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RUHBC Working Paper #3

EVALUATION OF THE HEALTHY LIVING CENTRE PROGRAMME IN SCOTLAND

Report of phase 1

Stephen Platt¹
Kathryn Backett-Milburn¹
Mark Petticrew²
David Rankin¹
Julie Truman¹

1. Research Unit in Health, Behaviour and Change, University of Edinburgh
2. MRC Social and Public Health Sciences Unit, University of Glasgow

Published August 2005

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**Research Unit in Health, Behaviour and Change (RUHBC)
School of Clinical Sciences and Community Health
University of Edinburgh
Teviot Place
Edinburgh EH8 9AG**

Telephone: 0131 650 6192/3

Fax: 0131 650 6902

www.chs.med.ed.ac.uk/ruhbc

ISBN: 1-901577-18-X

Disclaimer

The Research Unit in Health, Behaviour and Change is funded by the Scottish Executive Health Department. The opinions expressed in this review are those of the author(s), not of the funding bodies.

Published by RUHBC, University of Edinburgh
First published in August 2005

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Paper No 3
ISBN: 1-901577-18-X

Also available on <http://www.chs.med.ed.ac.uk/ruhbc>
Printed in United Kingdom by kallkwik, Edinburgh

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EXECUTIVE SUMMARY

The Big Lottery Fund (BLF) has invested £300 million in supporting 352 healthy living centres (HLCs) across the UK. These centres are expected to deliver services that respond to public health priorities, and promote and improve the health and general well-being of the most disadvantaged people. The Scottish Executive commissioned the Research Unit in Health, Behaviour and Change (RUHBC), University of Edinburgh, and the MRC Social and Public Health Sciences Unit (SPHSU), University of Glasgow, to conduct an evaluation of the Healthy Living Centre Programme in Scotland. The evaluation, conducted over a three year period (2002-05) has explored the pathways between activities, processes, contexts and outcomes in a purposive sample of six HLC projects, using a longitudinal research design. The sample of HLCs was selected to reflect the range of interests, anticipated health outcomes and geographical locations of the 46 HLC projects within Scotland.

Findings cover six key aspects of HLC strategic and operational activity: initiation and development of the HLC; partnership working; community involvement; tackling inequalities in health; sustaining the HLC beyond the initial BLF funding period; and monitoring and evaluation. Learning points relating to each aspect are presented in the report.

The main research questions addressed in the study are:

- What are the projects' objectives and anticipated outcomes?
- What is the context in which the projects operate?
- What are the processes and explanations of change by which intended outcomes are to be achieved?

Objectives and outcomes

There was no emphasis upon evaluation at the bidding stage and BLF did not provide support for evaluation activities; performance management tended to be prioritised over local learning. This posed considerable difficulties for HLCs seeking to provide evidence of their impacts on individuals and communities, one prerequisite for demonstrating success and perhaps obtaining further funding. Lack of expertise and knowledge of evaluation among the HLCs, combined with a lack of local ring-fenced funds available for evaluation, compounded these difficulties. Unsurprisingly, therefore, HLC evaluation plans were not well constructed, and the outcomes of their activities were difficult to conceptualise, identify, and measure by the staff themselves. In the face of such difficulties, HLCs instead tended to focus on measuring and reporting *activities* and *intermediate outcomes* which they theorised would indicate subsequent impacts on health. However, while there are difficulties in determining the impact of the overall programme, there are good reasons for believing that HLCs do make an important contribution to the communities in which they are located. They have adopted novel and successful approaches to reaching excluded groups and achieving their social inclusion goals of the HLC programme. Unpublished data suggest that HLCs have been successful in their targeting activities; contrary to some expectations, HLC services have not been taken up by those who need them least, but are located in the poorest areas, and are used by the section of the community who are in the poorest health. This is indirect evidence of HLC success: HLCs are targeted appropriately, and are reaching those with greatest capacity to benefit from their services, and in this respect make an important contribution to their communities. The final links to health and health inequalities outcomes remain elusive, as for many other complex, area-based initiatives. To HLCs this is probably not perceived as a problem, as they consider that they are just one element of a much broader strategy for tackling health inequalities.

HLC contexts

The most obvious aspect of context, the social and economic history of the HLC area, was discussed in a previous report (*Year Two Progress Report*, Section 3.5, March 2004). However, the past 'regeneration history' of an area also affected HLC success in some cases. It may be assumed that the overlaying or targeting of poorer areas with multiple initiatives (such as SIPs and HLCs) would have major benefits; for example, through increasing the availability of services or the 'intensity' of delivery of those services. It is clear, however, that this is not always the case. For some, the existence of previous regeneration activities counteracted the potential influence of the HLC; most obviously, the continued existence of social problems, despite earlier regeneration programmes, was sometimes taken as proof of their ineffectiveness, and made it more difficult to engage the local community in the HLC's work.

The HLC staff themselves are part of the context. In one form or another the capacity and skills of HLC staff were found to be of considerable importance to the perceived success of the HLC. With large and ambitious remits, and continuing pressure on HLCs to innovate, project management was sometimes difficult, and clear leadership became particularly important. Overload on staff was, however, frequent, particularly when staff turnover was rapid, and training opportunities were too often seen as limited.

Processes and explanations of change

HLCs were frequently unable to describe a clear pathway between aims, objectives, projects, expected outcomes and actual outcomes. Typically, they had considerable difficulty in identifying the outcomes that their activities were intended to achieve. Even where outcomes could be stated, they were rarely being measured (or measurable). It is therefore not surprising that HLCs struggled to articulate how they understood the linkages between activities, processes, contexts and outcomes. The search for alternative, plausible explanations of successful outcomes was equally uncommon. A straightforward association between intervention, activity and beneficial outcome was most often assumed or implied, as is often the case for many public health or other social interventions. This may even (in some cases) be an accurate reflection of the relationships in question, but is not testable using the existing data.

Final learning points for practitioners

- Be realistic in the amount of time that it will take to establish an HLC, either from the expansion of an existing project or through the genesis of a new project. It may in some cases be possible to employ key staff in advance of the main funding provision – although this course of action involves the risk that the project does not eventually go ahead. Plan in advance for the need to fill vacancies due to illness, maternity leave, etc. Seek managerial support from partners at the outset and make sure that reporting chains for projects are clear and agreed with staff. Identify training needs early on, and seek adequate resources.
- Activities to promote user engagement should follow current guidelines on best practice, such as the *National Standards on Community Engagement*.
- Relationships with stakeholders and partners can be changed over time, if necessary. However, it is important that all stakeholders know their responsibilities, and that suitable agreements are in place early on. Ensure clarity of purpose (of programmes and projects) which is known to, and agreed by, all stakeholders.

- Limited consideration had been given by most HLCs to sustainability beyond BLF funding. This is where HLCs could usefully draw on the experience of staff, management, local people, and partners at an early stage in the lifespan of the project, to ensure that HLC plans are abreast of current policy and funding patterns.
- HLCs seeking sustainability through becoming constituted should exercise caution. Although creating new funding opportunities, the onus for service delivery is placed on voluntary bodies and could result in a loss of statutory agency support.

Final learning points for policy makers/funders

- New projects should be encouraged to be realistic in the amount of time that it will take them to become established, and in terms of what can be achieved. From this evaluation it was clear that capacity can be stretched when working with vulnerable groups, and across large geographic areas.
- Resources should be made available for training and managerial support, or to ensure that this support is forthcoming from lead and other partners.
- It should be recognised that there is a need to make changes to workplans during the course of the programme. Local contexts evolve and local needs change over the course of bidding and delivery of operations.
- Evaluation is important, but 'evaluation' is frequently poorly understood and poorly conducted, and, as in the majority of regeneration and area-based initiatives in the UK, monitoring and performance management tends to take precedence over outcome evaluation. Expectations that evaluation takes place, and that outcomes are identifiable, are unlikely to be realised unless concrete support is provided to those delivering the intervention (as is being done by BLF under the recent development and support contract). This could involve ring-fenced resources for local evaluations, and support structures (including training). (An example of local ring-fencing was found in site 1.)
- Funders should consider what indicators of health impacts are most appropriate for each project; in some case, outcome assessment will be feasible and appropriate; in many others alternatives will need to be sought. In these cases projects should be required to specify clearly the nature and scale of the intermediate outcomes they expect to attain, and how they relate to final health outcomes.
- This can/should mean considerable investment in training, support, and resources for evaluation activities. Current models place the onus to evaluate on HLCs, which struggle to cope, and find it impossible to demonstrate actual health outcomes – which are largely unmeasurable within the lifespan of the projects. Similarly, the range and purpose of HLC activities and their effects are not well captured by current quantitative output monitoring systems.
- Many poorer urban areas in the UK have now considerable experience of the roll-out of short-term area-based projects, where early apparent success is followed by cessation of funding and withdrawal of the same initiatives. Consideration should be given by funding bodies to providing continuation funding for successful projects where unmet need remains.

Implications for research

- Future evaluations need routinely to explore with practitioners the theories of change within which their projects are implemented or services delivered. Without understanding these, it may prove impossible to grasp the rationale for project activities, and impossible to understand or measure success.
- Within this framework researchers need to identify a range of relevant intermediate outcome measures which indicate that projects are progressing towards their outcomes. Success in targeting services should be one of these outcomes, but the systematic collection of data on other relevant intermediate outcomes (consistent with the intervention's logic model) should be prioritised.
- Evaluations should attempt to capture the indirect benefits of the intervention – such as capacity building, training of users, employment, and other benefits (or otherwise) reported by volunteers.

1. INTRODUCTION

1.1 The Healthy Living Centre programme

The Big Lottery Fund (BLF)¹ has invested £300 million in supporting 352 healthy living centres (HLCs) across the UK, of which 46 are located in Scotland. These centres are expected to deliver services that respond to public health priorities, and promote and improve the health and general well-being of the most disadvantaged people. The programme as a whole is intended to address the wider determinants of health, such as social exclusion, poor access to services, and social and economic aspects of deprivation which contribute to inequalities in health. Healthy living centres provide a wide range of services and activities, including, for example, smoking cessation, dietary advice, physical activity, health screening programmes, training and skills schemes, arts programmes and complementary therapy. These services/activities are targeted at different population groups, including people on low incomes, young people, older people and people from minority ethnic groups. Grant schemes are expected to involve local people, communities of interest and project users in all aspects of the design and delivery of a project. The programme supports the health strategies of all four countries of the UK. Grant schemes are also expected to work synergistically with local priorities for improving public health and tackling social exclusion.

1.2 Purpose of the evaluation

The Scottish Executive has commissioned the Research Unit in Health, Behaviour and Change (RUHBC), University of Edinburgh, and the MRC Social and Public Health Sciences Unit (SPHSU), University of Glasgow, to conduct an evaluation of the Healthy Living Centre Programme in Scotland. The evaluation, conducted over a three year period (2002-05) has explored the pathways between activities, processes, contexts and outcomes in a purposive sample of HLC projects, using a longitudinal research design. The main research questions addressed in the study are:

- What are the projects' objectives and anticipated outcomes?
- What is the context in which the projects operate?
- What are the processes and explanations of change by which intended outcomes are to be achieved?

In-depth process evaluation generates rich datasets which require considerable research resources and time. We have therefore adopted a case study approach, focusing on six projects (representing about one in seven of the 46 funded in Scotland) which have been purposively sampled. The final sample was intended to represent the diversity of projects funded under the programme, with respect to a range of characteristics:

- geographical location (2 urban, 2 rural, 2 mixed)
- centre-based (2) or virtual (4)
- in Social Inclusion Partnership (SIP) area (4) or not (2)
- geographically defined community (5) or community of interest (1)
- existing infrastructure
- organisational location.

Only HLCs with a budget of over £0.5m were considered for inclusion; smaller projects were excluded on the grounds that the amount of fieldwork and contact with

¹ The Healthy Living Centre programme was initiated in 1999 by the New Opportunities Fund (NOF). In 2004 NOF was merged with the Community Fund, creating the Big Lottery Fund (BLF). For simplicity this report refers only to the BLF (even when reference is made to the period before 2004).

the evaluation team was likely to place an intolerable burden on their limited resources. Two workshops were held in June 2002 and November 2002, to which selected HLCs were invited. A major purpose of the workshops was to learn more about candidate case study HLCs and therefore ensure a more informed approach to sample selection.

The final selection of case study sites was agreed with the Advisory Group at three meetings during 2002 (May, November) and 2003 (March). The start of fieldwork was staggered, so that the demands of fieldwork could be properly managed. Case study sites 1 and 2 were incepted into the study in summer 2002, sites 3 and 4 in winter 2002/03 and sites 5 and 6 in spring 2003. Fieldwork was concluded in autumn 2004. Data collection continued, however, *via* telephone contact in December 2004 and during the February 2005 dissemination workshop (see section 2.7).

Appendix 1 provides an anonymised description of each of the case study sites.

2. FIELDWORK AND METHODS

2.1 Background

This process evaluation has focussed on all aspects of the delivery of the six case study Healthy Living Centres. As such the evaluation has generated a large and diverse body of in-depth longitudinal data about the projects and the communities involved. This has included not only information about the constituent implementation activities, but also the local context, history, environment and other developmental stages of the implementation process.

The focus of the evaluation has been essentially on 'how' and 'why' questions, concentrating specifically on what may have helped or hindered progress in the first two to three years of implementation towards the achievement of both outputs and outcomes.

The sample of HLCs was selected to reflect the range of interests, anticipated health outcomes and geographical locations of HLC projects within Scotland. As a result of the disparate nature of the sample, the evaluation has had to accommodate each site's unique configuration, partner alliances, target groups, geographical coverage and intended health outcomes. The ongoing challenge of a multi-site process evaluation is to combine the gathering of comparable data across all HLCs with obtaining in-depth illuminative data which reflect each site's unique history and implementation.

2.2 Methods

A range of methods, predominantly qualitative, was employed to collect relevant data from different stakeholder groups. Interviews focused on all research questions, with topic guides responsive to the particular needs of each case study site. The qualitative research methods used in the evaluation included: taped semi-structured interviews; discussion groups; documentary research; participant observation; formal and informal observations of activities, meetings, events and daily interactions; mapping the local area; telephone interviews and email contact. When devising instruments, consideration had to be given to the development of the organisation and the personnel structure of each HLC. Across (and sometimes within) the participating HLCs there were variations in start-up times, structures of management, deployment of staff, types and numbers of partner organisations, use of volunteers, levels of community involvement and user groups. Instruments were customised for each site following the collection and assimilation of information from background documentation.

The case-study design incorporated two periods of intensive fieldwork (separated by a one-year interval), and telephone and email contacts with each HLC in between and after the fieldwork visits. This has permitted an in-depth investigation of processes within each HLC. Such longitudinal research requires sensitive attention to be paid to the close association and relationships required between evaluators and participants, particularly those with the key contacts or gatekeeper, in most instances, the project manager/co-ordinator. Throughout, issues of timing were negotiated so that the work and progress of the HLCs were not affected by the fieldwork, while still meeting the demands of the evaluation.

2.3 Setting up and managing the fieldwork: the importance of a flexible approach

Following introductory workshops with HLCs to introduce the evaluation and recruit them into the study, site visits were carried out to each case study HLC by the research fellows and the senior qualitative researcher, Kathryn Backett-Milburn. Further negotiations then took place between the research fellows and HLC

gatekeeper to obtain background documentation, such as business plans, minutes of meetings and relevant reports in advance of going into the field.

The cooperation of gatekeepers and the careful management of the fieldwork by the two research fellows have been central to the successful implementation of the evaluation. The process of identifying, with the gatekeeper, key individuals to participate in the evaluation involved discussion to determine which stakeholders had strategic and/or operational knowledge about the HLC. It is acknowledged that this gave gatekeepers an influence over the evaluation as they may have selected favoured stakeholders or partners to participate. However, there have been many advantages to this relationship. For instance, on several occasions, gatekeepers helped to smooth the path when approaching hard-to-reach target users during fieldwork, as many vulnerable and sensitive groups were involved. The good long-term working relationships established with the gatekeepers have also acted as the principal contact between formal periods of fieldwork, ensuring prolonged access to the site and opportunities to follow-up how work was progressing. Moreover, the emphasis placed on developing and maintaining relationships with HLCs and key individuals has assisted the evaluation by creating an atmosphere of openness, which has broken down some of the mystery and anxiety surrounding the evaluation process and, in many instances, led to the divulging of information that had not originally been requested.

A crucial element in this has been getting the timing right – ensuring a balance between the needs of the project and the needs of the evaluation. For instance, the establishment and equipping of premises, recruitment of staff and launch of each HLC differed markedly and necessitated moulding the fieldwork to each HLC's work trajectory. Subsequently, the timing of fieldwork was negotiated to allow for busy periods, seasonal variations in attendance, and to ensure an adequate representation of staff were in post. In some sites residential fieldwork, ranging from a week to overnight stays, was required; at other sites it was possible to visit on a daily basis. Some additional return visits were made to several HLCs to respond to unforeseen events and to conduct follow-up interviews with key staff who were leaving the organisation to take up new posts. Such flexibility in accommodating individual projects' requirements during fieldwork probably helped to ensure continued and open access to staff, stakeholders and service users. Moreover, the ensuing cooperativeness of each site and the effective management of fieldwork meant that the fieldwork was finished on schedule.

2.4 Fieldwork

Fieldwork also had to take into account the size and scope of each HLC (multi-focus and single focus), whether it was centre-based or 'peripatetic', the type of lead organisation (statutory or voluntary/community) and the range of stakeholders and partners. As a result of these differences the amount and length of fieldwork varied between HLCs - in some cases intensive fieldwork had to be carried out during a single day's visit; in others cases the interviewing and observations could be spread out over several days of fieldwork. Overall, however, similar numbers of interviews, observations and fieldwork contacts were achieved for each case study site. There were about 12-14 interviews and 3-4 observations per HLC per fieldwork visit. As originally proposed, interviews were conducted with three main groups: project team members (including grant applicants, paid staff and volunteers, and Board members/advisors); users/beneficiaries of the services; and key local partners and stakeholders. It was agreed with the advisory group that, because of the logistical and conceptual problems involved in sampling and interviewing, non-users would not be included in the evaluation. The main difficulty experienced in all sites was obtaining user interviews; some were achieved in each HLC, though the research

fellows had to make opportunistic assessments regarding the amount of time needed to make these contacts.

Although it was important to prepare interview schedules in advance and to collect background documentation, each HLC provided a different quantity of information, the quality of which often only became apparent when interviews were conducted. In many instances changes or expansion had occurred in both the structure and level of operation of the HLC since bid documents and business plans had been compiled. Consequently the research fellow had to adjust and remain responsive to the information divulged by participants during fieldwork. Instruments for user groups also had to be refined depending on the characteristics of target interviewees and observations had to acknowledge a wide spectrum of society including, for instance, young homeless people, older housebound groups, people experiencing mental health problems and entire communities within a geographical location. The second round of fieldwork entailed a continuing flexible use of a basic topic guide in order to track specific areas of progress, explore aspects of process, and obtain accounts of emergent challenges and successes.

2.5 Ethical issues of managing data and trying to ensure confidentiality

Informed consent was sought from all participants, whenever possible (e.g. before formal interviews); however, in some instances, such as during observations at school events where an HLC was providing activities, this was not possible. A high degree of openness among gatekeepers, stakeholders and users was also experienced on several occasions. As a result participants had to be continually made aware that the evaluation sought to gather data from both formal and informal contacts and not only during taped interviews. In accordance with the research team's wholehearted commitment to ensuring the anonymity of respondents and the confidentiality of data obtained from them, it was felt that reporting of contentious issues of a personal nature should not be used to influence the form or content of planned fieldwork, and should be handled with extreme sensitivity when providing HLCs with interim feedback.

Despite this stance the research team experienced several dilemmas when faced with frank stakeholder accounts which, if made public, had the potential to cause harm to other participants. Even sharing information within the research team was problematic; a coding system had to be developed to safeguard anonymity and confidentiality when data were transferred electronically or transported as hard copy. It remains a challenge for any research team to reach consensus as to what information a researcher can or should divulge to other members of the team or to a wider audience, while seeking to do no harm to research participants or to the integrity of the evaluation.

2.6 Data analysis

Data analysis has been iterative. Findings have been generated using grounded theorising principles and constant comparative methodology involving systematic analysis of accounts generated within and between the case study sites. As the body of fieldwork developed across the six sites, the team analysed and debated issues and challenges which were taking place across all sites, or perhaps happening differently in sub-samples.

The data were rigorously analysed in various team groupings. The two research fellows worked closely together, discussing and comparing emergent concepts and findings. Half day analytical workshops, involving KB-M and the two research fellows, have been conducted at approximately monthly intervals throughout the project. These entailed prior reading of selected transcripts and detailed qualitative analysis and discussion of emergent themes, usually focusing on data from one of

the sites. However, as more data were collected, the workshops increasingly involved iterative comparative analyses between sites. The key findings from these workshops were shared between grantholders and research fellows at regular whole team meetings and the insights at these meetings then fed back into the overall analysis. This qualitative process has formed the basis of the coding and retrieval framework that has been developed using the QSR N6 computer-assisted data analysis package. Subsequently, coded sections around particular themes have been analysed in greater detail. This collaborative method of team-working has been extremely effective in facilitating agreements about emergent themes and key processes involved in the evaluation of the case study HLCs.

2.7 Refining analytical insights through dissemination

A variety of dissemination activities has taken place where emergent findings have been aired by the research team and discussed in several settings; insights gathered through these activities have been fed back into the analysis (see appendix 2). After the first round of fieldwork each HLC was provided with a customised feedback report of key findings. Comments on this report were sought during the second round of fieldwork. There have been several rounds of feedback to the Advisory Group to this evaluation and discussion at Advisory Group meetings has fed back into the analysis. The research fellows have presented at a variety of conferences; comments and suggestions from diverse policy, practitioner and academic audiences, such as public health, evaluation, health promotion, and medical sociology, have informed the further development of the team's thinking. Finally, a workshop for the participating case study HLCs to hear and react to the findings in the draft final report resulted in very useful discussion and suggestions about implications for policy and practice.

3. FINDINGS

3.1 Initiating and developing the HLC

3.1.1 Introduction

Fieldwork usually began within a few months of each HLC's launch and tracked the developmental progress of the six case sites for two years. This section examines contextual and organisational features of HLCs, followed by start-up issues raised during the establishment phase, before looking at how have HLCs adapted, developed and bridged these issues over the course of the evaluation.

3.1.2 Contextual features which influence development

History of the area

The local history of areas in which HLCs are based has influenced the development of each site. Several urban sites have adopted Social Inclusion Partnership (SIP) boundaries to define target communities. Although facilitating identification of target users, the urban renewal initiatives (e.g. improving the housing stock) underway at site 4 were considered a barrier to enhanced community involvement as local people perceived that their residency may not be permanent and some were already in the process of moving. Several urban and rural locations served by HLCs (sites 3 and 5) had experienced a decline in traditional forms of employment and an increase in isolation exacerbated by poor public transport options and limited local services and facilities. Seasonal work patterns were noted to compound the problems faced by rural locations at sites 1 and 5. Some communities (both geographical and specific target groups, e.g. elderly) targeted by HLCs live within areas that are considered affluent. The experience of poverty within such socially mixed areas may, however, be relatively greater as living costs, such as rent and food, were higher than in other areas of Scotland.

History of working arrangements

HLCs were established both as new projects (sometimes incorporating pre-existing partnerships) and as programmes which built upon earlier community-based projects. In sites 3 and 4 a series of short-term community-based initiatives predated HLC operations; however, local people were concerned that the HLC was just the latest in a long line of such initiatives, many of which had ended despite local involvement. HLCs sought to overcome apathy among local people which resulted from earlier failures to address social problems. A history of working arrangements impacted on whether HLCs sought to facilitate the development of new services to address unmet need or to develop networks between existing services. A shared working history among partner organisations benefited a voluntary-led HLC in gaining rapid access to target groups and early opportunities to deliver joint services. A project within one HLC, sited in an area where significant regeneration had taken place, was able to adapt local partnership arrangements, e.g. which had established a GP exercise referral system, to facilitate work quickly. Several sites made attempts to fit with pre-existing partnership arrangements at a local level (see section 3.2).

Geography of an area

The geographical coverage of the case-study HLCs ranged from densely populated and compact urban areas to large and sparsely populated rural areas. HLCs undertook work within these areas, developing services for groups living in certain locations. Some sites targeted groups that live within wider community settings, e.g. elderly or disabled groups, whereas other sites sought to address the needs of the whole community through setting up services for a large number of groups living in an area. Both formats present challenges relating to the size of the area in which

staff must work and the difficulties in reaching and attracting the most excluded individuals to attend activities.

3.1.3 Organisational structures of HLCs

HLCs have been developed and led by statutory and voluntary organisations, and also functioned as independent, community-run ventures. Organisational structures have influenced the developmental progress of each site. Lead partner organisations (see section 3.2) have been supporting HLCs in developing functions such as management groups, budgetary advice, and with recruitment, personnel, training and fundraising procedures. HLCs led by statutory organisations (LAs and NHS) have had opportunities to become connected to broader policy agendas. In a voluntary-led HLC (site 6), staff considered that the HLC had enhanced freedom to innovate as they considered statutory agencies to operate with increased levels of bureaucracy; on the other hand, they were less connected to wider policy frameworks. One community-led HLC (site 3) has adopted funding partner organisational structures, e.g. recruitment procedures, and drawn on their support, e.g. training to facilitate local management committee decision-making processes. On the other hand, another community-led HLC (site 4) developed its own procedures, based on current best practice.

3.1.4 Establishing the HLC

First round fieldwork visits found that a number of features within and across sites characterised the early establishment of HLCs. Each HLC was, or had recently been, involved in the following:

- setting up and equipping premises to provide a number of functions, e.g. as office/administrative space and as places to deliver services
- recruiting staff
- developing staffing and managerial procedures
- undertaking training
- establishing or re-establishing contact with partner agencies
- determining staff and partner responsibilities
- seeking access to target groups
- beginning to deliver services to potential users.

Management of the HLC: overview

Different managerial systems operate across the sites. Managerial responsibility within three sites (1, 2 and 5) lies with groups comprising partner organisations and HLC staff, e.g. managers. These sites followed the procedures of lead statutory organisations, which some stakeholders considered to be overly bureaucratic but stable. (In site 2, however, many stakeholders referred to the *instability* of statutory agencies due to frequent reorganisations, leading to dramatic changes in procedures, structures and personnel.) In one remotely located site (5), managerial support was only available at a distance due to the geographic location of the HLC in relation to the lead partner. In the voluntary-led HLC (site 6), the management decisions were retained, mostly autonomously, by the HLC manager who reported to an internal board within the host organisation. The remaining two community-led sites (3 and 4) had devised a management committee structure comprising local representatives, who sometimes met in smaller sub-groups to discuss individual projects.

At several sites (2, 4 and 6) no concerns were expressed about the establishment of managerial frameworks, which had been implemented as stated on bid documents. However, HLC managers at sites 1 and 3 noted that they had difficulty in finding adequate time to dedicate to project management. Some management functions

had been added on to the remits of statutory agency employees, e.g. health promotion specialists and local authority officers. Stakeholders in these sites considered that having dedicated leadership functions would have assisted decision-making and strategic planning, as the following respondent explained:

"We always seem to be scrabbling around at the last minute to try and pull all these bits and pieces together. I think it's big, I think it's too big in many ways and [...] everybody's coping brilliantly but there isn't quite the cohesion that could be brought if we'd had a dedicated leader." (Project co-ordinator, site 1)

In one community-led HLC (site 3), which operated as a company limited by guarantee, there were problems about the ability and willingness of community members to take decisions on matters such as funding and employment rights. In several instances committee members indicated that they had been given insufficient support by partners when making decisions, although key partners cited a skills deficit among some local members as a barrier to effective decision-making.

Amount of time required

Sites 3 and 5 were attempting to begin delivering services to meet their targets while simultaneously establishing working procedures and developing administrative and service delivery spaces for staff. Three sites (1, 3 and 5) did not appear to have adequately prepared for the amount of time required to set up facilities and working procedures while concurrently delivering activities. The following statement, taking recruitment as the example, reflects the views of several managers about the time pressures faced following six months of HLC operations:

"...things have taken longer in some instances than we thought they would just to get going [...] ...folk are only now just come into post..." (Project manager, site 2)

Sites 3 and 4 had, however, built in time for a pre-operational phase where key members of staff were appointed to equip office spaces, establish partnerships and networks, recruit staff and formalise employment procedures. Matched funding from partners facilitated this process, allowing key staff to be appointed in advance of the release of BLF funding. In several instances staff were in post for several months prior to BLF funding and official launch, as one project manager explained:

"...obviously we have been up and running now for just over about 6/8 months. [...] we are now starting to develop the services." (Project manager, site 4)

Building in an allowance of time prior to beginning service delivery was found by these HLCs to be beneficial as staff were free to concentrate on practical set-up arrangements without simultaneously attempting to deliver services. In some HLCs, targets for the first year were set to take account of the first year of development. However, in other HLCs targets for year one were unrealistic and did not take into account initial set-up pressures.

Planning, preparation and overload

The appointment of key staff members, prior to launch and draw-down of BLF funding, assisted sites 3 and 4 in planning service delivery. In site 1, where project co-ordinators and workers began immediately to devise and deliver services, measures were taken to put in place more considered planning, as illustrated below:

"...what we did ask them to do was just to stop, go back, get the partnerships established, concentrate on that for a little while rather than just parachuting in what we thought..." (Project manager, site 1)

Post-launch, some HLC managers (e.g. sites 3 and 4) identified a requirement to reappraise communities' needs which were found to have changed in the time since bid documents were written and funding was allocated. One project manager commented:

"[The] stage two bid was written two and a half years ago. The areas like [Anytown], major changes have happened to them which isn't necessarily reflected in what we are sort of saying. So we are in [...] a process of having to re-evaluate what we are doing." (Project manager, site 4)

In conjunction with changing local needs, the addition of newly funded elements of work and changes to partnership configurations meant that, during bidding, business plans were referred to as a "best guess at the time". This commonly expressed sentiment was articulated as follows by one stakeholder:

"...there's only one thing that you can ever say with a business plan and this is that it won't reflect reality." (Chair of the board, site 1)

Several managers within HLCs (e.g. sites 1 and 3) indicated that they were unprepared for the administrative functions and time-consuming nature of the job. As a result they had to redistribute the time they had available for strategic, managerial and (sometimes) operational roles.

Recruitment

Recruitment at most sites was complete when evaluation fieldwork began, approximately 3-6 months after start-up, although one site was continuing to advertise to fill vacancies. Recruitment decisions took into account the benefits of employing trained individuals and local people possibly requiring training, but who were considered to be uniquely placed to attract hard-to-reach groups. Sites differed in the emphasis they placed on employing local people. Where communities of interest were targeted across larger geographical areas, e.g. socially excluded young people, HLCs placed less emphasis on the need to employ a local person. When HLC work was focused on a particular location and the geographically based community living within the area, more attempts were made to employ local people either as project workers or as lay health workers. Additional training for new recruits (see section 3.1.5) was required on several occasions where local knowledge outweighed formal qualifications.

Qualifications in fields such as community development were considered beneficial, although a proven track record in working with communities was also considered to be a useful attribute. Pay scales for equivalent posts differed between sites and were graded according to the employment practice of the lead or key partner organisations. One community-led site (4) had matched pay scales for project staff with equivalent statutory grades in order to attract a high calibre of staff. Over time, the external posts used to match HLC pay scales were found to increase, while HLC grades remained static as funding levels did not permit similar raises in pay. The implications of this on subsequent recruitment were hard to gauge, although the manager, recruiting to fill a vacancy, speculated that potential applicants might not necessarily be of the same calibre as the initial post-holder.

Capacity issues

The capacity of HLC staff to deliver programmes differed between sites and depended on the size of the remit and business plan adopted (e.g. number and type of target groups, geography of area), staffing allocation, managerial roles and partner

inputs. Optimally, HLCs with appropriate levels of trained staff, clearly defined managerial functions (strategic and/or operational), robust work plans and co-operation of partners in undertaking shared agendas appeared to experience fewer resource capacity problems. However, several HLCs did experience problems in meeting demands among target groups, for a variety of reasons.

In site 5, the size of the agenda undertaken by the HLC was considered by staff and partners to be excessively large: several activity streams were being developed by a small complement of staff. One stakeholder commented:

"Its almost as if there's too many ideas and unless you can pick out the forest from the trees, [...], things get a bit lost and lose momentum." (Stakeholder, site 5)

Small team size often left few options for back-up support and potential burnout among staff was noted to be a problem in several sites (e.g. 4, 5 and 6), as is illustrated below:

"...like the staff team we've got, we just manage and no more sometimes, which doesn't give you any scope if you're feeling strung out about something, or just dealt with something distressing, there isn't the scope to just go away into a room [...] or say "Right, I'm away out for a walk for an hour" (Project manager, site 6).

In site 3, additional project funding provided by statutory partners led to increases in the HLC staffing complement. While this additional funding increased service provision and was considered a benefit to target groups, it was undertaken without a corresponding increase in provision of funding for managerial support, which many stakeholders considered to be an omission. Meanwhile, site 1 stakeholders commented that the project bid had underestimated the amount of uncosted managerial time required from the lead partner to oversee and run the HLC.

Staff capacity within publicly accessible (centre-based) HLCs was a particular issue. Although two sites indicated that unprompted drop-in calls from vulnerable service users sometimes increased their workload, staff considered that this provided a vital service for this group. Furthermore, each of the six sites found it difficult to ensure service delivery during periods of annual leave, sickness absence or when recruitment was on-going (see section 3.1.5). As all HLCs operated with limited or no additional resource capacity, it was reported across sites that services were sometime scaled back to meet changing staffing levels.

The capacity of several HLCs to deliver services was affected by several factors, including:

- travelling time in sites covering large geographic areas or those operating in remote regions
- nursery workers' strikes
- partner disputes
- ring-fenced funding
- limited availability of suitable premises
- the implementation of the Disability Discrimination Act
- unanticipated demands from adjacent communities to have their own form of HLC service.

As HLCs became more established, recognised and valued, managers from several sites (e.g. 1 and 3) noted that additional work requests were made of the HLC.

There was uncertainty as to how current staff levels and resource capacity could meet these changing demands.

3.1.5 Development of the HLCs

The longitudinal design permitted an examination of the developmental progress of the HLC sample over two years. During this time some sites continued to experience problems that had been encountered at the outset, whereas others had evolved new procedures, training programmes, staffing arrangements and management functions to manage their workload.

Sticking to plans

Changing local needs within HLC target groups (since bids had been devised and funding allocated) required sites to make changes in their provision of services. Although HLC stakeholders articulated this during round one fieldwork, changes in service delivery methods were more evident during the second visit. In several sites, working in partnership led to an increasing awareness of target group needs, as the following quotation illustrates:

"[Through working in partnership] you do have a wider awareness of organisations or people that can also serve the folk that you're trying to benefit... [...]... whereas before I perhaps wouldn't have even picked up on and responded [to a particular issue]." (Project worker, site 2)

In some HLC locations (e.g. sites 1 and 3), it had become evident to managers and project workers that it was important also to address the needs of groups that had not been included on the original bid, which in one instance included the expansion of a project to include a geographical area not included on the original bid. In site 1, lifestyle services aimed at reducing coronary heart disease were modified to be delivered to all age groups. Similarly, site 3 shifted part of its emphasis to address newly identified needs in men's health and also post-natal support. Unexpected demands of service users, e.g. mental health problems, made it necessary for HLCs to modify programmes and undertake additional training for staff. Furthermore, as HLCs progressed through their business plans, services were sometimes rationalised or adapted to reflect the continuing development of other community initiatives and to avoid duplication. By the second fieldwork visit, several sites were noted to be involved in an increasing amount of work in support of existing services, as one project manager explained:

"...so I then became quite conscious, right, there's no point setting that service up if there's a service existing. How can we complement that service and how can we work with them?" (Project manager, site 3)

As each site made some changes to proposed activities and services, communication with BLF funders was necessary. Some sites were more adept at explaining proposed changes than others and reports from managers indicated that some case managers were more flexible about making changes than others. Although each HLC proposed changes for what were considered valid reasons (e.g. to avoid duplication, to enhance the attraction to users), clear communication with funders was felt to assist when making changes to programmes. In two examples, a counselling service evolved into a weekly session of alternative therapies involving acupuncture and massage, and a trim (or exercise) trail evolved into a Green Gym involving outdoor conservation activities. Further changes have been proposed to whole projects. In one site a project which had struggled to obtain partner support and attract service users was being redesigned at the completion of fieldwork. Changes included attempting to include a broader coalition of partners in order to

work around the issues (e.g. childcare) that had beset the early stages of development.

Although all sites indicated that there was a need to change certain aspects of their work, one site indicated that the original business plan posed a constraint to the development of new pieces of work. Communication difficulties and delays to beginning operational work compounded the problems faced by the "tablets of stone" contained within what was subsequently perceived to be an excessively large business plan, given the resources available.

Changes to management functions

Four of the HLCs made few changes to management groups over the course of the evaluation, although new members were appointed to account for staff and partner turnover. Two sites (1 and 3) underwent more pronounced changes during the course of the evaluation. One community-led and managed site incorporated an advisory group of funding partners to assist with project expansion and to aid the local board with decision-making processes. This was justified as follows:

"...we've had such a lot of additionality. So it's a lot more complex in terms of the general day to day running, the structures are a lot more complex and I also think the funding streams are very complex as well..." (Partner, site 3)

It was reported that local community members were often overloaded in terms of the number of sub-groups established for individual projects and administrative functions within the HLC.

"We had to say, 'Stop!' We actually said to ourselves, 'Stop, it's getting too bad, that's enough, we need to stop. We need to start working with what we've got and then make sure that's working properly before we could take any more'." (Chair of the board, site 3)

In the above site, committee members and partners considered that the size of the operational remit had become overly large for a limited pool of local people to manage, given the number of sub-groups operating. A process of consolidation was advocated and suggestions were mooted regarding the introduction of a new layer of management, although no further funding was available to facilitate this role. By the end of the evaluation sub-groups had been rationalised and a new form of project management, using advance planning meetings, was being trialled.

In a second HLC (site 1), operating a series of linked projects, limited project management time had been allocated to oversee development. The lead partner within this HLC was able to fund a part-time administrator to take over some of the managerial functions. Further changes within the central co-ordinating post were discussed at the conclusion to fieldwork which were considered to offer an opportunity to provide more dedicated management time to oversee the running of the separate projects.

Changes to staffing

During the evaluation several project managers, co-ordinators and workers left post and one site replaced its entire staffing complement. The longitudinal design permitted follow-up interviews with several members of staff who were leaving post. Reasons given for leaving included: new or permanent job opportunities; higher rates of pay; personal reasons; inappropriate appointments; project failure; personal animosities between members of staff; home relocation; and departures to seek new challenges.

Staff turnover and subsequent recruitment posed some difficulties for HLCs. The majority of sites operate small staff teams, which, following departures, left little spare capacity. As a consequence of turnover, work outputs were reduced while replacements for managers and project workers were sought. In one instance, the departure of a project manager led to the interim appointment of another key member of HLC staff. This temporary appointment was continued for several months during which time some community development functions were suspended. In site 1, the departure of a member of staff produced new opportunities to revise job descriptions and to expand the role further, as the project manager explained:

"[Paul] had worked so effectively that he had got systems up and running that are running very smoothly, maintenance can be limited and therefore we can be looking at other aspects of the work, for example you know the interest in food and access to food, all these issues, and put more of an emphasis on that, so we could look at the job description..." (Project Manager, site 1)

Staff in several sites also received promotions in role, pay rate and an increase in hours. HLCs vired funds from other budgets (e.g. sessional budgets) and sought additional support from lead partners to accommodate these changes. The departure of a project worker in one site led to an increase in the number of sessional staff employed. Although operating with a small team of staff, this change permitted the HLC to deliver more projects simultaneously. Another site also increased the use of sessional staff to meet demands to increase service delivery and to free up project workers' time to devise new services rather than to focus on on-going activities.

Additional staff resources became available within a local authority-led HLC (site 1) as staff within a particular department were issued with revised job descriptions to include HLC-related roles. This enabled the HLC to draw on additional support for activities and large events. A similar, but informal arrangement existed in a voluntary-led HLC (site 6), which was able to draw on support from projects that came under the remit of the same lead partner organisation.

Training requirements of staff

The training provided to staff differed between HLCs. Training needs were often identified by staff and requests made to managers and management committees. The size of training budgets varied between sites. In-house training was available to statutory-led HLCs and by arrangement with lead partners in community-led sites. Other partner organisations offered training to statutory- community- and voluntary-led HLCs. Some sites found that staff had to attend training before services could be delivered. In remote locations the need for training, coupled with travel requirements, meant that limited operational resources were further stretched, as the project worker explained:

"Yes I think the more time I'm away, I mean the less I'm actually doing on my projects. [...] but it's like training that I've had to go on" (Project worker, site 5)

Several sites were still devising training plans for staff during second fieldwork visits and training offered in these instances was *ad hoc*. For example, staff at one site had indicated a need to receive community development training which was subsequently delivered by a local consultant. In a second site, staff skills were found to be unsuitable when dealing with mental health concerns of users. Partner organisations were drawn upon to assist in training staff. By the second round of fieldwork visits staff in several sites voiced discontent at the lack of, or inappropriate, training opportunities available to them. Factors which influenced this discontent included:

uncertainty over legal ramifications in advising users without appropriate skills; short-term contracts and future employability; and stagnation within current job remits.

Centre-based and virtual HLCs - use of premises

Case study sites differed in the availability and use of premises and whether they operated as a centre-based HLC, offering services and activities using a dedicated building, or as a virtual HLC, using office space for administrative functions while delivering services on an outreach basis. The use of dedicated and outreach facilities was dependent on a number of factors. These included:

- the type of target group (e.g. providing target groups with an identifiable location to meet in, or providing a focal meeting point for members of the community)
- the types of service being provided (e.g. stress-management required private locations, provision of childcare, ease of accessibility)
- the geographical spread of the population (e.g. dispersed groups are less likely to travel to a central location, requiring that services be delivered at local venues)
- the availability of appropriate accommodation.

HLCs with publicly accessible premises operated to deliver both independent services and jointly-run services with partner organisations. In one instance an office space shared with a primary care team created tensions between staff working to address health using social and medical models. HLCs with centre-based facilities often made their facilities, e.g. meeting rooms, available to partners or other groups delivering services to community groups. Centre-based HLCs sought to develop an ethos and culture that were welcoming for service users.

The location of centre-based HLCs was also important. In an urban HLC (site 6) targeting users from a number of different communities, the neutral city-centre location reduced conflict between individuals and groups living in different areas. In a rural HLC (site 5), the centre operated as an informal drop-in service for members of the community and was easily accessed by people who were doing their shopping. Meanwhile, stakeholders in site 3, which delivered a percentage of services from a dedicated centre considered that its location was beneficial in trialling new activities but was unsuitable for some groups e.g. crèche and parents group.

Virtual HLCs developed administrative offices for staff, but used the existing community facilities and those of partner organisations to deliver services. One HLC (site 2), operating to enhance and fund a network of existing organisations, was not involved in seeking accommodation for services. A second, local authority-led HLC (site 1) benefited from access to leisure and community facilities owned by the council. Accessibility remained an issue when geographically dispersed groups were targeted; sites 1 and 5 arranged transportation to venues for particular activities.

Over the course of the evaluation two HLCs redesigned their premises to reflect the needs of the projects and to appeal to service users. During later fieldwork, two, mainly virtual, HLCs (sites 3 and 4) had redesigned their office environments, due to inadequate external venues, to provide facilities to deliver part of their programme of activities. The use of premises, both to deliver activities and as office space, was given continuing consideration among sample sites. In seeking to meet the needs of a geographically diverse community, site 3 had originally operated two administrative bases. This was subsequently rationalised to one location, although a future move to a publicly accessible location was discussed.

Innovation in service delivery

All sites have devised innovative services in order to attract hard-to-reach groups. Through experimentation, HLCs have found that a number of experimental methods have had success. Following periods of innovation, sites have continued to deliver services in a similar manner. As noted above, the employment of sessional staff in some HLCs allows such services to become regular features and allows permanent staff to retain creative roles.

In some HLCs, successful innovative activities within projects, such as walking groups, have been adopted through transfer of best practice to other locations. Modifications to such activities have also been introduced to accommodate different groups, including mothers with young children. Further innovations to traditional forms of exercise class have been successful in attracting hard-to-reach groups, e.g. belly-dancing, men-only exercise classes. Other HLCs have developed innovative ways to encourage healthy eating, linking with local food retailers and suppliers to promote and increase the uptake of healthy food choices.

A constantly evolving range of service delivery methods was a feature of one HLC. Staff indicated that changing the programme influenced both uptake amongst service users and the motivation of those delivering activities. The project manager said:

"I suppose just there's a need to be creative with whatever you're doing and there's also a need to recognise that just cause something works, it's not always going to work and in a lot of things we've had to think long and hard about why we're doing this in the first place. It comes out to two things, it comes out in [service users] being bored and also staff being bored..." (Project manager, site 6)

While several projects indicated that innovative projects were useful, one manager raised concerns about the need to be constantly innovative and deliver 'new' projects. In this instance, the manager considered that there was a necessity to maintain work that was proven to be effective over the long-term and beyond BLF funding, rather than to become involved in an "innovative grant culture."

Within several HLCs, staff have had to adapt their methods of work to fit with the models of health employed by partner organisations. For instance, a food issues worker who used a community development approach had to adapt methods of work to accommodate the more medical approaches used by a dietician. Some clashes were evident between the different models of health employed by HLCs and partner organisations. In some instances partner organisations operating a medical model of health were felt by HLC staff to undervalue the social health role of the (usually smaller) HLC.

Innovation in service delivery: example 1

In order to encourage uptake of primary care services among hard-to-reach groups, site 6 developed links with a number of primary care service providers (e.g. community dentist, chiroprapist). Practitioners visited the HLC to help users become familiar with their equipment and modes of practice. Following these periods of familiarisation HLC stakeholders reported that block-bookings were made at local surgeries leading to an improved uptake of primary care services.

Innovation in service delivery: example 2

To encourage uptake among a rurally isolated group, site 1 utilised partner organisations' knowledge to target and approach hard-to-reach users. Taxi transport was provided to a central venue where services were delivered in a flexible manner to accommodate the different circumstances faced by service users; crèche facilities were also provided. As the project developed, similar services were being developed in outreach locations to overcome barriers to access for target users who were unwilling to travel to a central delivery point.

Innovation in service delivery: example 3

Site 4, perhaps aided by its location in a large conurbation, had successfully negotiated access to a local major retailer. This had led to healthy choices being promoted with HLC support:

"Over the last five weeks we've been in Kwik Save two hours a week and we've had five hundred people, a hundred people a week sort of coming and chatting to us. We've got money from the Scottish Executive to do a promotional leaflet for each. so we've done ... like one week we did wholemeal breads, so we did a wholemeal bread leaflet, advertising that with the healthy living telephone number and the logo on the back. And then we did oily fish, we did pure fruit juice, next week we're doing pasta, carbohydrates as a basis for your meal." (Project Worker, site 3)

These attempts to influence local retail structures, although innovative in terms of HLC remit, were notable for the length of negotiations required to establish access. Project workers indicated that a series of meetings had taken place between the HLCs and retailers in order to establish these projects, more so than was required to develop food-related initiatives with other partner organisations.

3.1.6 Strengths and weaknesses in set-up and evolution

A number of strengths and weaknesses of HLC set-up and development have been identified.

Strengths

- Ensuring a pre-operational phase to facilitate set-up arrangements
- Setting realistic targets in the first year of operation
- Recognition of need to change tack if services are not working
- Recognition of changed remits since bids were constructed
- Ensuring that adequate managerial support is available
- Identifying suitable and on-going training for staff
- Adaptability: innovating and identifying new methods of work to attract target groups.

Weaknesses

- Isolation from managerial support mechanisms
- Not being able to provide adequate support for community members involved in management functions
- Being unrealistic in scope and reach of projects given the resources that have received funding
- Need to evolve mechanisms to ensure that staff turnover can be accommodated without jeopardising service delivery
- Limited facilities can impact on ability to deliver services effectively.

Key learning points

- Be realistic in the amount of time that it will take to establish an HLC, either from the expansion of an existing project or through the development of a new project. If possible, employ key staff in advance of main funding provision.
- Recruitment and staffing issues continually arise in short-term funded projects and some measure should be taken to fill vacancies during illness, maternity leave or during recruitment, e.g. secondment of external personnel.
- Capacity within staff teams can be stretched when working with vulnerable groups and when working across large geographic areas.
- Managerial support from lead and other partners should be defined at the outset and a clear reporting chain identified when projects are devised. Procedures should be revised at periodic intervals thereafter.
- Recognition should be made of the need to amend workplans during the course of the programme. National and local policy contexts and local needs change over the course of bidding and delivery of operations.
- Training needs should be clearly identified and adequate resources made available to meet these needs.
- Changing local circumstances have required adaptations to be made in the use of office and service delivery premises.
- HLCs argue that innovative activities have been successful in attracting hard-to-reach groups across a number of sites.

3.2 Partnership working

3.2.1 Introduction

When developing bids, Healthy Living Centre applicants were asked by the BLF to meet several assessment criteria. While these did not define how HLCs partnerships should be structured, they stated that HLCs should "be supported by a broadly based partnership, which includes statutory, voluntary, community and private sectors" and that "partnership structures for managing the project are well thought out and allow partners to participate on an equal basis" (invitation to bid 1999). In line with government policies, BLF views partnerships as one of the main tools for facilitating work to reduce inequalities in health.

Partnership working has been constructed at each site in different ways and partnerships have developed at different rates. During bidding, first and second stage bid documents completed by HLCs show variations between sites in respect of: the number of partners (between 7 and 33 organisations across the sample sites); the types of partner organisations represented (including statutory, voluntary, community and private organisations); and the role of partners (including strategic inputs, operational matters, access to target groups, financial support, provision of in-kind support to boost capacity and/or provide training, and support with administration).

From the outset of the evaluation, HLCs partnerships have differed in the length of time they have been established, how they are constructed and in their decision-making capacity. The following sections examine the development of partnerships over time and take into account different starting points, strategic knowledge and inputs, and operational aspects for each HLC.

3.2.2 Establishment of partnership working

When applying for HLC status, applicants were informed that both new and existing projects (with previously established partnerships) were eligible for funding. In sites 1 and 5, partnerships at strategic and project levels had evolved from previous working arrangements, while the remaining sites developed new partnership structures during bidding and when establishing the HLC. Partnerships vary in scope, e.g. strategic and/or operational, which subsequently influences their composition. Across all HLCs, partnerships comprised community groups, voluntary groups, representatives from larger organisations, e.g. NHS or LA (often drawn from a number of departments or sections with each department representative listed as an individual partner), individual community members, and, in one HLC, several local businesses.

Structure of partnership within each site

HLCs operated with a number of broad partnership structures. Two sites (3 and 4) had devised a community-led partnership with statutory funders inputs, one voluntary-led site (6) had devised a partnership of mainly voluntary agencies with statutory inputs at operational levels, two further sites (1 and 2) operated with statutory-based partnerships for strategic functions and devolved responsibilities to operational partnerships comprising a wide mix of community, voluntary and statutory inputs. The final HLC (5) operated a statutory-based partnership with operational inputs from a number of local community and voluntary organisations.

Each site had devised a central partnership to oversee HLC work. Central partnerships operated in an advisory capacity in community- and voluntary-led HLCs, and in a decision-making capacity in local authority- or NHS-led HLCs. In community-led HLCs, partners with advisory functions were permitted to attend management committee meetings in a non-voting capacity (see section 3.1.4). In practice, these partners had an influential role in informing decision-making. Four sites (3, 4, 5 and 6) operated a central partnership where representatives had both strategic and

operational roles. Sites 1 and 2 had devised central partnerships with predominantly strategic responsibilities, co-ordinating the work of several local and/or thematic partnerships which delivered operational work plans. One community-led HLC (4) partnership feeds information into a series of local area and city-wide health and wellbeing partnerships. Local authority-led HLCs have well established connections to mainstream agendas through their project manager's integral role within the local policy process.

Time taken to develop partnership working relationships

It was evident that each HLC found it necessary to devote substantial time and resources to devise and establish partnership working.

"...it does take a while for partnerships to come together and I wouldn't see that as a drawback, I would see that as one of the challenges the partnership is working through." (Partner, site 2)

In two sites (3 and 4), key members of staff were in post for around six months prior to the launch, which allowed for the partnership to be developed before services began to be delivered. Similarly, in another site (1), historical working relationships meant that partners were already engaged in delivering services within a particular project, which were subsequently adopted and modified by the HLC when it began operations. However, several HLCs found it necessary to re-engage with partners, following a lull in communication post-bid and pre-launch. This was noted to be a time-consuming process and one which competed for resources during project launches as HLCs sought to establish a wider awareness of activities and services within local communities. Resources were stretched between enhancing partnerships and delivering services and activities. In many cases the emphasis was placed on service delivery.

In the majority of sites, partner organisations had worked together both formally (e.g. in a SIP) and informally (e.g. provision of staff support in earlier projects in site 6) prior to HLC funding being granted. However, in some newly established projects with no history of working arrangements, partnerships had been conceived of on paper during bid stages and no further inputs took place until project launch.

"...I remember asking about, when I was already working on the programme for about three months and I wasn't even aware that there was supposed to be a local partnership group. One of the line managers [...] looked shocked and horrified etc. that I hadn't had that going right from the first month". (Project co-ordinator, site 1)

In one HLC (site 6), partners had been approached in order to reduce competition for limited financial resources and to enhance service access to users, while another site (5) had to reassure partners that the HLC did not seek to supplant their role.

"...there were times when I actually felt a bit threatened by what was going into the plan and I think it's important to pick up on that because there was a lot of community development being built into it. That was what my job is about." (Partner, site 5)

In one site, further tensions emerged including instances where partners were unable to meet their commitment to the HLC. Changing roles and personality clashes following a successful bid led to disputes and reaching a resolution was found to be very time-consuming. Differences in support mechanisms affected the speed of resolution of such disputes.

Aims of partnership working

The aim of partnership working varies across the six sites. The majority of the sample have devised partnerships in order to permit joint working arrangements to be established which assist in delivering the HLC agenda. However, in site 2, the aim of partnership working is to create networks of organisations which can then determine how individual needs within communities can be met such that partnership working is established as an end in itself. Other sites are based in areas where much partnership working has taken place in the past and where the HLC represents a continuation of working patterns previously established.

3.2.3 Development of partnership working over time

The evolution of partnership working is examined both within sample HLCs and at overall HLC programme level through learning from the experiences of early-funded sites. The development of partnerships differed within each site and was dependent on several factors, including: type and length of working history, changing policies, incorporation of new members, ascertaining roles and responsibilities, time, and perceived success of the HLC among partner organisations.

Development of partnership working within HLCs

Operationally, all HLCs reported successes in engaging with both formal (bid listed) and informal (non bid-listed) partners, in delivering services and activities. Wider policy changes within key partner organisations (e.g. NHS, LAs and SIPs) have meant that some partners' roles have changed as their workloads and portfolios evolve. HLCs have, on occasion, had to renegotiate working arrangements and service delivery methods with partner organisations. As HLC projects continue to be developed according to each site's work schedule, partner inputs vary according to when their services are required.

At a strategic level, HLCs experienced mixed levels of success in maintaining and operating partnerships. Community-led HLCs underwent changes in partnership working, with key funding partners inputting more information and advice to assist local people in the decision-making process. These changes were noted to provide enhanced support while allowing the community to retain effective control of the HLC. Notably, community-led HLC partnerships were considered to have become one of the main focal points for examining local health agendas.

"So I think partners have recognised that we [the HLC] are important. I think they've also recognised that we do have a role in looking at some of the strategic work that's done in the area and some of the work that we do is, it's partly to strengthen the wider health agenda." (Project manager, site 4)

However, at several sites (1, 5 and 6) the inputs from partners had reduced by the second round of the evaluation, which was felt by some managers to have had a negative impact on developing the HLC strategically.

"... like the partners are just quite, there's input, yes, but the partners aren't really directing it. They're quite happy with the way things are going and we're only maybe having two or three partners at the meetings." (Project Co-ordinator, site 1)

In several instances partnership meetings were being held less often and were felt by some managers to operate mainly as feedback or reporting mechanisms. Although operational success was noted to be one reason for the decline in attendance, managers were mindful of the strategic function of the partnership and attempts were in place to reinvigorate partner inputs. Lack of time was the main factor noted by

partners themselves for declining attendance. However, it was also suggested that the function of partnership meetings might be re-examined.

"...the organisation would develop with a lot more strength if it had a steering [partnership] group that was adding something to what they are trying to do. So perhaps a review of the steering group would say, 'what is it that is wanted from the steering group, what would be useful, what would actually make the organisation function better, what would make it more effective?'" (Partner, site 6)

In two sites (1 and 2), locally based partnerships, overseen by a central partnership, intended to manage the workload of HLCs covering large geographical and thematic fields, were noted to have expanded to include more partner organisations. Plans were also in place to encourage more local people (or HLC users) to attend partnership meetings. In one of these sites, where several partnerships were in operation, managing different elements of the programme, future development was aimed at working across partnerships through the use of issue-based groups.

Development of partnership working across the HLC programme

There seems to be a distinction between earlier and later funded sites in respect of the emphasis placed by HLCs on the establishment of partnership agreements and how these should be drawn up. In early-funded case studies, partnership working was loosely defined and partners had often only signed a short pro forma indicating their role in delivering services to meet HLC targets. In one of the later case-studies it was indicated that the HLC had been advised by its BLF case-manager to implement more binding partnership agreements to clarify roles, responsibilities, targets and a procedure for conflict resolution. It is possible that problems encountered by early funded HLCs account for this shift in emphasis in later funded projects.

3.2.4 Partner roles and responsibilities

At the outset it was evident that each HLC operated with a different understanding of roles, responsibilities and also definitions of organisations or individuals who were considered partners.

Who is considered a partner?

In conjunction with retaining partner support for operational and strategic roles, key stakeholders indicated that the bidding process had led to the inclusion of some partner organisations to appease local sentiment, to reduce competition for client-users and to enhance the attraction of the bid to funders.

"Well there was a political, [...] there was a cynical element to the choice, okay. How do we, what partnership can we construct that looks good to a funder?" (Chair of the Board, site 6)

Distinctions applied to partners differed between sites. In several sites, all bid-listed organisations were considered partners, whereas, in other instances, partners were considered to be any organisation with which the HLC worked. In community-led sites, partners were considered to be those agencies which provided funding to the HLC. In other sites, the inclusion of new partners was an ongoing process aimed at establishing networks between agencies, organisations and individuals engaged in working in a particular geographic area or in a particular thematic field.

Role of partners

Roles of partners differ according to the function of the HLC and the type of partnership (e.g. central and strategic, and/or local/thematic and operational). Roles included: delivering services jointly or independently, providing in-kind support (e.g. staff time, access to premises), making financial contributions, assisting with recruitment, personnel and training programmes/policies, fundraising, evaluation guidance, referring clients, disseminating HLC work to wider audiences, as consultants to assist programme delivery, and providing systems and project management experience.

At the commencement of operations, some sites found it necessary to clarify partners' roles.

"People have just seen this [the HLC] and thought that we're actually here to award money [...] to sort of smaller organisations and I don't know how that misinterpretation came about". (Project administrator, site 5)

During the evaluation period the function of partnerships and partners' roles had become more defined across the sample. Although time constraints were still a major factor in determining partner inputs to the HLC, most sites had developed methods of working with the majority of partners. In several instances, work patterns were changed to avoid overburdening some representatives.

"...as it has evolved it has been fairly obvious that each partner would have an area of interest within the project [...] so what we have been looking at is having sub-committee meetings if you like so that the medical people can meet up for the active referral side of it..." (Line manager, site 1)

Furthermore, the advisory function of partners was becoming increasingly relevant towards the end of the evaluation as HLC managers sought a range of opinions when considering how operations might be sustained beyond BLF funding (see section 3.5). Many sites sought to re-engage partner interest with a view towards continuation of the HLC.

Lead partners' roles

One of the key roles offered by a lead partner is the support they provide to HLCs and their staff. This can take various forms and includes: managerial functions, adoption of staffing procedures, budgetary advice, administrative functions, conflict resolution, in-kind support, and strategic sounding board. Further analyses suggest that the type of lead partner and the support they offer have had a number of impacts on HLCs development.

Several features and inputs of lead partners were noted. The advisory function and close working relationships with local committees in community-led HLCs allowed statutory agencies to have substantial influence over project development.

"... we do very much reflect some of their key, eh, health agendas. [...] we do reflect some of the key things that sort of our [statutory agency] partners want" (Project manager, site 4)

Statutory organisations also provided vital support with employment legislation and when seeking additional funding. In-kind support is also substantial within statutory-led HLCs and in one site (1) job descriptions within a council department have been amended to incorporate HLC functions.

The practical support offered by lead partners differed according to the location within and prominence attached to the HLC by the lead host organisation. Several organisations considered the HLC as being at the vanguard of their attempts to improve health and wellbeing. However, line managers from within several statutory agencies had had HLC responsibilities added to their existing remits, which made the provision of adequate support a challenge.

3.2.5 Strengths and weaknesses of HLC partnerships

During the evaluation several strengths and weaknesses of HLC partnerships were identified which contributed to successes and failures experienced during the establishment phase and subsequent development.

Strengths

Features which aided partnership development included:

- Prior working arrangements
- Maintenance of contacts between partners following bid and prior to HLC launch
- Good interpersonal relationships
- Enthusiasm and approachability of project manager
- Clarity of understanding of the role of the HLC and how partners can adapt to this
- Coterminal boundaries (both geographic and thematic)
- The ability to reflect the changing needs of partners and communities.

Although several HLCs had multiple partners, strong partnerships were only evident for those agencies prepared to put in effort.

"So I think that the partnership works well for the organisations who put a lot into it. I think that the ones who don't put a lot into it probably don't get a lot back out of it either." (Chair of Board, site 5)

Further strengths of partnership working included an increased level of communication, contact with and wider awareness and networking between, and sometimes within, organisations.

"The contacts that have been made, I've witnessed during a number of occasions when one partner turns to the other and says, 'oh it's you that does that, I've been meaning to talk to you about such and such'". (Project worker, site 1)

Weaknesses

Several weaknesses in partnership working were found and among these the widest ranging feature to impact on HLC development was time. Features include:

- Lack of time to meet
- Lack of time to plan
- Lack of time to understand partner requirements
- Lack of time to make effective decisions
- Poor interpersonal relations
- Limited partnership agreements
- Changing workloads
- Poorly defined partner roles
- Differing expectations of partners.

"Some people on the steering group I think have been quite precious of their own services and I think that was their concern... that was the reason they were perhaps on the steering group in the first place, to make sure there wasn't an overlap." (Manager, site 3)

Key learning points

- Allow time to develop partnerships. This includes time to implement, maintain and review partnership structures from bid stages, through to launch and during service delivery.
- Partnerships are not static and it may be necessary to change the function and structure of partnerships if required.
- Ensure partnership agreements are in place and outline responsibilities of all partners.
- Encourage attendance throughout and ensure clarity of purpose of programmes and projects amongst all stakeholders.
- Ascertain roles and responsibilities and accept that changes may be required when operations begin or at different stages of HLC development.
- Identify key individuals within organisations and develop appropriate mechanisms and resources to obtain support.

3.3 Community involvement

3.3.1 Introduction

When the Big Lottery Fund invited agencies to bid to become a Healthy Living Centre, involving local people in all aspects of the operation was one of the fundamental principles. The Fund stated that potential HLCs should ensure that "the local community is involved in all areas of project planning, development and management." This section details how HLCs approached this aspect of their work.

3.3.2 Involving and reaching users

The majority of the case study HLCs reported no difficulty in attracting local people to use the services they offered. Only in site 5 were difficulties reported. Here it was felt that the large number of existing community groups covering a relatively small population meant there was a lot of competition. Further, site 6 aimed to encourage community members to develop and run individual projects; but this had been hard to achieve and led to a change in practice when the HLC became more established. In contrast, site 4 took the administrative responsibility of organising events away from the local community. They saw their role as listening and responding to community needs, rather than encouraging communities to establish their own services. For example, one of the project workers identified a demand from local people for a walking group; the HLC then set up a group and worked in partnership with other agencies to establish a network of safe walking routes. In contrast, site 1 encouraged local people to volunteer to become walk leaders, trained them and supported them during the duration of the HLC. This HLC anticipates that, following the end of funding, these aspects should be self sustaining, although as time went on the HLC reviewed the practicality of this model.

HLCs used various methods and differing relationships with existing groups and agencies, to attract users to their services. For example, site 6 used targeted marketing techniques with other agencies that supported a similar client group. Site 4 focused on developing partnerships with other community-based groups in order to add a health dimension to existing work, whereas in site 2 most of the work was conducted through existing voluntary and community groups. Site 1 reported some

difficulties with the groups which they were asked to target. In one area the rationale for focusing on over 45's was disputed; in another, 'women with dependent children' were difficult to attract as there had been little planned provision for childcare and the HLC was struggling to market themselves to this segment of the population. Site 5 focused on developing informal contacts with known local people. The project worker was an 'islander' rather than an 'incomer' and it was felt that his personal approach when asking local people to attend events had been particularly effective. However, the project worker required some specific training in order to fulfil certain other aspects of his role, such as project planning, monitoring and evaluation. Site 4 sought to recruit staff who lived locally and could demonstrate experience of working with similar client groups:

"We recruited local people as employees...we sourced staff that are extremely community orientated. One of the major things when we were recruiting our staff was the amount of professional experience they had working in communities who are socially excluded." (Project Manager, site 4)

The location of the HLC was a further consideration. In site 6, the project manager felt that the physical location, in a central area of the city, had facilitated its success in attracting the client group. Site 4, however, was located at the rear of a rubbish bin store area in the base of a tower block that was popularly associated with drug users and street crime. Interviewees had mixed views about the benefits and disadvantages of this. Some felt that it was beneficial as the service was located in an area with few local services, whereas another respondent reported that it was off-putting to come to the office due to the reputation of the area. However, this HLC delivered most of its services in other community venues; only training for volunteers and counselling services were offered in the office base. Site 5 had secured a shop location on the main street. This led to many informal drop-in visits, but also gave a prime location in which to advertise HLC events.

HLCs also differed in their approach to the short- and long-term challenges involved in supporting local people. For example, site 4 felt it was appropriate to develop long term relationships with clients that were sustained for the lifetime of the project. As the project manager said:

"If we have to be here for the next 20 years offering free badminton classes to the same people, then that's those people getting the recommended amount of physical activity for the next 20 years." (Project Manager, site 4)

Other HLCs wanted to see a throughput of users. For example, site 6 expected the users of its services to gain confidence and skills, perhaps take on a volunteering role, then move on to other things. The project manager described her reservations about users who did not move on:

"There is another issue there, about people that will come to everything, so you become like a safety net for them so they don't actually have to go and make pals of their own or worry about their life because Monday-Friday they can just come here. So you know people coming back isn't necessarily an indicator that things are all right." (Project Manager, site 6)

In each site, service users were given opportunities to benefit from peer support. This was noted to be a feature in encouraging initial engagement among users and in ensuring their continued involvement over time, as illustrated in the following quotation:

"My partner works offshore so she [health visitor who suggested using the HLC] was, like, 'come down and try this' and then I started coming and I

thought, this is great, I like this and just kept coming back. It's, it's been really good. It's been, not just the actual structure of the courses, it's to hear everyone else's, their sort of family story, you know. It makes you feel that you're not alone, that other people go through what you're going through as well..." (Service user, site 1)

3.3.3 Volunteers

The majority of HLCs used volunteers in some of their work. However, there were marked differences between, and even within, HLCs about the approaches that were used.

Site 2 operated through a network of existing voluntary agencies. Each agency had its own methods of recruiting and supporting volunteers. This is illustrated by taking two voluntary groups as examples. The Community Food Initiative decided not to recruit volunteers through advertisements as they had concerns about the type of person who might apply:

"We don't advertise for volunteers...if we advertised for volunteers then we could get people looking to volunteer from one part of town and they're needed in another part of town...they find how people choose to live in that community not one that they personally would accept. There's a "do-gooding" element to volunteering that's too judgmental, I suppose, in terms of people who you're trying to work with. Whereas, within that community I'm not saying judgments don't happen within that community as well, but within that community it's more likely that there's an acceptance of people just getting on." (Project Worker, site 2)

This project felt its role was to support existing volunteers and encourage a wide range of community food initiatives to flourish. Homestart, on the other hand, took a different view: they advertised for volunteers to allow them to expand their service across the whole of the city. They interviewed applicants to ensure they were fully aware of the demands and expectations of volunteering; sought references and ran checks through Disclosure Scotland. A full training programme was provided and an ongoing mentoring system was in place to support and manage the volunteers. Thus, Homestart took a more active role on advertising, selecting and training volunteers. These examples illustrate how, even within one HLC, quite different practices are observed regarding the recruitment, training and ongoing support of volunteers.

Site 4 had a contrasting view of volunteers. They recruited and trained volunteers to fulfill specific roles, such as sports coaching or participatory appraisal, and then offered paid sessional work. Site 3 took the paid involvement of local people a stage further by developing lay health worker posts. The aim of these posts was to offer paid employment with training opportunities which would enable local people to obtain experience and skills in community-based projects. It is anticipated that lay health workers will move onto other more highly paid roles after a period of time. Site 3 had planned to recruit volunteers in addition to lay health workers but this had been delayed due to practical difficulties within the HLC.

There appears to be a gradient of recruitment, training and payment practice amongst Scottish HLCs, from an unpaid, untrained approach in site 2's Community Food Initiative to a fully paid training 'apprenticeship' of the lay health workers in site 3.

Some HLCs raised difficulties about working with volunteers. For example, in some of the food co-ops in site 2, certain residents would not use the facility due to long standing disagreements with the individuals who ran the project. In site 1, a "tight

bunch of volunteers with a strong local identity” (Project Worker, Site 1) were seen as off putting to a new volunteer who was considered an outsider to the group. These interpersonal difficulties were seen as particularly challenging when they emerged in volunteers, as the project workers felt they had limited influence over challenging their behaviour. In site 1 the ‘outsider’ was moved to a walk leader role with other ‘incomers’; in site 2, the project worker encouraged any groups who felt they were not welcome at a food co-op to establish their own service.

Volunteers reported tangible benefits from their involvement with HLCs. For some it was the opportunity to do something worthwhile for their local community that was more flexible than paid employment. Others learnt new skills and received support from HLCs.

“I enjoy it really, they’re giving me an opportunity to [get qualified in] coaching....I enjoy the planning and the implementation of the event...they’ll help me, but they also like they take a step back and they allow me to get on with it as well...and if your feeling bad one day you can just come in for a chat and they’ll listen to you and talk you through.” (Volunteer, site 4)

3.3.4 Local people on committees

There are several ways in which local people have been involved in shaping the strategic direction of HLCs. For example, site 1 developed a network of local partnerships which fed into the overarching HLC approach. Site 1 described its work as a “bottom-up” approach. However, these local committees actually comprised local professionals (GPs, leisure managers, district nurses, police, health promotion officer, childcare providers); only the community council and health council representatives could be considered lay members of the public. So, while a ‘top down’ agenda was not being imposed from the Local Authority headquarters, neither was there a truly ‘bottom-up’ approach, where lay members of the local community were actively recruited to identify their needs.

A second approach was offered by site 3 and 4, which have developed boards where local lay people have voting rights; the professionals who attend the board are present only in an advisory capacity. They recruited community members by advertising in libraries, free newspapers and other community-based programmes, such as the SIP. This approach has been successful in identifying the 8 community representatives required to operate the board. However, most of these people sit on a host of other community based project boards. For example, in site 4, one board member also sits on the SIP board, the local tenants’ association and the local enterprise company. This led to one respondent to admit:

“If there were more people you wouldn’t get what we call the usual suspects where I can attend a meeting about one thing and the next week I’ll be at a meeting about something entirely different and 90% of the faces will be the ones that were at this meeting. There’s not enough community involvement at decision making level and that is not a fault of the project. It’s a fault of apathy on behalf of the community” (Board Member, site 4)

Another Board Member highlighted that she worked for a regeneration company in another area of the city and that it was her professional role that had led her to become aware of the HLC. However, she felt that the general public may not be as knowledgeable:

“I take a personal interest in social exclusion issues through work and as a board member – but if I was an ordinary member of the public I wouldn’t know those structures exist” (Board Member, site 4)

The project manager in site 4 recognised that the Board comprised the “usual suspects” and was actively trying to recruit new board members who offered an alternative view. However, this raised issues regarding the skill levels of new board members. He saw one of his key roles as offering support and securing training for board members.

Some HLCs reported that it was difficult to recruit local people on to committees. In some areas local people were willing to help the HLC in many ways but were reluctant to take on a more formal role on a committee. As one interviewee said:

“It is something quite different if somebody then came to you, okay, so do you fancy being a director of this company, employing five people and all that goes with that and so on and I think that, at that point a couple of people dropped out and they were just too hesitant about that responsibility and I think that they felt daunted by that and I don’t blame them one bit” (Partner, site 4)

Conversely, in site 6, workers have been able to develop a close relationship with some of the users who attend the HLC. This relationship has developed so that some users now assist in recruiting new staff and represent the HLC at various events.

HLCs have found that it is time consuming to involve local people in their work, but feel their involvement is worthwhile. As one respondent said:

“What do they bring? Millions of things...their lived experience of their own particular circumstances and their own interpretation of what’s going to make a difference to than and not someone else’s interpretation of what’s going to make a difference to that. Also ... they provide a challenge for a lot of the bullshit that we come against...it really that kind of precious kind of intelligence about what we think we’re doing and what we’re actually doing and how people are actually experiencing that as opposed to how we planned it” (Board Chair, site 2)

There are many voices in HLCs and it seems that representing these voices on strategic committees remains challenging. The methods for recruiting local people on to committees are not always successful and the committee structure itself is often daunting to local people. If HLCs are to involve local people in the strategic direction of their services, and this is not simply tokenistic, they need to look to more innovative methods for engaging lay members of the public. Existing practice does not appear to be entirely effective.

Key learning points

- The physical location of the HLC has been important in recruiting local people to the project in some areas.
- Influential local people, targeted marketing, working in partnership and using existing networks from other voluntary groups have been used by HLCs to attract users.
- Some HLCs view the continued long term support of local people as a worthwhile venture, while others want local users to move through the initiative. Very long term support would be considered over-dependency.
- There appears to be a range in the practice, recruitment, training and payment of local people, from areas where local people are largely untrained and unpaid to HLCs that offer fully paid and trained lay health worker posts.
- Tangible benefits resulting from involvement in HLCs, reported by volunteers, included acquisition of new skills and giving something back to the local community.
- Some respondents suggest that local people do not want to get involved in strategic decision making; whereas another HLC groomed trusted users into taking a more formal role in the HLC.
- There have been several difficulties in local voices influencing the strategic direction of the HLC, such as local committees made up of professionals rather than lay members of the public or board meetings made up of “the usual suspects.”

3.4 Tackling inequalities in health

3.4.1 Introduction

HLCs were designed to tackle health inequalities by focusing on the most disadvantaged sections of society. In practice, interviewees had difficulty conceptualising the many ways in which health inequalities may be addressed. The programme has become a way for local agencies to come together and take a social justice approach to tackling disadvantage by developing:

- new ways of targeting disadvantaged groups
- services which enhance lifestyles, improve lifeskills and tackle fundamental determinants of ill health and health inequalities
- strategies for overcoming barriers to accessing services.

In doing so, HLCs have had to consider how to target and attract specific groups of potential users.

3.4.2 Targeting users

HLCs have used a number of different methods to target potential users. Each site has undertaken some work with existing organisations. This has enabled ready access to target groups and facilitated an early expansion of service delivery which many HLCs felt under pressure to achieve. Site 2 provided a good example of this type of work. Here, thematic networks have been developed to administer ‘seed funding’ to various community-based groups, thus enabling previously separate projects to create links, develop joint work and enhance the cross-referral of clients with multiple needs. A project manager states:

“...people have started to be quite creative about how they actually make use of each other, you know. Homestart have had debt counselling folk in and

benefits advice folk, you know, to work with their parents in a way that they would have never had had before..." (Project manager, site 2)

Sites 3 and 4 found that several new organisations with similar aims had developed during the bidding process. Rather than duplicate efforts, the HLCs sought ways in which they could work in partnership to enhance what was already underway in the area, as this quotation illustrates:

"...so I then became quite conscious, right, there's no point setting that service up, if there's a service existing. How can we complement that service and how can we work with them?...they don't have health workers, so we used to help by either, if we can't offer the service, telling them where to get that information from....so we've had community midwives involved, our lay health workers have been involved..." (Project manager, site 3)

Some sites (e.g. site 6) worked with particularly hard to reach groups. These HLCs had no option but to develop new services as their potential clients had few local services focusing on their needs. This presented challenges as the exact nature of service required by these clients was unknown until they started to use the HLC, as illustrated below:

"I mean, you can set targets and plan, but until you can get people through the door, you don't actually know what you can do..." (Project manager site 6)

Clients raised issues around mental health and wellbeing which led to staff seeking additional training to boost capacity in order to meet the demands of service users.

Other HLCs (site 1, 2, 3 and 5) conducted extensive health needs assessment before the bidding stage. This helped them to identify specific areas in which to develop new services. Site 1 and 5 focused on key population groups, for example, older people, women with children and young people. Sites 2 and 3, on the other hand, focused on mapping health and socio-economic information. This helped to identify the geographical areas which suffered the worst health and were most disadvantaged. These areas were then targeted through HLC activity.

3.4.3 Strategies to attract service users

HLCs have used a number of strategies to attract service users to their events. In attempts to break down barriers and to reach the most excluded groups and individuals, rural HLCs (such as sites 1 and 5) delivered information via local media outlets. Newspaper columns were considered a useful way of reaching service users who might not necessarily attend groups or services.

Some sites experienced marked success in attracting the proposed target group, previously considered by many partner organisations to be particularly hard to reach. Staff worked with users to overcome challenging behaviour and provided enticements such as free food to encourage people to use the venue. This was a 'hook' to attract users to access other forms of service delivery, such as the health education component of the HLC, as shown in this quotation:

" The key attraction, or one of the key attractions, is food and the fact that, you know, if the young people show up this afternoon and you ask them why they come here, they'll say, 'Because there's free scran', right, and I think that again is a bit of learning" (Project manager, site 6)

This HLC continued to think of more innovative ways to attract new groups who were not using their services. For example, it was felt that the provision of basic domestic services might attract people living in bed and breakfast facilities who could not

access these services affordably elsewhere. It was anticipated that, once new users came to the HLC, they would discover and participate in the more health-focused work on offer:

“ [We’re] also looking to put in a couple of showers and washing machines and actually service some of the basic needs and I think we might get some more of the [target groups] in. [There are] very basic needs which I don’t think we really cater for at the moment. I think we’re slightly higher up the need ladder. But that will get people in and start going to the groups and [lead to] some focused group work when they are in.” (Project manager, site 6).

All HLCs had developed good links with individuals and partner agencies. Cross referring clients gave some users the confidence to try new approaches to health that they might not have considered previously, for example:

“I was referred from [a partner agency] who thought I would benefit from this service....I first came for stress and I was just put at ease right away...I like this alternative style..” (Service user, site 3)

The informality of many locally based HLC services was attractive to a number of users, as this quotation illustrates:

“The sports centre, some of it’s too heavy...I’m not a swimmer and I don’t go to the gym every week. [The HLC] it is exercise but it’s not too much... I feel guilty if I don’t go...it’s a community thing we are all in the same boat, we’re not all fit, we’re just trying to give our confidence a wee boost...we’re not all size 10 in a leotard, that just doesn’t do it for me.” (Service user, site 4)

Many sites found it necessary to attempt to deliver services on an outreach basis within each community location. This was evident in both the rural HLCs covering larger geographical areas and in urban locations where several distinct communities formed the target groups. Ease of access to delivery locations differed for each site and for projects within HLCs, as this quotation illustrates:

“I mean the [group] for the parents drop-in, if it were centred in [location A] that might be all that is needed in [that area]. But because of the geographical outline of [location B], we can’t do it that way.” (Project manager, site 3)

Outreach services were delivered by both centre-based and virtual HLCs. Latterly, site 6, operating from a city centre location, undertook work in locations where potential service users were living. Rather than rely on new users attending the HLC facility, this outreach work was considered an additional ‘hook’ to attract new attendees. Within several sites (e.g. 1, 3, 4 and 5) service users living in a number of different locations were either believed, or found, to be unwilling and/or unable to travel to central service delivery areas. These difficulties were overcome through the establishment of services within a number of different target areas.

3.4.4 Examples of the type of work conducted in HLCs

As already illustrated, a wide range of work is being conducted in HLCs which reflect multiple models of health promotion between and within HLCs. Some HLCs have developed services which tackle the fundamental determinants of ill health. For example, projects at site 2, 5 and 6 have tackled income levels by developing debt counselling services, credit unions and fuel poverty. Sites 1, 2, 3, 4 and 6 have adopted a lifeskills approach and developed projects which tackle lack of confidence, skills training for employment, and cooking skills. All sites have focused on lifestyles and developed projects which encouraged participants to stop smoking, eat a healthier diet and take more exercise.

This section provides some more detail about specific projects that operate in the case study sites.

Tackling fundamental determinants in site 2

The HLC supported a travellers' information project in partnership with other agencies. The aim of the project was to support settled and mobile travellers by:

- working with statutory agencies to provide direct services to travellers
- encouraging travellers to attend and seek help from statutory services, such as schools, primary health care, occupational therapy and physiotherapy
- developing new services to support travellers (examples included a girls club, a pre-5 play group, a food co-op and a credit union).

The project reported success with some travelling families, including obtaining access to bathing aids for an individual with mobility problems, and to respite care for a family with caring responsibilities.

Developing lifeskills in site 1

This project aimed to improve the health of young children in an isolated, rural location. Services were initially offered at a central base, with transport provided to attract users. Partner organisations assisted in identifying people who would benefit most from the service. A parental education course operated several times, while more informal activities (e.g. led-walks, social drop-ins) have taken place with the groups. Over time the HLC has sought to replicate its work on an outreach basis by using existing members as volunteers to provide peer support. Subsequently the project has held events to raise the profile of special needs in the area which, staff believe, were previously neglected.

Capacity building and lifestyles in site 3

The HLC established a number of lay health worker posts, which trained and employed local people in community/networking skills. Lay health workers were expected to use their new skills and their knowledge of the local areas to help encourage people to attend activities who might be put off by more 'professional' models of service delivery. The posts were themselves capacity building and provided training for local people, while the people employed were used to support existing services and aid identification of gaps in these services. Examples of lay health worker activity included provision of support to breakfast clubs operated by local schools, support to existing mental health services and support to weight management groups.

Developing lifeskills and enhancing healthy lifestyles in site 4

Site 4 took an outreach approach and delivered services to specific communities within the boundary of the HLC. This particular project occurred on a weekly basis and operated in partnership with the other local community health projects and the community college. The project was free of charge and followed a regular format which included: optional weigh-in and social time, 30 minutes exercise (examples included salsa, belly dancing, chair aerobics), talks and interactive sessions (examples included voice coaching and parenting skills), aromatherapy and reflexology sessions, preparing and eating a healthy two course meal. Orders from the fruit barras could be made and collected during the session. A free crèche operated at the same time to encourage women with young children to attend.

This area was due for demolition and there were no other community services (e.g. local shops, social clubs or venues) open in the area. Participants were enthusiastic about the difference the HLC had made in their area. As one service user said:

"[The HLC] has helped me take regular exercise...you like to sit and it helps you get out... and the healthy eating, I couldn't believe that soup was so easy."
(Service user, site 4)

3.4.5 Problems in attracting the most disadvantaged groups

Despite the wide variety of projects supported by HLCs and their undoubted success in attracting users to services, some are still hesitant about the claim that their activities were effectively reaching those most in need, as illustrated by the quotation below:

"...see I'm swithering about this answer, because are we actually reaching the most neglected part of society? Because if you were actually going to a group already, then you have got over the first hurdle..." (Project manager, site 3)

Two sites (1 and 2) sought to deliver services to disadvantaged groups living in socially mixed areas. Ensuring that services reached those most in need was sometimes problematic, as this quotation illustrates:

"And really we have to evaluate whether the people that we have got at the early years course are really the people that we need to be there. We had referrals from social work and we had referrals from health visitors but there have been some drop-outs according to [the administrator] and the people that have dropped out are really the people that we most wanted." (Project manager, site 1)

In a separate project, stakeholders in site 1 indicated that the target group was not clearly defined, resulting in problems for the co-ordinator in targeting services. Changing housing stocks in site 4 meant that demographic target groups were also changing, which impacted on the HLC's ability to focus services on those deemed most in need. Meanwhile, in site 3, target groups were defined according to pre-existing SIP boundaries. However, some people had clear needs but did not necessarily live within targeted areas and this presented some issues regarding eligibility for service provision. According to the project manager:

"...when you're talking about people who're very vulnerable themselves, who are then identified as being vulnerable, they may not live in that vulnerable area, but they're equally vulnerable." (Project manager, site 3)

3.4.6 Overcoming barriers

HLCs used a number of strategies to overcome the barriers which prevent users from accessing services. For example, site 6 recognised that several of its users had limited access to primary healthcare. They developed links with a local dentist and encouraged users to meet the dentist informally before block bookings for dental check-ups were made, as this quotation illustrates:

"...People don't like the dentist surgery but if you get the dentist to come in and sit on the couch and drink a cup of tea with people first, then it's not hard to get them to get their teeth checked." (Project manager, site 6)

Many HLCs (site 2, 3 and 4) noted the difficulties experienced by parents in attending events and therefore developed childcare to run alongside projects. Some HLCs achieved this by working in partnership with other agencies (e.g. site 2), whereas others had dedicated budgets to allow them to develop childcare as part of their service (e.g. site 4). However, some HLCs found the lack of resources available to provide local childcare continued to hinder some users from attending services (e.g. sites 1 and 3).

Users sometimes experienced difficulties travelling to services. Some HLCs chose to address this by developing outreach services in a number of different settings (e.g. sites 2 and 4), while others (sites 1 and 5) provided transport to central service delivery points, as illustrated in this quotation:

“[There are] some people you can’t get through the door but we are getting some of them through the door and they are the people that you actually need to drive to their door and pick them up and get them.” (Project manager, site 5)

Some HLCs have developed services that are free to users or are provided at reduced cost. For example, site 4 offered a pre-school gymnastics class, but reduced the fee compared to the local leisure centre, whose charges were seen as prohibitive to many:

“If I see people, more people using the leisure centre..... I don’t think enough local people use it and to me it’s because of the pricing structure. That place was built with European money andyou go in there and ninety percent of the users are from out with [site 4]. I think [site 4] residents should get a really, really reduced rates. Not just the one that the Council said, right you can buy the [site 4] Leisure Card,.... residents in [site 4 should] get it free. You know, but that’s too radical for some people.” (Service user, site 4)

Many of the services offered by this HLC were free. This was viewed as positive encouragement to local people on low income to attend.

3.4.7 Capacity issues

Some HLCs experienced difficulties in establishing and responding to the needs of users due to wider capacity issues. Limited resources and small staffing teams, coupled with evolving needs, were considered by some HLC stakeholders to result in only limited opportunities to impact on the inequalities experienced by some communities. Additional training in sites 1, 3 and 6 was required to provide staff with the skills to address the needs of particular groups. Site 4, however, found difficulties finding suitable venues in which to run services: many community venues had been demolished to make way for new housing developments.

In several instances, partner difficulties were considered to act as barriers to the HLC’s ability to address inequalities effectively. In one site, a key partner organisation was found to be resistant when developing work with the HLC. Although most sites indicated that they had developed close links with a range of primary care services, some HLCs (sites 3 and 5) experienced difficulties in developing links and referral mechanisms with some clinically orientated statutory services.

3.4.8 Challenges of demonstrating impact on health inequalities

Stakeholders were hesitant when discussing the impact of the work in their HLC on reducing health inequalities. Site 3 considered that, at best, measures of attitude might show positive change, although behavioural change would take a longer time. Many managers felt that the funding period of five years was too short to show an impact.

“I don’t think we’ll have the evidence to say that we’ve eliminated health inequalities in any of the communities or at that level. I suppose the individual programmes will have had benefits for the individuals but I think that will be a challenge to really demonstrate to what extent we have achieved that...I mean that’s not going to happen within five years.” (Partner, site 2)

Another project manager considered that the HLC’s impact on health inequalities should be part of a long- term strategy, where successful pilot activities within sites were used to promote future continuation of initiatives designed to improve health, as this quotation illustrates:

“Some of that agenda is going to take 20 years to come to. Some of it may be around the long term sustainability of the project, in the sense that what we can do is use the next five years to demonstrate new and innovative best practice which this should be taken up by the existing service providers or else by recognised by our core funders as being crucial...” (Project manager, site 4)

Some HLCs (sites 1 and 2) reported being well placed to influence wider agendas regarding health inequalities. A board member at site 2 stated:

“We’re trying to build up an understanding totally within the city around what we should be doing around tackling health inequalities across the network and each partner obviously brings a little bit of that. So what we’re trying to do is build up that information, show that this is the networks perspective on how we should be taking forward work on health inequalities [more widely].” (Board member, site 2)

Key learning points

- HLCs have focused their efforts on attracting communities and groups from disadvantaged areas. They have achieved this by using many different approaches (for example, including using local media, offering free food and/or basic domestic services and delivering services on an outreach basis) and taking into account the different contexts in which they work. Some have sought to enhance existing provision and others to develop new services.
- HLCs have overcome several barriers, such as lack of transport, lack of childcare, working in areas with few venues from which to operate, working with particularly hard to reach groups.
- Some sites experienced capacity problems which slowed the development of services. These included: the need to train staff in specific skills in response to the wide ranging needs of service users; difficulties with partners; and difficulties identifying venues from which to operate.
- HLCs worked with multiple models of health promotion and have developed projects which tackle fundamental determinants, enhance lifeskills and improve lifestyles.
- Most HLCs felt it would not be possible to demonstrate a measurable impact on inequalities within a five year period but hoped that the initiative would form part of a broader strategy to tackle inequalities.

3.5 Sustaining HLCs

3.5.1 Introduction

In information provided to applicants, HLCs were asked to ensure that "there is a sensible funding plan to sustain the project in the long-term" (invitation to bid, 1999). HLCs were informed at the outset that BLF funding was time-limited and that it was important for bidders to develop either an exit strategy or a strategy to sustain operations through seeking further funding, building community capacity and working in partnership.

The initial second stage application to bid document did not request information on sustainability plans and, although this process was subsequently modified, only one of the six case-study HLCs was required to provide written information in bid documents on its plans for continuation beyond BLF funding. However, BLF Board reports into funding applications indicate that additional information on HLCs' long-term sustainability plans was requested by case officers. These reports provide limited information on plans for sustainability post BLF funding. Two case-studies expected that capacity building within the community, along with the development of robust partnerships, would help sustain projects beyond BLF funding. One HLC specified that key positions, including project manager and administrative support, would continue to be funded by the lead partner after the end of BLF funding. Another site indicated that a sustainability strategy would only be considered in later years (3-4) of funding, while the remaining site had no clear plans to sustain the HLC beyond BLF funding at the bid stage. Where core funding for staffing was being considered, few fundraising plans were specified to continue initiatives beyond BLF funding at the bid stage.

3.5.2 Salient issues when considering sustainability

It was evident throughout fieldwork that case-study HLCs had to consider many local and national issues when seeking sustainability beyond BLF funding. During first round fieldwork visits, most sites were at a very early stage in considering their long-term future. The second round of fieldwork indicated that each HLC was becoming more involved in discussions around sustainability, although finalised procedures to continue operations were not evident in any site. This section provides an account of the HLCs' progress to date in seeking sustainability.

Mainstreaming

Within each of the sample sites, managers raised the possibility of initiatives becoming part of mainstream (statutory) service provision. One project within a multi-project HLC (3) had already received assurances of future mainstream funding provision. Other statutory-led sites, while continuing to explore external funding options, were considering how they could continue operations within lead (often statutory) partners organisations. However, several HLCs and in some instances projects within HLCs had raised concerns that their services were not suitable for mainstreaming, as they would always require additional funding inputs (e.g. food co-ops) or would lose independence to mainstream providers. A project worker suggested that:

"Some things are not mainstream-able, some people will always cost a lot of money, like supporting children with special needs." (Project worker, site 2)

Alternatively, several HLCs (including community- and statutory-led) were sceptical about the benefits of mainstreaming services set against the need to build community capacity. In these examples, HLCs were working closely with NHS providers in attempts to become preferred contractors, paid to deliver services to disadvantaged groups. As the manager in site 4 illustrated:

"In five years' time, if you take [the HLC] away from them and say its going to be mainstreamed by the NHS now, what kind of message does that sort of give? [...] we have to have core funding but maybe there has to be a sort of different model for projects like ourselves which recognise the importance of the voluntary sector in working with primary care." (Project manager, site 4)

Furthermore, several sites indicated that, although mainstreaming could offset a funding shortfall, larger organisations might seek to fragment and absorb an HLC through cherry-picking successful elements. This risked losing the goodwill and attendance at services built up in local communities.

Community ownership and becoming constituted

In the sample, community-led HLCs had formed companies limited by guarantee with charitable status which gave control of decision-making to a board of local people. In statutory- and voluntary-led sites decision-making powers were more heavily influenced by the lead partner on the bid. In seeking sustainability, these structures influenced each HLC's managerial capacity, ability to draw on additional (in-kind) support and fundraising capacity. Three statutory-led HLCs, or projects within these sites, had discussed becoming constituted during the evaluation. A constitution and community ownership were considered to confer benefits in attracting external funding. On the other hand, stakeholders perceived that operating as a voluntary organisation could lead to a reduction in statutory support (both financial and in-kind) and increased competition with other voluntary organisations for such support. Such discussions were continuing at the conclusion to fieldwork, as illustrated in the following quotation:

"I think that they really do need to look at their management structure, their board of directors [...] how they're going to operate in the future, under what sort of articles, and what sort of parameters, are they going to get funded in their own right, will they be able to instigate a project, become a project leader and as that drive it through?" (Partner, site 5)

Although becoming constituted was considered to improve external funding opportunities, stakeholders in community-led and constituted HLCs had concerns about how they could obtain large enough funding packages to sustain operations. A partner discussed how:

"...there's an inherent danger in establishing something [an HLC] that's so expensive, unless there is a long-term plan to pick it up if it's successful and mainline it..." (Partner, site 3)

Continuing discussions in non-constituted HLCs and the experiences of community-led HLCs suggest that having a constitution should not be regarded as a panacea to the problems of long-term sustainability. Community-led management groups were sometimes found to have decision-making and skills deficits and experienced difficulty in obtaining the level of community interest and support required to manage projects successfully. Many HLCs, while considering long-term sustainability, were taking account of how their lead partner's role might change if they were to pursue this route.

Leaving a legacy

Several sites had indicated in bid documents and during fieldwork that the structures they sought to devise were intended to leave a legacy whereby partnerships and

networks would become self-sustaining and require less funding than that provided by the BLF. In one LA-led HLC, continuation funding for project staff was being considered, although no future funding would be given to projects. Options for future funding for projects would be sought through the network of agencies that had been established. A second LA-led HLC had initially considered that, through building community capacity, project co-ordinators would be gradually phased out and operations would become self-sustaining. Latterly, this site determined that project co-ordinator support would be necessary beyond BLF funding in order to maintain the support offered in building community capacity and to help establish new projects and services, as illustrated in the following quotation:

"I'm conscious that, that we need to leave a legacy in terms of the community capacity side of things but I think you would lose a lot if you didn't have these individuals [project co-ordinators]..." (Chair of the Board, site 1)

In conjunction with seeking the continuation of support provided by HLC co-ordinators, there was recognition of the continuing administrative support required to sustain HLCs' work and that this was a major factor when seeking long-term sustainability.

Strategic positioning: allies for the future

At the completion of fieldwork, many case-study HLC project co-ordinators were still determining the strategic position to adopt to aid sustainability discussions. Several forms of strategic positioning with partners and potential funders were evident. First, two community-led and one NHS-led site were attempting to reflect the needs of core funding organisations through developing more concrete links. The project manager in site 5 discussed how she was:

"...keen to nurture the whole statutory agency-side partnership work and certainly in the Trust side, is that if they do see us as a resource, we're just going to be so good in five years' time, they can't say no to us." (Project manager, site 5)

However, while the importance of strategic positioning with funders was recognised, HLCs had to continue to meet local needs. In several sites, funding partners were considered to operate with dominant agendas that did not always co-exist with the needs of all the communities targeted by HLCs. This raised central challenges for future continuation of some projects, as shown in the following quotation:

"Are we planning for the future because of the directives that are coming down and being dictated by the powers that be, or are we planning for the future [based] on the needs of the community we work with? There has to be an element of both." (Project manager, site 3)

Second, sample HLCs have been operating during a period of intense change among statutory service providers and during the establishment of organisations which will have control of funding at local level (e.g. community planning partnerships and community health partnerships). At the outset of the evaluation, several managers indicated that they sought to locate the HLC strategically to attract funding whenever new structures are finalised. Several sites had direct representation (via manager and lead partner line managers) within partnerships devising community planning structures and community health partnership planning groups. Voluntary-led sites had little input to these processes. In the near future it is likely that community planning structures will lead to the streamlining of partnerships, although the impact of this on HLCs operating in areas with existing community health organisations is unknown. Ongoing developments within both community planning and community

health partnerships will have an impact on HLCs' partnership development and on future funding streams. Maintaining an input to these structures was discussed as follows:

"...I try and stay involved in the community planning partnership stuff and the community health partnerships because, at the other end, we could be *the* organisation. Because both of those streams, which almost all of government policy seems to be linking into, all end up coming down to a locality group with decisions being made with local involvement, and, if there was, in terms of health and wellbeing, a group, [...] we have all those people around the table already." (Project manager, from non-case-study HLC)

Thirdly, a number of HLCs within particular regions, including Edinburgh/Lothian, Glasgow and Argyll and Bute, have developed manager networks to discuss issues such as sustainability and to further the community health agenda.

Networking and useful contacts

At the conclusion to fieldwork, sites 3 and 6 (voluntary and community-led) were engaged in opportunistic meetings with key personnel in local councils who had expressed an interest in the HLC or who were considered to have knowledge or access to information which could enhance sustainability. In both sites, concerns had been raised about the future autonomy of the HLC if they were to seek continuation funding from such sources.

3.5.3 Potential routes to sustainability

Although multiple options were being explored by sample HLCs at the conclusion to fieldwork, few definitive mechanisms for ensuring sustainability beyond the initial funding period had been identified. While raising questions about the timing of work to sustain operations, managers across the sample did identify several aspects of work which had been undertaken by HLCs when attempting to continue HLC operations in the longer term.

Raising awareness of achievements

Each site had undertaken work to increase the profile of the HLC among service-users, partner organisations and local communities. The level at which HLCs sought to raise their profile sometimes depended upon the target group, as focused attention was considered off-putting for certain hard-to-reach groups (e.g. socially excluded young people). Profile raising measures were felt to have influence at different levels within each HLC. Statutory-led HLCs often sought to raise awareness within their lead partner organisations in order to become included in future budgetary discussions. Profile raising was considered by each site to increase external attention to its efforts and HLC stakeholders were often vocal in promoting the achievements of innovative projects, which were considered useful in attracting the attention of key decision-makers within lead organisations and external funders.

At the commencement of operations each site had devised a logo and many gave away items such as pens, key-rings, badges and t-shirts to users, partners and community groups. Many sample HLCs used local media outlets (both newspapers and news-sheets in remote areas) to promote a healthy living message and also to further enhance the HLC profile. Some HLC project co-ordinators were particularly adept at using local media press releases and in one instance a local magazine article to promote their work among wider audiences. Within local communities, several sites had organised health 'taster' events where a number of services and activities would be demonstrated and offered. Conference-style events within target areas and travelling roadshows to outlying communities were used to enhance public profiles further. One HLC had also achieved recognition through an award scheme

run by a partner organisation and was seeking nomination for a national award scheme. Further dissemination at health-based conferences was used to focus attention on certain HLC services.

While HLCs typically sought to promote awareness of the achievements of innovative projects, some went further, actively lobbying at a national level to gain funds for small projects. In site 4, for example, the project worker made direct links with the Scottish Executive Food and Health Co-ordinator and obtained funds for a small innovative project conducting healthy food tasters with a national food retailer. Another project worker lobbied to become a pilot site for a new national initiative on mental health (mental health first aid training).

Reviewing the needs of target groups

During fieldwork, the majority of the HLCs were giving consideration, through monitoring and evaluation (see section 3.6), to the services that were currently being delivered and would be required in the future to meet the needs of target groups. Changing demographic characteristics of groups, newly created organisations and services, and unmet needs from initial service provision had led to uncertainty regarding the continuation of existing activities and the development of new services. This state of flux was characterised as follows:

"So I actually have problems getting my head around where it's going to be in another three years' time, 'cause it is this changing animal." (Partner, site 2)

Two sites, which had developed separate projects in different geographic areas, were involved in transferring best practice between locations. This was a feature of the services and activities already delivered at this site and was also discussed in terms of future long-term sustainability. Time-limited, externally funded services in one site were also being reviewed in terms of the changing needs of the local population and the likelihood of obtaining funding to continue existing services (see below).

Rationalisation of HLCs' operations

Several sites were considering how HLC operations might be rationalised in any future permutation of the organisation. In one site, mechanisms to sustain operations beyond BLF funding had to take into account additions that had been made to the HLC portfolio of projects through the provision of external funding. The termination of project funding had already led to the discontinuation of some services. Stakeholders within two further sites indicated that the HLC workload was such that projects needed to be downsized in scope and to take into account changing needs within target groups.

In HLCs which had established projects to build community capacity and to create networks of community organisations, consideration was being given as to how an HLC could continue to operate with reduced funding. As a result fewer staff resources and workplaces might be required to continue the work that had been developed.

Resource implications: finding time and mobilising partners

The structure of each HLC created different opportunities for managers and key partners to engage in strategic work to examine sustainability options. Paradoxically, as a result of a lack of time among partners, coupled with successful service delivery by the HLC, some partners were considered to have a reduced perception of need of external inputs, and several sites had difficulty in engaging partners in discussions

about sustainability. In addition, several managers indicated that their working remits were such that they found it difficult to balance operational and strategic demands. In sites with limited numbers of staff, managers had to balance the need to deliver services with the need to seek continuation of services beyond BLF funding, as the following quotation illustrates:

"...and you might have to give up service delivery to do it [strategic work] and if you're asking people who are passionately committed and driven to help service users and clients who are very very vulnerable, they will always work with the client." (Partner, site 6)

The experience gained from establishing HLC services and activities led some managers to suggest refinements that could be made to future bidding processes for community health initiatives. Community-led sites indicated that laws relating to charities made it necessary for them to hold a surplus of funds. Other sites also suggested that permitting cash reserves to be held would assist in covering staff absences (e.g. maternity leave or illness).

Continuation versus 'new' funding: "we can't do 'new' forever"

Multiple stakeholders within case-study sites suggested that initiatives such as the HLC programme should not be established without greater consideration given by funders and funders' sponsors to long-term sustainability. Although HLCs were required to outline mechanisms to sustain operations beyond BLF funding, several partners suggested that large funding grants should only be given with greater provision of support for continuation of projects that have met their objectives and where need is still evident. One partner commented:

"Sustainability as well, if the Scottish Executive keep asking us to create new initiatives all the time, which has been the case for years recently, we can't do new forever. Okay, that's a good initiative, it's a new initiative but some things are really good and we could lose the really good stuff by encouraging folk to think new, new and new all the time." (Partner, site 2)

In several instances, HLC managers and partners indicated that strategic thinking should be applied by funding bodies to develop programmes where there are options to continue to receive funding following the expiry of initial grants. A partner in site 6 commented:

"There needs to be some sort of strategic thinking about what works, what needs to be funded beyond a programme so its not just a funding programme, five years, then walk away from that. It just seems to be daft, plain daft." (Partner, site 6)

One manager suggested that greater understanding by funders should be given to the long-term issues being addressed by HLCs, as many sites find it difficult to identify major improvements in health amongst target groups over the lifecourse of BLF funding.

"...I think there's an ethical issue about you setting up programmes which are about lifestyle change and short term funding them, when to show some of the behavioural changes that your programme has set out, won't be in five years, it won't be in ten years, it'll be in fifteen years' time." (Project manager, site 4)

Several partners and HLC managers noted that large funding packages obtained by HLCs were rare and could only be made by the Scottish Executive or large statutory organisations such as the NHS or LAs.

Key learning points

- When seeking to mainstream projects, a number of features need to be taken into account, including: additional and changing projects, attracting hard-to-reach groups, and maintaining a coherent identity for the HLC.
- HLCs seeking sustainability through becoming constituted should exercise caution. Although creating new funding opportunities, the onus for service delivery is placed on voluntary bodies and could result in a loss of statutory agency support.
- A central challenge in sustaining operations is to combine meeting the strategic aims of funding partners with meeting the needs of local communities. These needs may be in conflict.
- Several HLCs have become involved with working groups established to devise new structures and mechanisms for planning and delivering services within local communities, e.g. community planning, community health partnerships. At present it is unclear how these strategic discussions have aided HLCs.
- Profile-raising work seeks to create a brand image among partners and potential funders although it is as yet unclear what impact this will have.
- Sustainable HLC operations will need to review target group needs and take into account resource implications and possible rationalisation of activities.
- Several sites suggest that funding bodies should recognise their 'duty of care' when devising funding strategies in order to provide continuing resources for successful projects where need remains.

3.6 Monitoring and evaluating HLCs

3.6.1 Introduction

One of the aims of this process evaluation was to identify the links between the aims, activities, outputs and outcomes of the HLC. The evaluation was informed by theory-based approaches to evaluation, such as realistic evaluation and theories of change, although we did not use these approaches explicitly. These approaches to evaluation were developed in response to the challenges posed by complex community-based initiatives, which are characterised by the use of multiple tools to tackle a longer term aim. As we have indicated earlier, HLCs have used a variety of approaches to attract people to use innovative services. For example, site 1 has focused upon specific segments of the community such as the over 40s, and women with dependent children. Within each workstream many projects operate, including cooking on a budget, education programmes for parents with children, support with stress, and opportunities for exercise. HLCs have also, explicitly and implicitly, drawn from many different models of health (social, radical and biomedical). As a result, the evaluation of the HLC as a whole becomes extremely challenging.

3.6.2 HLCs' approach to evaluation

The HLCs' approach to evaluation was studied by examining the original BLF documentation (to identify how evaluation had been prioritised by the funders), the first and second stage bids, and monitoring information; and by interviewing key informants in case-study HLCs about the practical implementation of evaluation plans.

The BLF used several assessment criteria in order to make funding decisions. The presence/quality of proposed evaluation was not one of these criteria, although HLCs were asked to report on their monitoring and evaluation plans in supplementary information. The BLF stated that they would develop a monitoring system which would be linked to the release of funds. The monitoring system would focus on developing indicators of success and progress, and documenting activity levels. As such, a 'top down' system of monitoring was proposed, where the indicators are developed centrally by the funding agency with little or no input from the HLCs themselves. Moreover, interviews with project managers and analysis of the quarterly monitoring returns indicate that performance management, rather than learning from the process of developing and implementing HLCs, has been the main focus.

The BLF did, however, offer some support for evaluation. HLCs were encouraged to take up training on the Learning, Evaluation and Planning (LEAP) model of evaluation. LEAP is a practical toolkit for integrating planning and evaluation, targeted at community-based groups implementing complex initiatives. LEAP is promoted by the Scottish Centre for Community Development (SCDC) and is supported through a network of local consultants who may be commissioned to provide training and/or guidance through the LEAP process.

LEAP suggests that

"Evaluation and planning are two sides of the same coin. In order to evaluate we need a clear plan and plans are more effective when they are informed by good evaluation."²

Proposals from successful HLCs did not emphasise evaluation, and plans that were presented were rather sketchy. Given the lack of emphasis on evaluation in the original invitation to bid, this is not surprising. When HLC managers and staff were interviewed they were able to provide only limited information about the aims of evaluation and the methods that would be used. Some HLCs mentioned that they would use existing statistics or surveys but specific details were rarely given. Initial fieldwork with some HLCs suggested a certain confusion about the language of evaluation. For example, measures reported as outcomes (e.g. numbers attending events) were in fact outputs. (An outcome would have been a measure of the impact of attendance, e.g. quitting among cigarette smokers following delivery of smoking cessation services.) In other plans the links between aims, activities, outputs and outcomes were unclear or not articulated. More specific examples follow later in this section.

The monitoring information submitted to the BLF was lengthy, but, in line with their own requirements, focused on quantitative output information. However, in practice, the majority of HLCs reported a dissatisfaction with the focus on numbers rather than processes, as one respondent told us:

"[The] project is not about numbers and community development work is not about numbers and numbers don't always mean that you have achieved. They

² http://www.scdc.org.uk/leap_index.htm

may be good for some things but health inequalities is about sustaining much more subtle changes.” (Project worker, site 1)

The interviews provided greater illumination of the picture that was starting to emerge, namely that at set-up HLCs had sparse plans for local evaluation that would require much more detailed attention during the years ahead. (A major exception was site 1, which employed an external evaluator from the outset of service delivery. It should also be noted that site 5 commissioned an evaluation after the mid-point of the BLF funding period.) The main problem, which is indeed common to many complex but short term health interventions, appeared to be identifying appropriate outcomes from the work that was conducted. As a consequence, some HLCs focused on outputs rather than outcomes, while others identified outcomes that were unlikely to give an adequate assessment of the progress of their projects.

3.6.3 Common problems in evaluation

Based on data collected during fieldwork we can identify output focused HLCs which had clear aims and specified activities but were not successfully differentiating between short- and medium-term goals, outputs and outcomes. For example, site 6 aimed (amongst other things) to improve the sexual health of young socially excluded adults. The HLC evaluated this aspect of its work by counting the number of people involved in activities, the range of activities offered, the number of users involved in planning the event and the geographical spread of users. However, these are output measures rather than indicators of outcomes; none will identify if the HLC is moving towards its long-term aims. Although this HLC was undoubtedly interested in showing its effectiveness, it did not have in place the appropriate mix of qualitative and quantitative measures which might have enabled this to take place. An alternative evaluation plan for this service might be presented as follows:

For example:

<i>Aim</i>	To improve the sexual health of young socially excluded adults
<i>Activities</i>	Run a series of workshops on positive sexual health Offer free Chlamydia testing kits Provide free condoms Provide free pregnancy testing kits
<i>Outputs</i>	Number attending sessions Number of condoms provided Number of pregnancy/Chlamydia testing kits Number of users involved in planning the event Geographical spread of users
<i>Intermediate outcomes</i>	Young people feel more able to negotiate safe sexual practices Young people report using condoms more frequently
<i>Long-term outcomes</i>	Reduction in unplanned pregnancy in this group Reduction in sexually transmitted disease in the group

While it is possible, albeit unlikely, that an HLC could achieve these outcomes within a five year funding period, evidence of progress towards the intermediate outcomes would be expected to be demonstrated. Certainly, quantifiable data relating to intermediate outcomes would give a clearer indication of the successful direction of the project than examining outputs alone.

However, it is important to acknowledge the constraints of context. Site 6, for example, experienced a number of barriers to implementing evaluation plans. Its users were particularly vulnerable socially excluded young people who have had poor experience of statutory agencies. The users did not want to have information recorded about them.

“We don’t ask people to give profiles of themselves before we let them through the door. We know very little about people. We don’t have any case notes on anybody, we want to encourage people to attend.” (Project manager, site 6)

It is understandable that, given the challenges of their target population, project workers at this site were keen to use evaluation to identify projects that were interesting and enjoyable rather than measuring the benefits associated with attendance.

“We’ll use the last session as like pure evaluation and kind of go through, we’ve had five weeks, what did you enjoy about that and what was crap?” (Project worker, site 6)

Another practical barrier to effective evaluation was discussed by respondents in site 5 who indicated that evaluation had been difficult to implement as it was an unfamiliar process.

“I think the biggest difficulty I’ve had is with the planning and evaluation and having to actually show people my planning and evaluation because where I was working before I was just told ‘Do this and get on with it’. It was up and running and it all seemed to be fine.” (Project worker, site 5)

Thus, some HLC staff have experienced a number of difficulties in implementing evaluation strategies that will identify outcomes because they are essentially very skilled project workers and are unfamiliar with the culture of evaluation; they focus evaluation on learning how to make projects more user-friendly and enjoyable. Their difficulties are compounded by the unwillingness of some users to provide personal information about themselves.

More pragmatic approaches to evaluation were observed in some HLCs where they had clear aims, specified activities and clear outcomes, but the outcomes did not appear to be logically related to the activities that were being implemented. For example, site 4 aimed to reduce the risk of cancer and heart disease by increasing the amount of fresh fruit and vegetables eaten. They chose to do this by encouraging local cafes to sell and promote healthy food, promote fresh fruit and vegetables to be stocked in local supermarkets, and provide cooking courses. They identified outputs, including the number of activities offered and the number of people participating in projects. The outcome adopted by the HLC was a change in diet at a community level, measured by a local lifestyle survey that was repeated every five years. This was chosen for pragmatic reasons: the HLC had a baseline measure relating to an area that matched the boundary of the HLC. The fieldwork showed that there were implicit problems with this evaluation approach as the HLC was working with a subset of the population, individuals who used their facilities/resources, rather than the whole community. To use a community-based outcome measure assumes a diffusion effect, whereby individuals are responding to the work of the HLC by spreading messages or behavioural models, and that behaviours in the wider community are changing as a result. Another problem in taking this approach was that the local area was undergoing major regeneration, with the main tenure pattern changing from social housing to owner occupation. Thus, the characteristics of the

population were changing over the five-year period that the HLC would operate. This makes a community-based measure of outcome rather inappropriate, since the pre- and post-intervention communities would not be comparable. It would have been more appropriate to examine outcomes by identifying the changes (if any) in the diets of those involved in the activities run by the HLC over a follow-up (e.g. six month) period.

3.6.4 Common factors which helped facilitate local evaluation

Sites 1 and 2 are examples of HLCs that have been able to identify and link aims, activities, outputs and outcomes. However, it is important to note that these sites had set realistic limits from the outset regarding what the HLC could achieve. For example, in its bid document site 2 stated: “We are unlikely to show directly that our aim of improving health amongst those experiencing economic disadvantage has been achieved. Instead we will build a picture to indicate its progress in achieving our aims by measuring outputs and outcomes.” The HLC achieved this aim by training all projects in receipt of funding in the LEAP cycle, as was the case with some other HLCs. They also purchased continued support from local consultants to enable projects to complete the evaluation. This HLC was divided into three workstreams relating to income maximisation, parenting and life skills. The following is an example of one of these workstreams:

<i>Aim</i>	To ensure people in <<name of city>> achieve maximum income
<i>Activities</i>	Establishing and promoting credit unions Providing energy advice through existing agencies Providing benefits advice
<i>Outputs</i>	100 new people to join credit unions 500 people will receive energy advice 5 volunteers will be recruited and trained 1000 people will receive benefits advice
<i>Outcomes</i>	500 people with extra cash £250,000 of debt being tackled

The LEAP process helped local practitioners to decide what information to collect and to incorporate learning into the planning and refinement of the initiative. The HLC was able to identify tangible and specific measures for its work on poverty alleviation. However, the measures are quantitative and the place of qualitative information was still to be considered. In order to understand further how this project might, in practice, be having an impact on disadvantage, recipients could be tracked and the impact of additional income on household spending might be measured. However, such information was not required by the BLF. Further, the resource implications for tracking individuals over the long term are considerable.

3.6.5 Further practical challenges for local evaluation

Site 2 found LEAP to be a useful way of developing a local evaluation system, which was implemented not just in the HLC, but across the area for all monitoring and reporting purposes. This enabled projects to deliver monitoring information to different funding agencies in a consistent way. As one respondent said:

“I think the fact that everybody was reporting basically in the same way helped to kind of pull that together. So it was actually quite useful.” (Project worker, site 2)

However, some HLCs still experienced difficulties responding to multiple requests for monitoring information, as the project manager in site 4 told us:

"We could potentially be monitored by the SIP, the Health Board and the LHCC. The reality at the moment is that we are only be monitored by NOF and the SIP. SIP have a totally different monitoring system. I have raised this at <<name>> City Partnership, that we should have some form of core monitoring and evaluation." (Project Manager, site 4)

Crucially, many HLCs felt that the BLF's emphasis on quantitative information did not provide a true picture of the work that was being done and was easy to manipulate. As one project manager told us:

"You could run an event where you could run it with the local primary school and get 500 children quite easily, but... if we look at our counselling, a counsellor can only counsel two and half days a week and it's three people a day, we may counsel 15 people a week. Now does that mean that's different from running an aerobics class where you get thirty people?" (Project manager, site 4)

Respondents in site 3 told us about the difficulty in obtaining quantitative information for each contact the HLC made, for example:

"People come to the fruit barrow and we ask age and postcode, they think we're the Spanish Inquisition, and we're suppose to take their ages as well....some of them think 'oh why bother'." (Project worker, site 3)

In addition to LEAP, HLCs mentioned other models of evaluation that they had used, such as ABCD and Pathways to Change. While site 2 had found LEAP a useful tool to streamline its evaluation plans and help projects identify outcomes, other HLCs had experienced some difficulty with the model, as this conversation between two project workers illustrates:

Project worker 1 "Everyone is scared of LEAP, everyone is petrified"
Project worker 2 "I know nothing about LEAP"
Project worker 1 "You don't want to no... its just not clear enough, do you know what I mean?"
(Conversation between two project workers, site 3)

Key learning points

- BLF has prioritised monitoring and performance management of HLCs over learning and evaluation.
- At the outset, the majority of HLCs had sparse evaluation plans which required support, particularly in the development of demonstrable potential outcomes.
- We have been able to identify some common theoretical issues which hampered HLCs' attempts at local evaluation, including some misunderstanding of the terms of evaluation and identifying some outcomes that are not directly related to activities.
- We identified two HLCs that had developed clear, focused plans for local evaluation. One of these had secured training in the LEAP model, which had been a helpful tool in introducing evaluation terms to project workers. Both had the benefit of additional help for evaluation from local consultants skilled in quantitative and qualitative methods.
- We observed some practical barriers to evaluation, such as multiple requests for monitoring information from a variety of funders which overburdened project managers, a view that collecting data for evaluation was overly invasive, and project workers feeling the need for continued support with evaluation methods and systems.
- At this stage of its development it is not possible to indicate the success of the HLC initiative: local evaluation and potential for learning has not received sufficient focus.

4. DISCUSSION: LEARNING FROM HLCs

4.1 Introduction

The main aim of the study was to explore the pathways between activities, processes, contexts and outcomes in a purposive sample of HLC projects, using a longitudinal research design. Within this framework the project outlined three main sets of research questions, relating to objectives and outcomes, context, and processes and explanations of change. In this section of the final report we briefly discuss the study findings relating to these main questions, propose some overarching learning for policy and practice, and consider implications for future research.

4.2 Objectives and outcomes

It is of considerable interest to know whether HLC projects met the objectives, and whether there was evidence of anticipated and unanticipated outcomes. Other subsidiary questions for the evaluation included: How have objectives and outcomes been decided, and how do they change over time? Is there common ownership and understanding of these outcomes among stakeholders? Have HLCs demonstrated success with respect to commitment to community consultation and partnership working?

Answers to these questions may be found within the earlier sections of this report (and in earlier reports) on monitoring and evaluation. In summary, it was found that there was no emphasis upon evaluation at the bidding stage and that BLF did not provide support for evaluation activities; performance management tended to be prioritised over local learning. This posed considerable difficulties for HLCs seeking to provide evidence of their impacts on individuals and communities, one prerequisite for demonstrating success and perhaps obtaining further funding. Lack of expertise and knowledge of evaluation among the HLCs, combined with a lack of local ring-fenced funds available for evaluation, compounded these difficulties. (Exceptions were site 1, which had ring-fenced £3k pa for local evaluation activity, and site 5, which had set aside money for interim evaluation.) Unsurprisingly, therefore, HLC evaluation plans were not well constructed, and the outcomes of their activities were difficult to conceptualise, identify, and measure by the staff themselves. In the face of such difficulties, HLCs instead tended to focus on measuring and reporting *activities* and *intermediate outcomes* which they theorised would indicate subsequent impacts on health.

This approach can be illustrated with respect to health inequalities. HLCs were very often able to demonstrate how they were successful in targeting services at the most socially excluded; this was often achieved by adopting a highly flexible approach in which the means of targeting varied according to user group and location. Food was very often used as a means of attracting users – and often as a means of drawing the target group into using other services. However (as for many such interventions in the non-HLC world), the actual impacts on health outcomes, and on health inequalities in particular, were most often impossible to demonstrate. One is left then with undeniable evidence of success in achieving some intermediate outcomes – in particular, success in targeting excluded populations – but with a lack of clarity regarding HLCs' effects on health and other outcomes.

There is a further difficulty with describing how HLCs impacted on health inequalities. For HLCs, addressing inequalities was largely synonymous with targeting services at particular groups. Quite understandably; however, there is no way of knowing what impact, if any, this has on health *inequalities*. HLCs could be highly successful in accessing their preferred users, while inequalities simultaneously continued to

increase. It is probably impossible for HLCs to measure their effects on local health inequalities, and unrealistic to expect them to do so.

One further problem inherent in identifying effects of interventions delivered to communities (or areas) is that the numbers affected by those activities are often unmeasured, the denominator is often unknown, and data about the effects on individuals are often uncollected. So it proved here; identifying and tracking individuals was difficult, if not impossible, for HLCs, who were often working with limited evaluation expertise and resources. Although some invested considerably in evaluation, for the majority the LEAP evaluation tool did not fill the gap. The inevitable result of the lack of support for evaluation – and a greater emphasis on monitoring than on measuring change in health – is an absence of evidence on outcomes.

However, while there are difficulties in determining the impact of the overall programme, there are good reasons for believing that HLCs do make an important contribution to the communities in which they are located. They have adopted novel and successful approaches to reaching excluded groups and achieving their social inclusion goals of the HLC programme. Unpublished quantitative data from the wider HLC evaluation conducted by the Bridge Consortium suggest that HLCs have been successful in their targeting activities; contrary to some expectations, HLC services have not been taken up by those who need them least, but are located in the poorest areas, and are used by the section of the community who are in the poorest health. This is indirect evidence of HLC success: HLCs are targeted appropriately, and are reaching those with greatest capacity to benefit from their services, and in this respect make an important contribution to their communities. The final links to health and health inequalities outcomes remain elusive, as for many other complex, area-based initiatives. To HLCs this is probably not perceived as a problem, as they consider that they are just one element of a much broader strategy for tackling health inequalities.

4.3 HLC contexts

This evaluation of the HLC programme aimed to explore the *context* within which the project was operating; the available resources and capacities within the community, and the constraints and challenges which they had to face. It also seemed crucial to recognise the other local influences (economic, cultural, historical, and environmental) on community health status and well-being, and to identify the key stakeholders involved in the initiation, planning, development, use and evaluation of the project. Part of this context also includes the HLCs' understandings of the aims and intentions of the HLC programme, and how they expected to achieve their objectives.

Many of the answers to these questions are found in section 3.1 above. Perhaps the most obvious aspect of context, the social and economic history of the HLC area, was discussed in a previous report (*Year Two Progress Report*, Section 3.5, March 2004). However, the past 'regeneration history' of an area also affected HLC success in some cases. It may be assumed that the overlaying or targeting of poorer areas with multiple initiatives (such as SIPs and HLCs) would have major benefits; for example, through increasing the availability of services or the 'intensity' of delivery of those services. It is clear, however, that this is not always the case. For some, the existence of previous regeneration activities counteracted the potential influence of the HLC; most obviously, the continued existence of social problems, despite earlier regeneration programmes, was sometimes taken as proof of their ineffectiveness, and made it more difficult to engage the local community in the HLC's work.

This is not an argument against targeting poorer areas, but it does suggest that 'regeneration fatigue' among recipient communities may sometimes make it difficult to engage and maintain community interest in such activities. It can also make a positive difference: new initiatives can piggy-back on existing ones, and use existing partnerships for support. This was evident in some of the HLCs in this study and would seem to be a basic prerequisite for the success of future interventions of this type.

The HLC staff themselves are part of the context. In one form or another the capacity and skills of HLC staff were found to be of considerable importance to the perceived success of the HLC. With large and ambitious remits, and continuing pressure on HLCs to innovate, project management was sometimes difficult, and clear leadership became particularly important. Overload on staff was, however, frequent, particularly when staff turnover was rapid, and training opportunities were too often seen as limited. These demands and needs are reflected clearly in the learning points at the end of section 3.1.

4.4 Processes and outcomes, and explanations of change

This evaluation sought to understand the *processes* by which intended outcomes were to be achieved, and how these processes might change over time. However, HLCs were frequently unable to describe a clear pathway between aims, objectives, projects, expected outcomes and actual outcomes. Typically, they had considerable difficulty in identifying the outcomes that their activities were intended to achieve. Even where outcomes could be stated, they were rarely being measured (or measurable). It is therefore not surprising that HLCs struggled to articulate how they understood the linkages between activities, processes, contexts and outcomes. The search for alternative, plausible explanations of successful outcomes was equally uncommon. A straightforward association between intervention, activity and beneficial outcome was most often assumed or implied, as is often the case for many public health or other social interventions. This may even (in some cases) be an accurate reflection of the relationships in question, but is not testable using the existing data.

4.5 Working with users

While HLCs generally could not be sure about their impact on health inequalities, they could often be clear about their effects on particular communities, and within this evaluation there are considerable individual success stories in reaching out to communities. This 'outreach' often appeared most effective when local people themselves were sourced as employees and were recruited as expert advisors and committee members, although this posed considerable difficulties, and engagement of local communities remains an ongoing challenge. There are still few answers as to the most effective means of approaching this problem. All HLCs struggled to some extent to involve users while avoiding tokenism. The examples given by HLCs show a gradient from one-to-one consultations with unpaid, untrained users, progressing to greater involvement, such as offering peer support to other users, committee work, up to fully-paid training 'apprenticeship' of the lay health workers.

Lessons on involving the public could usefully be derived from other completed projects. "Designed to Involve", an Executive-funded project to support the development of public involvement in primary care, provides clear guidance on how public involvement can be supported, and while its focus is on primary care, its messages have a practical relevance to the delivery of non-NHS services. It also provides practical tools to allow projects to assess whether their activities are in accordance with existing "best practice". The new National Standards on Community Engagement, however, probably provide the most relevant framework aiming to promote better working relationships between communities and agencies delivering

public services. These standards include performance standards that can be used by bodies involved in community engagement to improve the quality and process of the engagement, and set out key principles, behaviours and practical measures that underpin effective engagement³. These would undoubtedly have been of considerable help to new HLCs.

4.6 Conclusions

Much of the above discussion has concentrated on the lack of evidence on impacts. However, there are positive lessons for the implementation of similar initiatives. Most of these are captured in the earlier learning points. There are lessons, for example, about how staff need to be trained and supported, and about what their expectations should be regarding 'HLC success'. There are particularly clear messages about the formation and maintenance of useful working partnerships, and pointers to some of the funding potholes to avoid in the pursuit of sustainability. There are particular lessons for the evaluation of the impacts of future similar interventions, and how such evaluations should be supported.

The findings outlined in this report are not inconsistent with those from other evaluations of area-based initiatives. For example, the conclusions of the 2003 ODPM 'Review of Area-Based Initiatives' (which covered HAZs, Sure Start, Education Action Zones, and other initiatives) emphasized the problems of bureaucracy and the burden this places on projects, and in particular the problems posed by inconsistent monitoring systems⁴. These were also common themes from this HLC evaluation. The comments regarding the difficulty of determining outcomes from this project also has some resonances with the report of the Evaluation Task Group Review of the Demonstration Projects⁵. This report spoke of "*the reluctance of academic researchers to engage in the evaluation of complex community initiatives ...largely related to their lack of involvement at an early stage in the intervention development process, the poor evidence basis of the initiatives, and their low evaluability*". In the current example, the HLC programme did not consist of one single intervention but a wide range of novel interventions, with much variability in how superficially similar interventions were delivered, to very different populations in different geographical locations. There was no opportunity for the research team to be involved in the development of the projects, and the evidence base for particular interventions was not clear. Given the HLC programme's emphasis on tailoring existing interventions and on innovation, the existing evidence – where it existed – may not in any case have been generalisable to HLC settings.

In such situations, theory-based evaluations hold great promise for understanding what effects projects have had, and how they may have been achieved, but considerable extrapolation from the data is required in order to claim actual effects on health. The plausibility of such claims is, however, increased if there is a clear *a priori* theory of change, if logical intermediate outcomes have been achieved (such as effective targeting), and if the process evaluation can assess the plausibility of those claims – for example, by including the perspectives of different stakeholders, and by an objective and independent assessment of both negative and positive impacts.

One outstanding issue remains a challenge for researchers and practitioners alike. Too little is known about the most effective ways to engage and maintain the interest and commitment of communities in planning services (or indeed in planning research), though examples of 'best practice' are available (see Learning Points,

³ <http://www.communityplanning.org.uk/>

⁴ <http://www.rcu.gov.uk/abi/whatsnew/impactsandoutcomes.pdf>

⁵ <http://www.scotland.gov.uk/Publications/2005/04/07105005/50195>

below). This message comes from the current evaluation and from other evaluations in which the research team has been involved, suggesting that there is an urgent need to identify, summarise, evaluate and disseminate best practice for engaging members of the public. Some of these issues will be a subject for future research and analysis in this project.

Final learning points for practitioners

- Be realistic in the amount of time that it will take to establish an HLC, either from the expansion of an existing project or through the genesis of a new project. It may in some cases be possible to employ key staff in advance of the main funding provision – although this course of action involves the risk that the project does not eventually go ahead. Plan in advance for the need to fill vacancies due to illness, maternity leave, etc. Seek managerial support from partners at the outset and make sure that reporting chains for projects are clear and agreed with staff. Identify training needs early on, and seek adequate resources.
- Activities to promote user engagement should follow current guidelines on best practice, such as the *National Standards on Community Engagement*.
- Relationships with stakeholders and partners can be changed over time if necessary. However, it is important that all stakeholders know their responsibilities, and that suitable agreements are in place early on. Ensure clarity of purpose (of programmes and projects) which is known to, and agreed by, all stakeholders.
- Limited consideration had been given by most HLCs to sustainability beyond BLF funding. This is where HLCs could usefully draw on the experience of staff, management, local people, and partners at an early stage in the lifespan of the project, to ensure that HLC plans are abreast of current policy and funding patterns.
- HLCs seeking sustainability through becoming constituted should exercise caution. Although creating new funding opportunities, the onus for service delivery is placed on voluntary bodies and could result in a loss of statutory agency support.

Final learning points for policy makers/funders

- New projects should be encouraged to be realistic in the amount of time that it will take them to become established, and in terms of what can be achieved. From this evaluation it was clear that capacity can be stretched when working with vulnerable groups, and across large geographic areas.
- Resources should be made available for training and managerial support, or to ensure that this support is forthcoming from lead and other partners.
- It should be recognised that there is often a need to make changes to workplans during the course of the programme. Local contexts evolve and local needs change over the course of bidding and delivery of operations.
- Evaluation is important, but 'evaluation' is frequently poorly understood and poorly conducted, and, as in the majority of regeneration and area-based initiatives in the UK, monitoring and performance management tends to take precedence over outcome evaluation. Expectations that evaluation takes place, and that outcomes are identifiable, are unlikely to be realised unless concrete support is provided to those delivering the intervention (as is being done by BLF under the recent development and support contract). This could involve ring-fenced resources for internal (self) evaluations, and support structures (including training). (An example of local ring-fencing was found in site 1.)
- Funders should consider what indicators of health impacts are most appropriate for each project; in some cases, outcome assessment will be feasible and appropriate; in many others alternatives will need to be sought. In these cases projects should be required to specify clearly the nature and scale of the intermediate outcomes they expect to attain, and how they relate to final health outcomes.
- This can/should mean considerable investment in training, support, and resources for evaluation activities. Current models place the onus to evaluate on HLCs, which struggle to cope, and find it impossible to demonstrate actual health outcomes – which are largely unmeasurable within the lifespan of the projects. Similarly, the range and purpose of HLC activities and their effects are not well captured by current quantitative output monitoring systems.
- Many poorer urban areas in the UK have now considerable experience of the roll-out of short-term area-based projects, where early apparent success is followed by cessation of funding and withdrawal of the same initiatives. Consideration should be given by funding bodies to providing continuation funding for successful projects where unmet need remains.

Implications for research

- Future evaluations need routinely to explore with practitioners the theories of change within which their projects are implemented or services delivered. Without understanding these, it may prove impossible to grasp the rationale for project activities, and impossible to understand or measure success.
- Within this framework researchers need to identify a range of relevant intermediate outcome measures which indicate that projects are progressing towards their outcomes. Success in targeting services should be one of these outcomes, but the systematic collection of data on other relevant intermediate outcomes (consistent with the intervention's logic model) should be prioritised.
- Evaluations should attempt to capture the indirect benefits of the intervention – such as capacity building, training of users, employment, and other benefits (or otherwise) reported by volunteers.

5. NEXT STEPS: PHASE 2 OF THE EVALUATION

5.1 Introduction

Three members of the consortium (Stephen Platt, Kathryn Backett-Milburn and David Rankin) have been commissioned by the Scottish Executive and NHS Health Scotland to extend the evaluation into a second phase, covering the period 2005-2007. Details about this phase are given below.

5.2 Aims and objectives

The study has 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 more specific 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.

5.3 Research questions

The main research questions being addressed in phase 2 are as follows:

- 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?

5.4 Research plan

The proposed study will employ a longitudinal, observational design. The sample will comprise approximately 30 key participants drawn from six HLC case study sites which form the sample of the current 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. The research team 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.

There will be four components to the study: analysis of documents provided by participating HLCs; individual in-depth interviews with each key stakeholder (both in the HLCs and in the wider health environment); observation of HLC activities, internal HLC board, partnership and staff meetings; and telephone communication with key individuals (usually project co-ordinators and lead partners) to ensure that developments are tracked and recorded as they take place. 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).

APPENDIX 1 ANONYMISED DESCRIPTION OF THE SIX SITES

Site 1

This HLC has been 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 has been devised to oversee the work of the five projects, which have 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 oversees 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 and parenting. 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.

Lessons learned

- There is a need to ensure that adequate support is given to develop projects which have separate remits. Increased provision of management resources would assist this development.
- There are benefits of a lead organisation that is able to find additional money for purely project related roles. Funding and support from the lead organisation has facilitated the development of each of the projects and changes that were made to their operations, use of space, involvement of partners and staff roles.
- While the work of HLCs has evolved and new issues relevant to the communities involved have emerged, more informed needs analysis at the outset may have reduced the imperative to make changes in projects during the implementation phase.
- The involvement of strategic partners should be enhanced. In some instances the success of a venture seems to remove the need for partners to attend meetings. In signing partnership agreements, partners were seeking to be involved in work or to have some of their own objectives met. Similarly their expertise was to assist in guiding the HLC if problems occurred and to give strategic direction when required. It is vital to encourage partners to meet and to attend meetings on an on-going basis so that problems that do occur can be resolved by a team.
- The role of an external consultant is beneficial in providing an operational and strategic overview of a large and dispersed HLC.

Site 2

This HLC was 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.

Lessons learned

- The HLC was able to become operational quickly as much of its work was run through existing voluntary and community-based agencies. Thus the infrastructure which supports the activities was already well established. At project level the HLC has benefited from making use of established community development methods employed in these agencies.
- On the other hand, the speed of development has led to difficulties in engaging the community in shaping the strategic direction of the HLC at all stages of its development.
- The local authority setting has meant that the project manager is well placed to influence emerging community planning partnerships and existing public health fora.
- Health inequalities can be tackled through projects which address the root causes of ill health, such as income maximisation schemes.
- The HLC used LEAP successfully to identify outcomes from its work. It achieved this by training all groups in receipt of HLC funds in the LEAP model of evaluation and securing additional long-term help from local consultants to help them through the LEAP cycle.

Site 3

The HLC has been 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 acts as an umbrella or host organisation for a number of inter-linked services and activities which work across a widespread urban and rural location covering two towns and their outlying rural housing areas. The targeted locality comprises an archipelago of sixteen Social Inclusion Partnership (SIP) areas. A large number of partner organisations work with the HLC to deliver services, while four core funding partners provide advisory support to the management committee. Additional funding from key partner organisations has facilitated the addition of a number of new services and employment of new staff to run in conjunction with the original BLF-funded remit. Services include a stress-management service, projects targeting youths, food/diet, education and skills training. Further identification of need and support is given by lay health worker staff. Following a rationalisation of office accommodation, the HLC has located within one set of premises in which all staff are based. Several services are delivered from this base, although due to the large geographical coverage required, the majority take place in community-accessible locations throughout the area. Approximately 23 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.

Learning points

- The size and structure of an HLC should be given greater consideration. While funded to provide management support for a total of around 12 full and part-time staff, the addition of new projects to this HLC remit was not supported by any additional management time to oversee and co-ordinate the overall programme. In effect this meant that the role became purely strategic, something that was not originally envisioned.
- The level and type of support required by a community-led HLC is significant. As decisions are made regarding funding of the organisation and the employment conditions of the staff, it is imperative that adequate training be given before and during the establishment of the HLC operations and on a continuing basis thereafter. The larger the size of the HLC, the more issues that will require management group attention. Effective decision-making requires ongoing training and oversight from professional organisations which have requisite expertise.
- The departure of members of senior staff should be covered by interim appointments in lieu of a new member of staff being appointed. The establishment phase of each HLC was longer than anticipated and, as systems (e.g. staff roles, training, seeking ongoing funding) became established, it was necessary to have a continual presence in positions of authority in order to assist in the bedding in phase and to adapt to change.
- Partner involvement is crucial. If partners have signed up to the original HLC concept then they must be encouraged to maintain their inputs, both operational and strategic. Roles should be clarified and structures put in place as far as possible before the draw-down of funding.
- It is important to establish effective communications across the organisation from community management representatives, to staff, managers and partner representatives.

Site 4

This HLC was a new project based in new organisation operated as a company limited by guarantee with charitable status. It was led by a management board comprising lay local community members and professional partners who act as advisers only. 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 meant there were few places from which this virtual 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 to existing community-based projects. An example of this is the work with asylum seekers where healthy cooking and tasting sessions have been added to an established drop-in centre.

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 a green gym, 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).

Learning points

- The project manager and administrator were employed for six months prior to project implementation. This enabled much of the policy infrastructure to be developed and the business plan to be redrafted prior to project workers taking up their posts. It was felt that this had been useful in the set-up phase of the project as it enabled a clear picture of the whole of initiative to be presented to the project workers when they took up their positions.
- While the HLC had been able to recruit local people onto its board of directors, initially they found they comprised “the usual suspects”. Following a second recruitment campaign the HLC was able to identify new local people. However, this led to a greater burden on the project manager since the new recruits required more support and training.
- The lack of suitable community venues was a key barrier to developing some areas of the HLC, in particular the counselling work. This led to some HLC funds being reallocated to redesign of the office base in order to accommodate a counselling suite.
- Requests for monitoring and evaluation information from multiple funders were difficult to manage and time consuming for the project manager in particular.
- This HLC was able to raise its profile by working and lobbying at a national and local level. For example the HLC was able to fund its taster sessions in a local supermarket by contacting an MSP directly. Locally, the project manager has a place on key policy making committees and partnerships.

Site 5

The HLC is based on a Scottish island and is led by the NHS health promotion department 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 full partnership meetings allow for wider inputs to strategy. 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) are delivered. Further activities, such as exercise courses, are delivered in a number of outreach locations. Many partners are 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 accommodation 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.

Learning points

- Support systems for small and isolated HLCs should be given greater consideration. Although lead by NHS health promotion, the HLC is distance managed from the mainland. The small staff team has had to adapt to managing the majority of the operational and strategic decisions that affect the HLC. Problems that might have been quickly identified and rectified on the mainland become time-consuming and all encompassing on a small island. Unforeseen delays, e.g. due to training, led to delays in establishing activities and exacerbated negative local public opinion about the HLC.
- Management and partnership systems should be given fuller consideration in small locations which operate with a limited staff capacity. Operational requirements of partners were, in some instances, uncertain. An over-reliance may have been placed on the skills of the project manager, resulting in a burdensome workload.
- There is a need to develop clear workplans at the outset. Without support from the partner organisations it is unclear how the HLC could effectively deliver across its workstreams. Several partner organisations were noted to view the HLC as a source of funding rather than as a partner to aid service delivery.
- There is a need to develop support from local people at the outset. Where an HLC is highly visible, such as in small island communities, it is essential to gain the support of local people as well as agencies.
- An allowance of time and changes made to the staffing structure has aided the HLC in overcoming some of its earlier difficulties. There has been recognition of the increased support required for projects operating in remote locations, especially where multiple services, activities and partnerships are developed with limited resource capacity.

Site 6

This HLC is based in a large Scottish city and is led and managed by a voluntary organisation which delivers linked services to the target group. The HLC operates from a centrally located, user-accessible base from which most 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. There are seven partner organisations involved in delivering services and in providing a strategic overview. The project aims to improve the sexual, mental and general health of its target users by attempting to overcome the barriers to mainstream service access that they experience. 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, are employed to deliver services. Several seasonal staff have been employed more recently in order to free up the time of project workers, thus allowing more developmental work to be undertaken.

Learning points

- This group, previously considered hard-to-reach, were in fact easier to encourage to attend than initially considered. Social models greatly assisted in increasing attendance. Close working relations with partners benefited the HLC at the outset, followed by word of mouth between users. Care was taken not to put people off through being overly intrusive when first attending. A supply of free food at most activities was also found to be highly attractive to the target group. Allowing new attendees space to express their problems before making attempts to accommodate them within services was found to improve attendance following first visits. Ongoing efforts were made to attract hard-to-reach individuals through attempting to provide for basic needs prior to involvement in health promoting activities.
- In order to maintain attendance and to encourage new people to come to events, HLC staff indicated that they needed to be constantly innovative and inventive in order to attract the target group.
- From the outset there was an underestimation of the nature of the problems that users would present with, and staff found themselves dealing with problems for which they were not trained. This necessitated more one-to-one support from staff. Recognition of the importance of training is essential.
- Developing a user group has been problematic. According to stakeholders, difficulties faced by users mitigate against taking a more substantive role in running and managing the HLC. The manager considered that to do this effectively would require a dedicated member of staff and additional time.

APPENDIX 2 DISSEMINATION ACTIVITIES

A2.1 Activities already undertaken

Conference papers

Truman, J., Rankin, D., Backett-Milburn, K., Platt, S., Petticrew, M.. (2003) Drop in services in Scottish Healthy Living Centres. What do they mean and how do they operate? Paper presented at the British Sociology Association Medical Sociology Group 35th Annual Conference, York (26th September).

Rankin, D., Truman, J., Backett-Milburn, K., Platt, S. & Petticrew, M. (2004). Healthy Living Centres' conceptualisation of health inequalities: use of food to convey health messages. Paper presented at the British Sociology Association Medical Sociology Group Annual Conference, York (18th September).

Rankin, D., Truman, J., Backett-Milburn, K., Platt, S. & Petticrew, M. (2004) Scottish Healthy Living Centres: an appraisal of food and diet related services. Paper presented at the NHS Health Scotland Faculty of Public Health Annual Conference, Hamilton, (19th November).

Truman, J., Rankin, D., Backett-Milburn, K., Platt, S., & Petticrew, M. (2004) Scottish Healthy Living Centres - searching for logic. Paper presented at the UK Evaluation Society Conference, Glasgow (8th December).

Rankin, D. and Truman, J. (2004) Scottish Healthy Living Centres: an overview of current work. Paper presented at Research Unit in Health, Behaviour and Change, Internal Staff Seminar, Edinburgh (4th November)

Rankin, D., Truman, J., Backett-Milburn, K., Platt, S., & Petticrew, M. (2005) Partnership working for health improvement: learning from a process evaluation of Scottish Healthy Living Centres. Paper presented at the UK Public Health Forum Annual Conference, Gateshead (7th April).

Book chapter

Platt, P., Gnich, W., Rankin, D., Ritchie, D., Truman, J., and Backett-Milburn K. (2004) Uses of process evaluation. In: M. Thorogood and Y. Coombes (eds.) *Evaluating Health Promotion (2nd edition)*. Oxford University Press.

Refereed journal articles (submitted)

Truman, J., Rankin, D., Backett-Milburn, K., Platt, S., and Petticrew, M. The contextual development of Healthy Living Centres services: an examination of food-related initiatives. *Health and Place* (under review).

Truman, J., Rankin, D., Backett-Milburn, K. and Platt, S. Drop-in centres in theory and practice: findings from an evaluation of the Healthy Living Centre programme in Scotland. *Health Education Journal* (under review).

Dissemination to participating HLCs

Platt, S., Backett-Milburn, K., Petticrew, M., Rankin, D. and Truman J. (2005) Healthy Living Centre workshop: dissemination of findings. Workshop delivered at the Teacher Building, Glasgow (16th February).

A2.2 Forward plans

We aim to publish articles in international peer-reviewed journals, linking our work to the UK-wide evaluation of HLCs being undertaken by the Bridge Consortium and other studies on the evaluation of health-related area-based initiatives. These publications will cover both methodological and substantive aspects of the evaluation.

We will publish a summary of the main findings of, and learning from, the project in a style which is accessible to policy maker and practitioner audiences. This will take the form of an issue of RUHBC 'Findings' series. It will be available in hard copy and on the RUHBC and SPSU websites.

We will explore ways of disseminating findings/learning from the project via electronic mailing lists and also via news items/features in publications aimed at practitioners, such as Public Health News.

We will explore with the Scottish Executive the possibility of linking a formal 'launch' of the findings of this project with the dissemination of the review of literature on supporting and developing healthy communities (commissioned by Health Scotland on behalf of the Supporting and Developing Healthy Communities Task Group).



**Research Unit in Health, Behaviour and Change (RUHBC)
School of Clinical Sciences and Community Health
University of Edinburgh
Teviot Place
Edinburgh EH8 9AG**

Telephone: 0131 650 6192/3

Fax: 0131 650 6902

www.chs.med.ed.ac.uk/ruhbc

ISBN: 1-901577-18-X