package)

The objectives of the study are:

- to elicit stakeholder understandings of how HLCs have adapted their approach over time to address issues of social injustice and inequality,

and to examine what future contributions HLCs will make to this agenda
- to describe evolving community development structures in HLCs and their impact on addressing inequalities
- to examine how HLCs meet local health needs while working to address national health priorities (e.g. mental well-being, diet and physical activity)
- to explore the involvement of HLCs in wider health economy structures (e.g. community planning, CHPs)
- to examine HLCs' attempts to ensure project sustainability, through taking account of community influences, type of HLC (e.g. voluntary, statutory or community-led), partnership construction and wider inputs at local and national levels
- to disseminate findings (from both original study and extension) to the Scottish Executive Health Department, practitioners working in area-based health interventions for health improvement, and the BLF.

Research questions

- How and why have HLC approaches to addressing social injustice and inequality evolved over the lifespan of the initiative? What methods in which contexts have been found to be most successful?
- How have the inputs and roles of the local community in each HLC changed over time?
- How have community learning and development structures evolved?
- What are the influences that impact on HLCs when developing new programmes of work: (a) within the HLC itself, (b) within partnership structures and (c) within the local health economy?
- How have recently implemented government policies impacted upon HLCs' operational and strategic development?
- What are the influences that impact on HLCs when seeking longer-term sustainability: (a) within the HLC itself, (b) within wider partnership structures and (c) within the local health economy?
- To what extent do HLCs adopt a health planning structure versus a community participation approach with regard to sustainability and future funding? How does the approach to sustainability affect future partnership working and community development?
- What wider lessons for policy and practice may be learned for future community-based health improvement initiatives?

Research plan

The proposed study will be of 24 months' duration. It will employ a full-time research fellow (DR).

Study design

The study will employ a longitudinal, observational design. The use of a mixture of qualitative methods will enable: (a) a continuation of the in-depth exploration of themes surrounding inequalities and sustainability that have already been identified during the initial evaluation; (b) the identification and

testing of new themes; and (c) the analysis and interpretation of data (to be guided by the experiences of participating HLC stakeholders).

Sample and recruitment

The sample will comprise approximately 30 key participants drawn from six HLC case study sites which form the sample of the current evaluation. The HLC sites are based in or around the following locations: Edinburgh, Glasgow, Aberdeen, West Dunbartonshire, Ross and Cromarty, and the Isle of Islay. These locations were chosen initially following workshop events which allowed the research team to sample purposively in order to maximise the generalisability of findings. Following on from the initial evaluation, gatekeepers (usually project co-ordinators) indicated to research team members that they would be willing to continue each HLC's participation in any future evaluation. During previous rounds of fieldwork, key individuals within each HLC have already been identified. These include: project co-ordinators, project staff, partners, volunteers, community members and service users. Most of these key individuals have been involved with the HLC evaluation over the past two years. On the basis of the previous experience of conducting the evaluation within the six HLC sites, we do not anticipate any problems with recruitment to the study. The research fellow will approach individuals who have been involved previously and also respond to suggestions from key stakeholders, to contact new informants (e.g. local authority officers, representatives from community planning partnerships and CHPs), and engage with more recently established networks (e.g. Lothian HLC managers network) to obtain relevant insights and information.

Methods

There will be four components to the study:

1) Access to documentation. Each HLC provided the study with extensive background documentation. It is envisaged that access to proposed workplans and annual monitoring reports, alongside further reports for external funders and partner organisations, can be secured from each site on a continuing basis.

2) Individual in-depth interviews with each key stakeholder (both in the HLCs and in the wider health environment), using a topic guide, will take place either face-to-face or by telephone. These interviews will focus on all research questions with topic guides responsive to the needs of each case-study HLC and external stakeholders.

3) Participant and daily observation. The research team has previously sought permission to observe individuals at work in each HLC and a range of HLC activities. A further period of fieldwork will include a visit to each of the six sites and visits with relevant external stakeholders. Observation of HLC work has proved insightful in the current evaluation and continuation of observations of internal HLC board, partnership and staff meetings will be sought. Requests to attend and observe external meetings including HLC network managers meetings and local health strategy groups (e.g. community planning, CHPs) will also be made. Extensive fieldnotes will be made during

these sessions and used to inform follow-up questions in interview (both in-person and by telephone [see below]).

4) Continuing telephone communication. Regular contact will be maintained with key individuals (usually project co-ordinators and lead partners) to ensure that developments are tracked and recorded as they take place.

Analysis

The analysis of qualitative data will be an ongoing iterative process. It will be informed by, and benefit from, the analyses that have been conducted during the current evaluation. Transcripts, fieldnotes and phone notes will be read and compared by the research team. Systematic analytical workshops involving the team will continue to identify key themes and processes to emerge from the data. These data will then continue to be coded within QSR N6, which facilitates indexing and retrieval of large datasets. Further analyses will continue to unpack the situated nature of the themes that emerge[16].

Outputs and dissemination

A series of output and dissemination activities will be delivered. These will seek to promote learning from both original and extension studies. Two seminars outlining findings and providing scope for discussion will be delivered: one will be targeted at Scottish Executive, BLF and local policy makers, while the other will be targeted at practitioners and organisations/agencies with a wider interest in the findings, such as community and voluntary groups. Ongoing collaboration with the development and support programme for HLCs, being delivered by Health Scotland for the BLF, will ensure that the latter is able to draw timeously on emerging findings from this study.

In addition to articles published in peer-reviewed academic journals, a short accessible RUHBC 'Findings' paper will be produced and widely circulated. A final report of the study, containing full information about study methodology and findings, will be submitted to the Executive.

Expertise available

A multidisciplinary team comprising the three applicants will oversee and conduct the research. SP has a background in medical sociology and social policy, and has extensive experience in the evaluation of complex interventions for health improvement; he will be the lead principal investigator on the project. KBM, a medical sociologist, has over 20 years' experience in areas such as health promotion and health-related risks and lifestyles; she will take responsibility for supervising the qualitative analysis. DR was one of two research fellows involved in the collection and analysis of data and report writing during the current evaluation and has established good relations with all HLCs.

Research outcomes relating to NHS implementation potential

The Scottish Executive's policy statement, Improving Health in Scotland[6], aims to develop a focused approach to health improvement initiatives. At the

broadest level the Executive seeks to tackle health inequalities as the 'overarching aim' of the health improvement agenda. The proposed research will continue the identification of methods used by HLCs to target the most disadvantaged groups and communities in society. The extension of the evaluation, focusing on communities, inequalities, and sustainability, and taking into account the evolving policy environment, will provide findings illustrating the mechanisms, techniques and models of best practice used by community-led initiatives to improve health and reduce health inequalities over the longer term and the longevity of such partnership operations.

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