Healthy Living Centres in Scotland

Lessons for Policy and Practice

RESOURCES

HEALTH INEQUALITIES

EQUALITIES

POLICIES

PRACTICE

Community-led health

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Preface

NHS Health Scotland and Community Health Exchange (CHEX) are pleased to share the learning from the evaluations undertaken by the University of Edinburgh's Research Unit (RUHBC) of part of the Healthy Living Centre (HLCs) Programme in Scotland This was a two stage process with Phase one (Phase one (Platt et al, 2005) examining the initial development of six HLCs working in different ways in different areas of Scotland. In Phase two (Platt et al, 2007), some of the original research team returned to the same six HLCs and followed their progress for a further two years through to mid 2007. Scottish Government and NHS Health Scotland jointly funded both phases of this evaluation process.

This Briefing is primarily aimed at policy makers and decision makers in services related to health improvement - senior managers in Community Planning Partnerships, Community Health Partnership and Community Learning and Development Partnerships and the Third Sector will also find the lessons of significance, particularly in relation to the delivery of Single Outcome Agreements.

It offers valuable insights into the unique role HLCs have played in shaping and delivering health improvement strategies and activity across Scotland. Achieving and assessing health improvement outcomes, tackling inequalities, developing community involvement, partnership working and sustainability are all addressed through the experiences of these community health organizations.

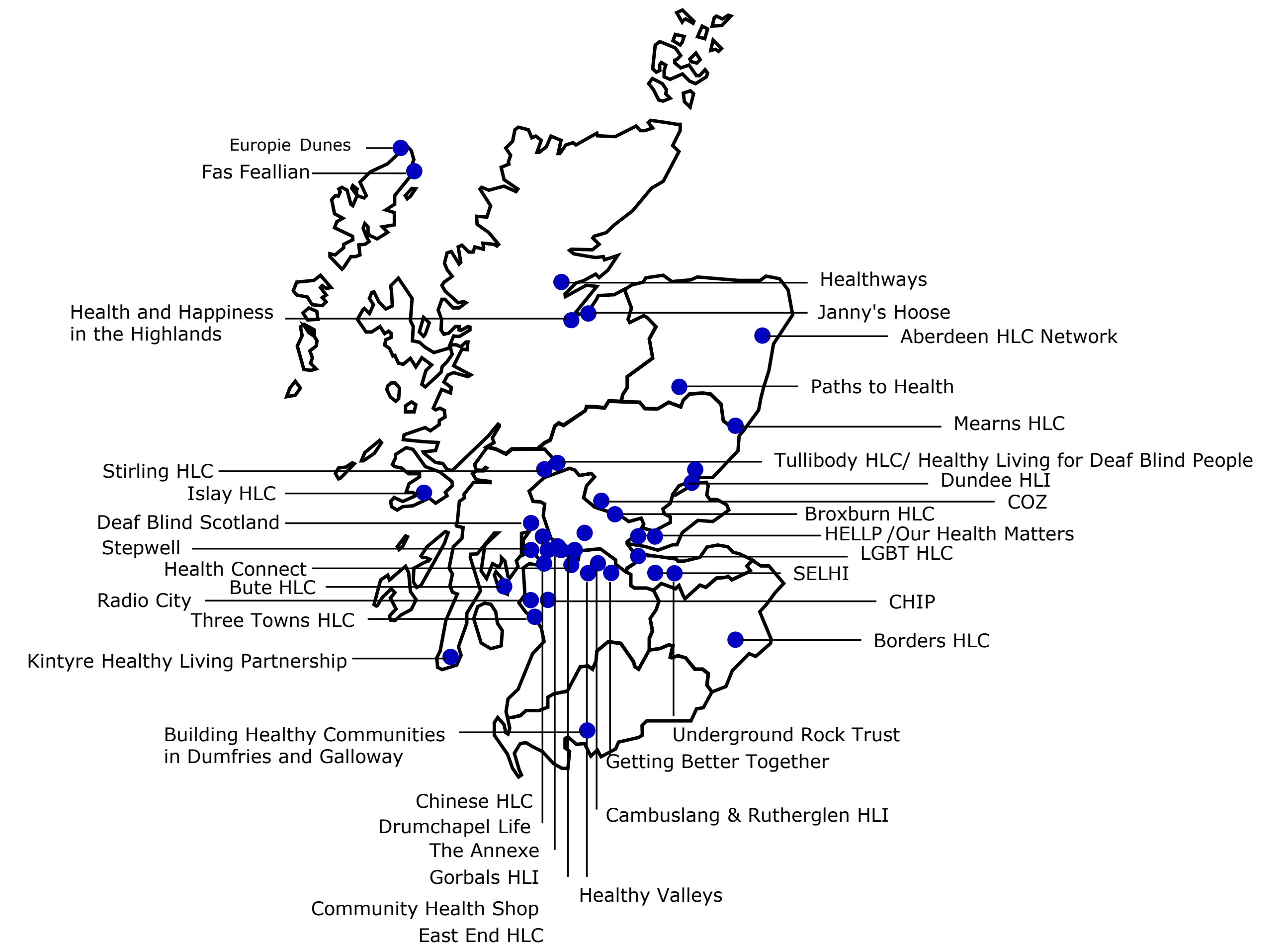
Placed within the policy context from 1998 to present day – from 'Working Together for Healthier Scotland' (Scottish Executive, 1998) to 'Better Health: Better Care' (Scottish Government, 2007), the Briefing highlights both the long-standing and recent public policy commitments which underpin the HLCs approach to improving health and tackling health inequalities. In looking to the future, it emphasizes the strong position that HLCs are in to support communities to contribute to the Scottish Government's five strategic objectives – wealthier and fairer, healthier, safer and stronger, smarter and greener.

It concludes by addressing the ever relevant issue of sustainability. It does this by highlighting to decision makers, present and future, the requirement to learn and build from the evaluation of recent practice.

Acknowledgement

We thank Peter Taylor (Peter D Taylor Consultancy & Research) for writing this Briefing on the Evaluations.

Map of Healthy Learning Centres in Scotland



Lesson for Policy and Practice

HLCs have already carried out a substantial amount of the groundwork involved in developing and adapting services and activities to respond to changing local needs and national priorities across Scotland.

University of Edinburgh's Research Unit in Health, Behaviour and Change (RUHBC 2007)

1. Introduction

The Healthy Living Centres (HLCs) programme was at the time the largest single investment in community-based health work in the UK. This briefing is intended to draw lessons learned from the evaluation of the work of the HLCs in Scotland to the attention of people who make decisions on strategic policy for health improvement or the management of services or projects.

The Big Lottery Fund (BLF), previously known as the New Opportunities Fund, established the HLC funding programme in 1999 (although the majority of grants were not awarded until 2002). The Lottery funds invested £300 million in supporting 351 HLCs. £34.5million was devoted to the 46 HLCs which were located in Scotland.

A 'Healthy Living Centre' could be and do many different things, but all were expected to:

- promote good health and well-being, in the broadest sense
- target disadvantaged groups
- both improve health and address health inequalities
- address the wider determinants of health, such as social exclusion or poor access to services
- respond to specific local health improvement needs
- involve people from the communities with which they worked, and centre users, in all aspects of the design and delivery of their work
- promote partnership working across sectors
- develop innovative solutions
- complement local and national health policies and priorities.

There are currently 38 HLCs in Scotland following the closure of eight due in most cases to lack of continuation funding and local partner support. The exception to this is one project which planned a phase exit from the start to allow partners to take responsibility for service provision. The existing 38 HLCs employ over 200 F/T staff, 300 sessional workers and support over 3,000 volunteers. On average HLCs work with 4,606 individuals, providing 19,629 sessions per year. It's important to note that some HLCs work with relatively low numbers of people in a very intensive way and other projects such as 'Paths to Health' work with thousands of people per year across Scotland.

A team from the University of Edinburgh's Research Unit in Health, Behaviour and Change (RUHBC 2007) was commissioned to evaluate the success of this programme in Scotland, in two phases. Phase one (Platt et al, 2005) followed the initial stages of six case study HLCs working in different ways in different areas of Scotland, and looked at all aspects of their operations, but especially

- the context in which they operated
- their objectives and expected outcomes
- the processes by which the outcomes were to be achieved, and what explanations of change lay behind these.

In Phase two (Platt et al, 2007) some of the original research team returned to the same six HLCs and followed their progress for a further two years to mid 2007. The study was funded by the (then) Scottish Executive's Health Department and National Programme for Improving Mental Health and Well-being, and by NHS Health Scotland. In this phase they concentrated especially upon how HLCs, and the partnerships that they work with, had tried to:

- address social injustice and inequality
- achieve community involvement
- meet both local needs and national priorities
- adapt to the major changes in the organisation of health and other services
- ensure sustainability in the longer term.

and especially at how they might have changed their approaches over time and with the benefit of experience.

This paper is based upon the reports of these two phases of the evaluation, and especially the second. It is not a comprehensive summary of their contents, but is instead intended to assist policy and decision makers to identify:

- the key features that were identified as contributing to the outcomes achieved
- the implications for tackling health inequalities and health improvement in future.

We shall refer to the two reports as (Phase 1 report) and (Phase 2 report). The great majority of the findings that we refer to and most of the suggested implications are drawn from these two reports, especially the second, and we have frequently used or modified their words. To ensure readability we do not constantly cite references to the two reports. However unless specific quotations are given, the interpretations here are the responsibility of the current writer.

The two reports do not identify the six case study HLCs by name or location. However, they do describe the target groups, health problems, governance, decision-making structures and geographical localities of each HLC.

The Scottish reports formed part of a wider evaluation effort, which included studies in all the nations of the United Kingdom. We shall also refer where appropriate to the findings of the main English study (Tavistock Institute with McDaid, 2005) and the report of the 'Bridge Consortium', which covered the whole of the UK (Hills et al, 2007). The BLF has also published a brief account of the lessons to be learnt from its evaluation and research (Big Lottery Fund, 2007) which helpfully sets the HLC findings in the context of those from other health programmes and its work in general. We also refer to 'Changing Lives' (Taylor, 2006), a series of case studies of HLCs and other community-led health initiatives produced for the national Task Group on the subject.

2. Summary of Implications

The HLC programme offers a wealth of experience on engaging with and involving disadvantaged communities in action to improve health. The following lessons for policy and practice are selected and adapted mainly from the 'learning points' identified in the two Scottish evaluation reports. General conclusions about the effectiveness of the work of HLCs, including the evidence from which these implications are drawn, are summarised in the following sections. The original reports should be consulted for fuller details.

Development of health improvement activity in communities

- HLCs have already carried out a substantial amount of the groundwork involved in developing and adapting services and activities to respond to changing local needs and national priorities across Scotland.
- Adaptability and flexibility are key attributes of HLCs. These attributes facilitate a wide variety of work with multiple target groups, and responsiveness to changing needs over time. They should be recognised as an important part of work to meet local health improvement outcomes
- The length of time that many HLCs have spent becoming familiarised with communities and the relationships that they have established should be seen as an aid to local planning for service delivery. Many HLC staff use informal and developmental methods of work, which promote improved understanding of local communities. The longer term provision of such developmental work should be taken into account in planning services.
- Capacity can be stretched when working with vulnerable groups, and across large geographic areas. Partners and project managers must be realistic about the amount of time that it will take to establish an initiative, either from the expansion of an existing project or through the creation of a new project

Tackling inequalities

- Impacts on disadvantage may be shown in a variety of ways. Drawing on the experience of HLCs, these include:
  - changes in attitudes or behaviour
  - changes to structural factors (e.g. changes in food supply or social circumstances)
  - assessment of 'holistic' effects for people (e.g. increased well-being or confidence).
- The successes of HLC approaches in tackling inequalities seem to be based on a combination of the ability to target disadvantaged groups successfully and obtain their participation and the fact that this participation has proved effective in improving the health of the individuals concerned.
- In some instances, targeting whole communities (or area populations) may be the only way to ensure that those most in need become involved or take up services and do not feel stigmatised.

Achieving & assessing health outcomes

- The contribution of HLC approaches to promoting mental health and well-being should be recognised and developed.
- Future evaluations need routinely to explore with practitioners the 'theories of change' which help to determine how their projects are implemented or services delivered. In particular a clear distinction needs to be made between 'intermediate' or 'short term' outcomes and overall effects on population health, and the former need to be recorded.
- Evaluations should also attempt to capture the indirect benefits of the intervention – such as capacity building, training of users, employment, and benefits reported by volunteers.
- Expectations that evaluation should be carried out and outcomes should be identified are unlikely to be realised unless concrete support is provided to projects for this purpose.

Partnership working

- Future initiatives would benefit from using some form of partnership agreement to provide guidance and to outline agreed roles and responsibilities.
- Key individuals within organisations should be identified and appropriate mechanisms and resources to obtain support should be developed.
- However, some of the most productive relationships emerged from the informal ways in which HLCs developed partnership working with a variety of agencies. Sufficient scope should be given to exploring emerging opportunities and to change the function and structure of partnerships if required.

Community involvement

- Community involvement should be recognised as an continual and evolving challenge requiring adaptability in responding to a range of groups.
- It requires staff support, informal approaches and long term commitment.
- Involvement builds the personal capacity of the people involved, but the ability to guide people into further learning opportunities is sometimes lacking.
- Activities to promote user engagement should follow current guidelines on best practice, such as the National Standards on Community Engagement.[1]

Successful delivery

- A variety of configurations of staff, including both dedicated project workers and sessional staff can be used to meet needs. But significant levels of staffing, skills and training of staff, and time are needed to become familiarised with communities. Professionalism of staff is very important for many HLCs.
- Resources should be made available for training and managerial support to project managers, or this support should be given by lead and other partners.

[1] See http://www.scdc.org.uk/national-standards-community-engagement/

Sustainability

- Achieving sustainability may require reconciling the strategic aims of funding partners and the needs of local communities. Conflict between these can be avoided if community initiatives are clear about the evidence on how they contribute to strategic outcomes, and funding agencies are flexible about the methods by which outcomes can be achieved.
- The time invested by HLCs in local capacity building, the length of time taken to gain trust and 'win over' local people, and the diverse models of engagement adopted with local communities should be recognised and built upon. Such connections can be easily lost if an HLC is discontinued.
- The potential negative impact of radical change to or the curtailment of some initiatives on local communities should be assessed.
- Organisations such as HLCs should pay attention at an early stage during their development to raising their profile with both decision makers and the wider community and making people aware of their role.
- The end date of funding for time limited initiatives such as HLCs is known. Statutory agencies and funders should be able to give more attention at earlier stages to their strategic future.

Current policy and practice context

- Statutory partners should learn from the experience of HLCs in finding effective and innovative ways of achieving outcomes in health improvement and health inequalities. They should seek to ensure that not only the outcomes but the community-based processes involved continue to be supported and developed.
- The type of work pioneered by HLCs is more relevant than ever to the outcomes that health improvement agencies are now expected to pursue. The lessons learned are therefore immediately relevant to current funding and organisational decisions.
- Long term efforts are required to make health improvement planning more effective in engaging communities and allowing them to identify their own priorities.

Lesson for Policy and Practice

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University of Edinburgh's Research Unit in Health, Behaviour and Change (RUHBC 2007)

Lesson for Policy and Practice

Adaptability and flexibility are key attributes of HLCs. These attributes facilitate a wide variety of work with multiple target groups, and responsiveness to changing needs over time. They should be recognised as an important part of work to meet local health improvement outcomes.

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Young people in costume workshop

3. Policy And Practice Context

Healthy Living Centres were created and have developed in the context of a growing emphasis in government policy on the importance of public and preventative health, from the Green Paper 'Working Together for a Healthier Scotland' (The Scottish Office, 1998) onwards. This emphasis draws on the internationally recognised 'social model' of health, which sees health as "a positive concept emphasising social and personal resources as well as physical capabilities" (World Health Organisation, 1986). The overall approach taken since the Green Paper is that action is necessary at all of three `levels'. These are: Life Circumstances, Lifestyle Topics and Health Topics.

In 'Improving Health in Scotland - the challenge' (Scottish Executive, 2003a), the relevance of work on social and economic factors to health improvement was reaffirmed. 'Community-led' approaches were designated as one of the key 'pillars' of health improvement.

These approaches have developed in the context of significant changes to how primary health care, including public health work in the NHS, is delivered. The 'challenge' paper accompanied the White Paper on Health in Scotland 'Partnership for Care' (Scottish Executive, 2003b), which led to the establishment of Community Health Partnerships (CHPs). CHPs represented a further step in the devolution of the key role in public health to local services built principally around primary care, and the sharing of responsibility with other agencies. They were expected to "play a pivotal role in delivering health improvement for their local communities".

It is recognised that action to promote positive health and well-being must involve many agencies besides the NHS. Bringing together local agencies, together with the communities they serve, is one of the central aims of Community Planning approach. All Scottish Community Planning Partnerships (CPPs) recognise health improvement as being one of their priorities. The principal joint approach to the health improvement aspects of the Community Plan is the Joint Health Improvement Plan (JHIP). The local authority is recognised as the lead body for developing a JHIP with its partners.

National strategies have been developed for all the priority 'Lifestyle Issues' and Health Topics'. One crucial health topic, mental health, is addressed through the National Programme for Improving Mental Health and Well-being[2]. This has been an organising framework rather than a particular policy statement, and is currently under review.

In order to take forward the emphasis that 'Improving Health in Scotland - the challenge' placed upon community-led approaches, a Community-led Supporting and Developing Healthy Communities Task Group (CLTG) was established. It reported in 2006 (NHS Health Scotland, 2006). The key themes of its findings were:

- Building the evidence base for community-led health
- Supporting Planning and Partnership Working
- Capacity building on community-led health
- Sustainability of Community Health Initiatives.

[2] See http://www.wellscotland.info/

Its recommendations cover a wide range of aspects of working in partnership with communities to improve health. But much of the experience upon which it draws come from the work of local community health initiatives, of which the HLCs form a prominent, but by no means the only, part. The development of these initiatives in Scotland has been supported since 1999 by the Community Health Exchange (CHEX). In 2005 this obtained additional funding from the Big Lottery Fund and Health Scotland for three years to allow it to create a Healthy Living Centre Support Programme, which has amongst other things helped to create an HLC Alliance for the Scottish centres.

Work on the implementation of the Task Group findings has now led to the establishment of a national support programme, 'Meeting the Shared Challenge'. This will work with both statutory and community organisations to support a shared understanding of, and strategic commitment to, a community-led approach to health improvement and addressing health inequalities[3].

Since the election in May 2007, the Scottish Government has both introduced new policies and reaffirmed some policies from the previous administration. The discussion document 'Better Health: Better Care' stated a focus on reducing health inequalities and improving health by harnessing resources across all sectors. Its aim was

> *"to help people sustain and improve their health, especially in disadvantaged communities, ensuring. better, local and faster access to health care" (Scottish Government, 2007a)*

The subsequent Action Plan (Scottish Government, 2007b) makes it clear that the recommendations of the 2006 Task Group report will continue to be implemented. It states a commitment to improving the capacity of the 'third sector' to reduce health inequalities and promises a national review of the way in which NHS Scotland supports organisations and initiatives in that sector.

The Ministerial Task Force on Health Inequalities reported in June 2008. 'Equally Well' made a series of recommendations which cut across government departments and local services and are set out with measurable outcomes to reduce health inequalities. Eight 'Test Site Partnership Teams' have been initiated across the country to pilot joined up working on the recommendations.

Of fundamental significance is the changes to the way government is organised and objectives are set at national and local levels. The Scottish Government has set five strategic objectives, for Scotland to become

- wealthier and fairer
- healthier
- safer and stronger
- smarter
- greener

[3] See http://www.scdc.org.uk/shared-challenge/

[4] See http://www.scotland.gov.uk/Topics/Health/health/Inequalities/inequalitiestaskforce

The key link between national and local level is the Concordat between the Scottish Government and COSLA (Scottish Government, 2007c). This sets out fifteen national outcomes, including:

> *"We live longer, healthier lives"*

and 49 high level outcome indicators, which include a number of lifestyle related health improvement outcomes, an indicator of increased mental wellbeing, and another of reduced health inequality ("Increase healthy life expectancy at birth in the most deprived areas").

Within this framework local authorities are working on local Single Outcome Agreements explaining how they will seek improvements in these and other locally chosen outcome indicators. By 2010, these Agreements are intended to become agreements between all partners in CPPs, including NHS and third sector organisations. In some areas this is happening immediately on a voluntary basis.

This new system is likely to set the context for the future sustainability of the work of the HLCs. It offers the potential for authorities and partnerships to be flexible about how they deliver outcomes, in ways which should include working with communities. Community based groups will increasingly be expected to show how their work can contribute to wider outcomes, rather than simply recording their own direct outputs..

Currently the NHS must work to the HEAT (Health Improvement, Effective, Access, and Treatment) targets[5]. The Scottish Government's Review of Health Improvement Performance Management for Shared Outcomes (NHS and Local Government)[6] is seeking a closer alignment of these to the outcomes and indicators established for the Single Outcome Agreements. It is looking at setting outcome targets related to:

- Inequalities and health
- Mental Health & Wellbeing
- Tobacco
- Alcohol
- Obesity
- Early Years (the healthy development of families, particularly those children most at risk).

There are therefore many aspects of both long-standing and recent public policy that support the approaches developed by the HLCs. However it must be noted that in early 2008 many community health initiatives were reporting a reduction of services and staffing, or indeed closures, as a result of some combination of:

- termination of BLF funding
- uncertainty over funding from local sources affected by the Single Outcome Agreements, including the merged Fairer Scotland Fund
- uncertainty over the level of ongoing commitment to supporting community-led approaches by NHS organisations.

[5] See http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273/targets

[6] See http://www.healthscotland.com/scotlands-health/evaluation/planning/hi-performancemanagement-nhs.aspx

But, although the past tense is used to describe the work of HLCs in this document, this is simply because it is based on report evaluating their past work. The policy environment and new initiatives described here suggest that there should be a considerable potential for their work to be continued in various forms. Decisions are being made now that ought to be informed by the lessons of the HLCs.

HLC staff team

4. Healthy Living Centres In Action

One lesson from the HLC programme is that there is certainly no one right or inevitable way of organising community-led health improvement activity, tackling health inequalities or involving communities.

> *"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" (Phase I report).*

Some projects established actual multi-purpose 'Centres' in their communities, others established 'virtual centres' or networks supporting groups to work on health issues (in fact "such a dichotomy may be too simplistic to capture the variation" (Phase 2 Report)). Some targeted particular groups such as elderly people or people from minority ethnic groups, whilst others sought to address the needs of the whole community through setting up services for many of the groups living in an area. The geographical coverage ranged from small densely populated urban areas to large and sparsely populated rural areas.

HLCs provided 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
- counselling
- complementary therapies.

These reflected both different local needs and wishes and different models of health promotion between and within HLCs. Some developed services which tackle fundamental determinants of ill health. For example, three case study projects tackled income levels by developing debt counselling services, credit unions and work on fuel poverty.

Four case study projects adopted a 'life skills' approach and developed services which tackled lack of confidence, skills training for employment, or cooking skills. All projects also focused on lifestyles and developed activities which encouraged participants to stop smoking, eat a healthier diet and take more exercise.

Projects generally tried to provide activities and use approaches and venues which did not single out and stigmatise their users as either ill or poor, and which had a spin-off impact on mental health and well-being. Activities such as walking groups or community gardens could be very inclusive. Traditional forms of exercise class, for example, might be modified to attract hard-to-reach groups, perhaps using non sporting venues or locally trained leaders. Some HLCs developed innovative ways to encourage healthy eating, linking with local food retailers and suppliers to promote healthy food choices.

Several HLC premises were increasingly used as social hubs, where service users would find it more acceptable to attend to take up services and providing opportunities for social contacts to develop. For example, one introduced a training café both to encourage new service users to come into the building and to allow a new focus to be given to volunteering and employability.

Facilities were also often made available to partners or other groups delivering services to the same communities.

Ensuring that services were accessible was often important. Providing a crèche could make participation possible. When geographically dispersed groups were targeted, services might be delivered at their local venues or transport might be provided. Conference-style events within target areas and travelling road shows to outlying communities were used to enhance the public profile of centres.

HLCs promoted community involvement at a wide variety of levels (see section 7), including:

- management of the HLC
- involving people in service delivery
- training and capacity building support
- developing and supporting independent community groups.

Local volunteers work in the majority of HLCs. The approaches used could vary greatly though, from using unpaid, untrained helpers to one project that recruited and trained volunteers for specific roles, such as sports coaching, and then offered them paid sessional work, and another that offered a fully paid training 'apprenticeship' for 'lay health workers'.

Volunteers reported tangible benefits from their involvement with HLCs. For some it was an 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 to make personal advances in well-being and perhaps employability.

Very different attitudes to how long people should remain involved in Centre activities were displayed. One project manager expected people to gain confidence and skills, perhaps take on a volunteering role, then move on to other things

> *"You become like a safety net for them so they don't actually have to go and make pals of their own ... So people coming back isn't necessarily an indicator that things are all right." (HLC Manager)*

But another was happy to develop long term relationships with clients:

> *"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." (HLC Manager)*

Perhaps each approach might be appropriate in the right circumstances. Certainly, throughout all of the case studies it was found that experience led to changes in the approaches taken by HLCs. Time was necessary both to establish services and to learn from them. Across the UK as a whole, the Bridge Consortium found that:

> *"A key theme to emerge has been the importance of working flexibly, adapting activities and approaches to changing circumstances within their local community. In particular, centres found that it was important to embed individual health activities in a broad programme, providing social opportunities as well as addressing particular local interests". (Hills et al, 2007)*

Centres regularly changed the activities that they were running, either ending some which were no longer popular, or adding new ones in response to a new opportunity, or a new need which had not previously been recognised.

Lesson for Policy and Practice

The length of time that many HLCs have spent becoming familiarised with communities and the relationships that they have established should be seen as an aid to local planning for service delivery. Many HLC staff use informal and developmental methods of work, which promote improved understanding of local communities. The longer term provision of such developmental work should be taken into account in planning services.

University of Edinburgh's Research Unit in Health, Behaviour and Change (RUHBC 2007)

Lesson for Policy and Practice

Involvement builds the personal capacity of the people involved, but the ability to guide people into further learning opportunities is sometimes lacking.

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Local resident enjoying the HLC services

5. Addressing Health Inequalities

One of the most important aims for HLCs has been to reduce differences in health between individuals and improve the health of the worst off in society. This is not necessarily achieved simply through seeking a general improvement in health. Macintyre (2007), in a summary prepared for the Scottish Government Ministerial Task Group on Health Inequalities, points out that:

> *"More advantaged groups in society find it easier, because of better access to resources ..., to avail themselves of health promotion advice... This suggests that interventions with more disadvantaged groups may need to be much more intensive and targeted than might be appropriate for more advantaged groups ... Poorer sections of society may also receive less benefit from lifestyle change or access to services; because they are still vulnerable to other damaging exposures, and/or their health may already be compromised by other factors. ... This suggests the need to address wider determinants of health and help seeking behaviour" (McIntyre, 2007: p8)*

The Bridge Consortium (Hills et al, 2007) reports that HLCs across the UK interpreted the concept of health inequalities in differing ways. It identified (from existing literature) seven types of possible explanation of the origins of health inequalities:

- Behaviour or lifestyle: poor health arises from individual factors such as lack of exercise and poor diet.
- Service appropriateness: variations in health arise because of a lack of culturally appropriate services and opportunities in some areas.
- Service accessibility: variations in health arise because no services are available, or people are unable to access the services.
- Community participation/involvement: services are inappropriate or inadequate because of lack of community involvement or consultation.
- Social exclusion/social capital explanation: poor health in parts of the population arises because of structural factors: age, sex, culture, race/ ethnicity.
- Poverty and income: poor health is related to poverty and unemployment in key sectors of the population.
- Environmental: poor health arises because of poor environmental quality – housing, available green space, poor air quality etc.

We have already seen examples of work addressing many of these factors. The Scottish Phase 2 evaluation report notes the obvious point that HLCs have limited scope to tackle inequalities at a societal level, with their efforts focused instead on disadvantage within target groups. But the Phase I report found that "they have adopted novel and successful approaches to reaching excluded groups and achieving the social inclusion goals of the HLC programme".

According to that report, unpublished data from the UK wide Bridge programme suggests that, contrary to some expectations, HLC services had not been used mainly by those who needed them least. Instead, they were located in the poorest areas, and were used by the section of the community who are in the poorest

Across the UK, many centres adopted a targeted approach from the start, focusing their activities on vulnerable groups such as homeless people, prisoners and ex prisoners, particular ethnic minority communities, or refugees and asylum seekers. Others opted for particular age groups – older people, or young families and children. In addition to this initial targeting, many centres also evolved programmes of activities designed to engage groups within the general community which were found to have particular health or social needs, with the majority of HLCs targeting several groups simultaneously (Hills et al, 2007).

All the Scottish case studies had devised innovative approaches in order to attract hard-to-reach groups, including:

- the informality of many services, which was attractive to a number of users
- delivering services on an outreach basis within each community
- peer support, which was seen to encourage initial engagement among users and help to ensure their continued involvement

  "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)

- providing enticements such as free food to encourage people to use a venue
- devising entirely new services based around particularly hard to reach groups, once initial contact had been established.

  "You can set targets and plan, but until you can get people through the door, you don't actually know what you can do" (HLC Manager)

- referring clients to health services that they might not have considered previously and supporting them to have the confidence to try these
- bringing local agencies together to develop new ways of targeting disadvantaged groups

Example

One HLC supported a travellers' information project in partnership with other agencies. The aim was to support 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 or primary health care**
- **developing new services to support travellers (examples included a girls club, a pre-5 play group, a food co-op and a credit union).**

Example

Staff in one HLC adapted existing services for new target groups, such as asylum seekers. They had to overcome challenges relating to language, culture and the appropriateness of services, which in this instance involved trialling alternative methods over more traditional forms of counselling.

The Phase 2 evaluation identified three main ways of working that have made HLCs effective in targeting disadvantaged people:

- adaptable and flexible ways of working
- relationship building within communities
- starting from a broad provision of services across the community.

Many HLCs were highly adaptive when seeking to address inequalities within their target communities, responding both to changes in communities and to knowledge gained through working with them" (Phase 2 report). This responsiveness led to the creation of new services, the establishment of new delivery methods and the employment of new staff to meet community needs. They often responded to things that were unlikely to have been envisaged at the outset of their bids, e.g.

- new groups moving into the area
- new needs concerning food and diet emerging following further consultation.

Relationship building involved the establishment of trust, and the 'embedding' of staff and services in their communities. HLCs benefited from having time (mostly five years' funding) to allow several staff to become an integral part of the community in which they were based. "Comments from a variety of stakeholders highlighted the trust that had been established between communities, HLCs, the staff and their services" (Phase 2 report).

> *"I think that there's no substitute for a well-rounded community based organisation which genuinely is committed to working on a local basis and, going to where people are... people who are living in a really difficult place won't relate to officials going in attempting to change their lives through whatever means, whatever interventions" (HLC partner).*

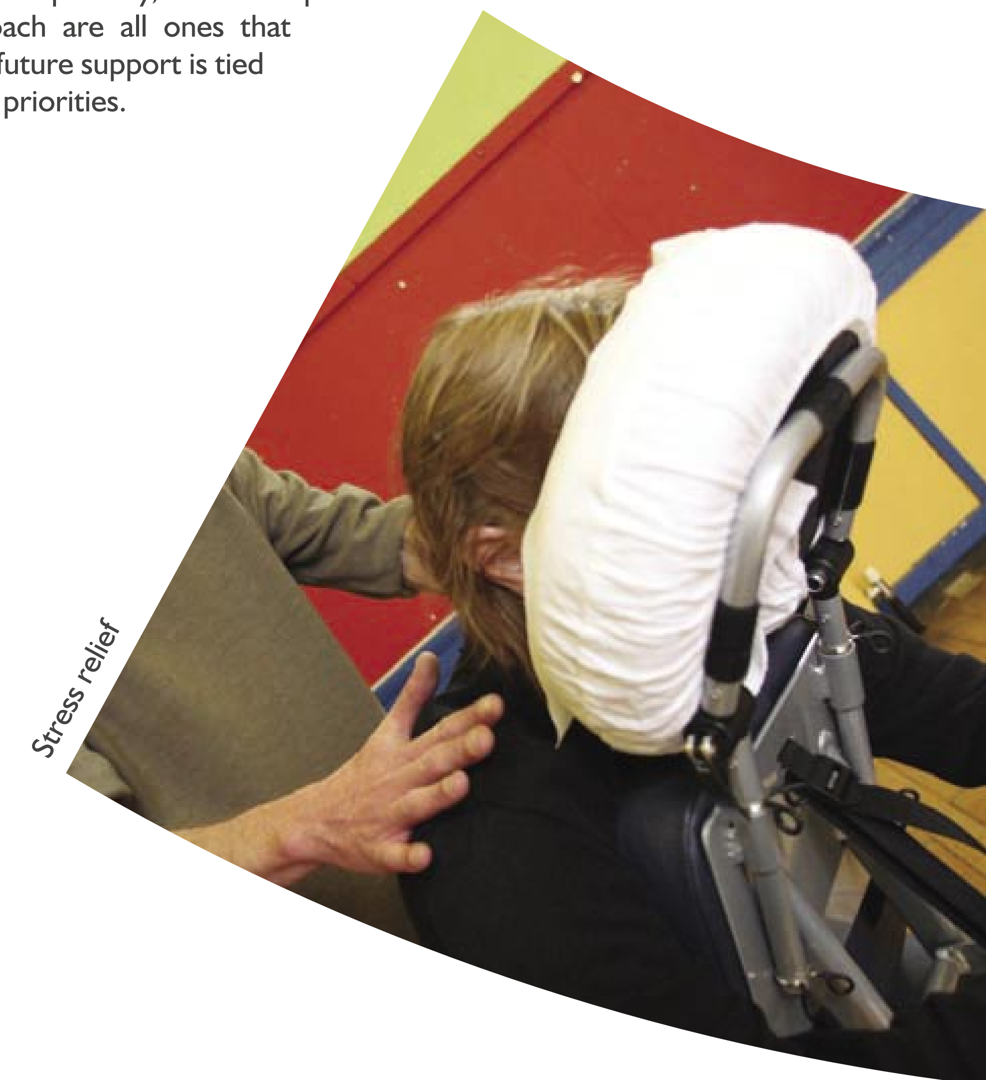
HLCs often started from a broad application of services across communities. Such universalistic provision was often used as a way of avoiding stigmatising more marginalised groups or individuals

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

This broader approach might also allow HLCs to gain knowledge which would then support a more localised and targeted approach to those 'priority' groups most in need. Three case study areas in their bids for future funding proposed to refine their focus on particular target groups based on the knowledge gained during their first five years of operation.

But others sought to retain a focus on the communities that their original programme had targeted, as it was suggested that the needs of these communities had not "gone away" and also that a non-stigmatising approach remained crucial.

Whatever approach is taken in an area, it is clear that the three success factors of adaptability, relationship building and a broad approach are all ones that could be inadvertently lost if future support is tied too tightly to narrow service priorities.



Stress relief

6. Achieving Health Outcomes

Many of the people involved describe the HLC approach as 'holistic'. This is not intended to mean some specific alternative type of therapy. What people do actually mean by it can vary – the Phase 2 report provides a salutary reminder of this. A 'holistic' approach could imply one or more of the following, each no doubt legitimate, emphases.

A) Person-centred approaches, where HLC services seek to address both the physical and mental health and well-being needs of an individual. For example, social activities were often promoted in conjunction with exercise or diet-related activities.

B) Service-centred approaches, linking the different services offered by the HLC and advising people of other opportunities on offer, or helping to connect people to the disparate services provided by other partners

C) The social model of health, where health and well-being are influenced by a wide range of social, economic and environmental determinants. Every HLC tried to apply this model, but as they developed some became aware of an even wider range of needs.

> *"[One] big development is the dawning realisation that while health is still our thing, more and more the young people are back in temporary accommodation or bed and breakfast, or their tenancy is teetering badly. So ... we do need to have a good grounding on issues around housing" (HLC worker)*

The pursuit of holistic approaches also led some projects to offer training to community members or to other agencies, seeking to raise awareness of wider factors that might impact on community health.

Another important aspect of the outcomes that most projects sought to achieve was a growing understanding of the central importance of mental health and wellbeing. For example, in the walking groups that were promoted by several case study projects, multiple benefits were observed:

> *"It's taking a different angle on dealing with stress. Although they're getting physical activity, they're getting peer support and they're getting relaxation" (HLC worker).*

Several projects found that their initial approach did not adequately cater for the level of mental health and well-being needs that they discovered when they got to know people through their other services. This increased awareness led to them adopting informal approaches to meeting mental health and well-being needs.

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

> *"It's just to get people out of the mindset that, when it comes to mental health and well-being, it has to be therapy or it has to be nurses …it's about looking a wee bit more normally at what people do to recover" (HLC worker).*

The non-stigmatising venues and ways in which HLC services were delivered were often critical to success in this work.

> *"This should be a mental health project, but if it was ... nobody would come in the door, it would be labelled... [But the majority of people who come through the door are on the 'first tier' of mental ill-health]... these are the people that are on the treadmill who end up at the doctor's" (HLC Manager)*

The evaluation reports do not make any attempt or claim to judge the overall impact of the programme on health, though they conclude that "there are good reasons for believing that HLCs do make an important contribution to the communities in which they are located" (Phase 2 report). Apart from the sheer diversity of their work, the outcomes that these relatively small projects sought to influence were large and complex. There were also some practical difficulties and shortfalls in beginning to identify these, which HLCs have been learning to overcome.

Broad outcomes for people's wellbeing are intrinsically difficult to track, many other services and factors influence them, and much of the work is delivered in partnership with others. The evaluation did however find, especially in the earlier stages, some avoidable weaknesses in the approaches taken by HLCs to their own monitoring and evaluation. The fact that the BLF asked for lengthy monitoring information focused on measuring the immediate outputs of activities was significant. Many HLCs felt that the emphasis on quantitative information did not provide a true picture of the work that was being done and was easy to manipulate.

> *"You could run an event with the local primary school and get 500 children quite easily, but if we look at our counselling ... we may counsel 15 people a week" (HLC manager)*

BLF had not asked HLCs to specify outcomes when they made the first call for proposals and HLCs typically had considerable difficulty in identifying the outcomes that their activities were intended to achieve. Even where outcomes were stated, they were rarely being measured (or stated in such a way as to be measurable).

Relatively small projects can not be expected to demonstrate their direct individual impact on the health and wellbeing of an entire population. But they should be able to explain the logic of their approach – the pathways by which the actions they take can be linked to wider outcomes and the short term and intermediate outcomes along the way that they can directly achieve. The evaluation found that the ways in which outcomes might be achieved were not always fully thought through.

> *"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" (Phase 2 report).*

For example, one HLC claimed that a change in diets in the whole community could be the outcome of its activity. It chose to do so mainly because baseline data was already available on current diets in the area. But the intermediate, directly observable outcomes of the HLC's activities involved increasing the amount of fresh fruit and vegetables consumed by a relatively limited range of individuals. The evaluators argue that relating this to a broader community outcome implicitly assumes that these individuals will spread messages or models of behaviour, and that behaviour in the wider community will change as a result. But this logic had not been spelled out or tested.

The difficulty of demonstrating contributions to wider outcomes is not unique to community based projects. There is

> *"a general recognition that a system of performance management that is effective at improving NHS service delivery must be based on intermediate outcomes which can be directly affected by Boards" (NHS Health Scotland, 2007).*

Other difficulties arose from:

- the limited resources available to projects; any evaluation effort tended to be devoted to the immediate task of learning how to make activities more user-friendly and enjoyable
- the deliberately informal nature of many of the activities; users might be people who had had poor experience of statutory agencies and 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 don't have any case notes on anybody, we want to encourage people to attend."*

> *"People come to the fruit barrow and we ask age and postcode, they think we're the Spanish Inquisition" (HLC workers)*

In spite of these difficulties, HLCs have begun to make significant progress in this area. The support of the national Healthy Living Support Programme will have been a factor. HLCs were encouraged to take up training on Learning, Evaluation and Planning (LEAP), which is a practical toolkit for integrating planning and evaluation, targeted at community-based groups implementing complex initiatives (SCDC, 2002).

HLCs increasingly became aware that measuring and demonstrating outcomes would be necessary in any future plans for the sustainability of their work. They used a number of techniques to overcome the problems associated with demonstrating impact on health measures. One case study project devised outcome measures which tracked groups of its service users over a one-year period. In another, stakeholders developed 'evidence-based, best practice models of service delivery' which allowed the services provided by the HLC to be benchmarked against other providers.

Overall, the evaluators concluded that there was undeniable evidence of success in achieving some intermediate outcomes – in particular, success in targeting excluded populations, which we look at in the next section. Many stories were also recorded about impacts on the health of the individuals with whom HLCs worked,

> *"We've had feedback from GPs and some people [saying] 'I thought it was a load of rubbish when it all started, but now I can see the difference' ... there's health improvements ... from their own word of mouth or from doctors, [people] taken off medication, or whatever" (HLC Manager).*

> *"[The HLC] has helped me take regular exercise… and the healthy eating, I couldn't believe that soup was so easy." (Service user)*

The UK wide study (Hills et al. 2007) emphasises the importance of looking at evidence from a number of levels in order to understand the outcomes and impacts of HLCs. In many of the centres studied, those who attended activities regularly experienced a protective effect - their health and wellbeing did not deteriorate in the same way as that of those who attended less regularly. They were also more likely to adopt, and sustain, healthier lifestyles. The importance of this becomes clear when seen in conjunction with further evidence that suggests that HLCs were successful in engaging some of the most deprived sections of their local community, including those with the poorest levels of health.

Taken together, these findings suggest that the HLC programme made some contribution to improving the health of the most disadvantaged, and possibly reducing health inequalities, across the UK.. But the importance of regular attendance also suggests that any improvement in health for individuals achieved by HLCs may be lost quite quickly once they or the activities they have supported cease to operate.

The UK study also suggests that HLCs had wider impacts that added to their effectiveness. These impacts:

> *"included the provision of new activities and resources for their local communities (including buildings for the community to use), encouragement of local people to take a more active role in improving their areas, and support for statutory and voluntary organisations in the area to make their services accessible and responsive to the needs of the local population" (Hills et al. 2007).*

We shall now look at the Scottish findings on the role of HLCs in promoting community involvement in particular.

7. Community Involvement And Its Outcomes

The HLC programme was established with the expectation that community involvement, and a community development approach to building local capacity, would be part of all levels of the work, including planning, development, delivery and management. One HLC Manager explained the approach:

> *"Community development is working with people, not for people or at people… So it's working from the bottom up with a community ... What would improve their quality of life? What are the health issues for them? ... Not telling them what to do, but enabling them and empowering them towards addressing what these issues are"*

Several things emerge repeatedly as important to building all forms of involvement.

Staff support. The persistence and dedication of staff were central. They drove forward efforts to engage and re-engage with people who might have been overlooked and to overcome hurdles to community involvement. "Stakeholders ... emphasised how community engagement could decline without the efforts of staff to support community involvement practices" (Phase 2 report).

Informal approaches. Becoming familiar with the needs of local communities involved a considerable effort to provide informal support to local people. "Face-to-face contacts were vitally important and culturally appropriate in most HLC groupings, where high value was often placed on personal contacts" (Phase 2 report). Much of this simply involved talking to people. In the longer run, this work could contribute to building social capital (i.e. social networks and shared norms and values) as a means of building health and well-being.

Long term commitment. HLCs needed time both to learn what was important in a community and to be trusted by the people in it. "Stakeholders tended to the view that five years of the HLC programme, while highly beneficial, merely marked the starting point in terms of delivering effective community development approaches within target communities" (Phase 2 report).

Responding to needs Culturally appropriate responses to local needs and demands.

HLCs do not provide one single model for community involvement. Contrary to some perceptions, though "community-led boards represent a sizeable proportion of Scottish HLCs (and other community-based initiatives), particularly in the Greater Glasgow area" (Phase 2 report) not all are community run organisations, or voluntary organisations of any kind. A higher proportion are run by a public sector agency, either in the NHS or local authority sectors.

Involvement can also take place at many different levels. At a basic level HLCs needed to engage with people to attract users to their services, using various methods, including:

- targeted marketing to agencies that supported a similar client group.
- developing partnerships with other community-based groups in order to add a health dimension to their existing work
- developing informal contacts with known local people
- recruiting staff who lived locally.

Involving local people in service delivery was important to many HLCs, not only as paid members of staff but as sessional workers or volunteers. However "much of this could not have taken place without the considerable support offered by project staff. While the HLCs have had considerable success in establishing these roles, it was clear that much further support is necessary both to maintain enthusiasm and to replenish turnover as people move on". (Phase 2 report)

Activities that were facilitated by community members included:

- weight management groups
- chronic disease self-management groups
- cycling activities
- exercise classes
- fruit barrows
- walk leaders (this was the most common example and was often assisted by Paths to Health, itself originally established as an HLC operating at national level).

One case study HLC trained and employed local people as 'lay health workers'. They were expected to use their knowledge of the local area and their new community and networking skills to support existing services, to aid identification of gaps in these services and to encourage people who might be put off by more 'professional' models of service delivery to attend activities. Examples of their activities included support to breakfast clubs operated by local schools, support to existing mental health services and support to weight management groups.

Training and informal 'capacity building' support was offered for different purposes. Training was given for volunteer roles or for participation in management. One case study HLC trained local people in 'participatory appraisal' techniques, to enable them better to seek and understand the needs of their community. Another provided several local people with supported employment and structured training opportunities within the HLC and in some partner organisations. As the 'Changing Lives' case studies (Taylor, 2006) show, involving local people as volunteers and building their personal capacity is seen by some initiatives as a major route to improving health.

The Phase 2 report suggests that the ability to guide community members who engaged with an HLC into additional future learning opportunities was sometimes lacking.

> *"Having created a throughput of local people in developmental roles, the lack of such wider capacity building opportunities sometimes proved problematic".*

Many, though not all, HLCs devoted efforts to developing independent groups. Several had now formed their own committees and successfully applied for funding to enable their activities to continue. This could be seen as building the capacity of the community to take action. Features of successful groups included:

- activities that were appropriate responses to local needs (e.g. gardening projects in rural areas to improve food access; support projects in housing areas to improve breast-feeding rates and reduce social isolation)
- the continuing provision of some form of support by HLC staff, even though they attempted to reduce this gradually.

Giving a role to community members and/or service users in the running of HLCs is an important, though not the only, aspect of involvement. Independent community-run HLCs had formed companies limited by guarantee with charitable status which gave control of decision-making to a board of local people. Others were less thorough-going in their approach. Even building up a user group to help design services might take years of patient effort. 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. In others a history of past initiatives that had come and gone made people suspicious of becoming too committed.

> *"There was ... a lot of things were way over my head ... with the partnerships and the amount of money involved and initially, I thought, I'm away out of my depth here" (Chair of HLC board)*

It is time consuming to involve local people in the work of HLCs, but those that do tend to feel their involvement is worthwhile. The Chair of the Board of an HLC explained what local people could bring to the process:

> *"Millions of things…their lived experience of their own particular circumstances and their own interpretation of what's going to make a difference to them. Also 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"*

The close relationships within some rural communities could help involvement. But gaining the interest of people in work that covered several small geographically isolated rural communities was felt to be difficult in several HLCs.

Overall, a wide variety of techniques, opportunities and roles were devised for involving local people in HLC services and structures, with differing levels of success. Many different roles were created for community members, as management, as volunteers, in paid posts and in consultation roles.

The Phase 1 report concludes;

> *"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 ... 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"*

Creative classes

8. Working With National And Local Priorities

HLCs had been asked to develop activities that responded to the health and well-being needs identified by communities, but they also to work with and complement local and national strategies and health priorities. This was a challenging set of demands for small organisations to meet.

HLCs were helping to contribute to a shift in national policy towards community-led approaches, and their broad agendas helped them to address many different priorities.

> *"The four pillars [of] 'Improving Health, the Challenge'... they were in our Business Plan in 1999. We're way ahead of JHIPs and Public Health Networks. We've been doing it"* (HLC Manager).

Many HLC activities address priority 'lifestyle' issues such as obesity or smoking, and several HLCs operated principally as service providers. Many others adopted a community-led approach. This does not lend itself to prior commitments to achieve very specific outcomes in such areas, even though it may have an important long term impact. The shift in policy towards an emphasis on promoting positive mental health and well-being is perhaps more immediately consistent with HLCs' approaches.

HLCs had to be continually aware of the need to accommodate to shifting positions at local levels (e.g. the establishment of CHPs and CPPs) and to national priorities arising from government policy, whilst seeking to retain community involvement and the relevance of activities to a variety of groups, and to ensure the support of their larger partners.

> *"HLCs are uncertain how to respond to such demands. This highlights the limited amount of central strategic guidance on offer, despite the support structures that were put in place"* (Phase 2 report).

How the links to local priorities and decision making bodies were achieved depended on:

- the type of organisation that each HLC was: some were already 'embedded' in the NHS; but even community-led HLCs could have close working relationships with local committees that allowed statutory agencies to have substantial influence over their development

  > *"We do very much reflect some of their key health agendas... we do reflect some of the key things that our [statutory agency] partners want"* (HLC manager)

- the geographical focus of the HLC, which could affect its ability to become involved in CHP or CPP structures
- the types of group targeted, which in some cases precluded a focus on wider policy, so that HLCs remained focused on their original aims and objectives.

The national Task Group on community-led health (CLTG) recommended that health improvement planning should be made more effective in engaging communities and allowing them to identify their own priorities and should bring agency and community objectives more clearly into line. This is a long term objective which will need effort from both directions.

Some HLCs reported that they were already well placed to influence wider agendas for reducing health inequalities.

> *"We're trying to build up an understanding within the city around what we should be doing around tackling health inequalities across the network ... each partner obviously brings a little bit of that."* (HLC Board member)

The promotion of community development practice within statutory agencies was an important part of some HLCs' work.

There could also be differing priorities at a professional, service delivery level and the need to create links. "In some instances partner organisations operating a medical model of health were felt by HLC staff to undervalue the social health role of the ... HLC" (Phase I report). 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.

But community development work could also be complementary to and perhaps reduce the pressure on more specialised services. One HLC set up relaxation groups to provide help to those waiting for further support:

> *"We felt that it was important to have them engaged as quickly as possible ... some people are now saying they don't need one-to-one support, the relaxation groups are enough to give them the skills to cope on their own with peer support" (HLC worker).*

These findings illustrate some of the ways in which HLCs sought to make the links to national and local priorities and some of the difficulties that they encountered. Evidence of success in making these links can be seen in the accounts that we have referred to of their progress in tackling health inequalities, achieving health outcomes and promoting community involvement.

Lesson for Policy and Practice

The successes of HLC approaches in tackling inequalities seem to be based on a combination of the ability to target disadvantaged groups successfully and obtain their participation and the fact that this participation has proved effective in improving the health of the individuals concerned.

University of Edinburgh's Research Unit in Health, Behaviour and Change (RUHBC 2007)

9. Partnership Working

The effectiveness of links to national and local priorities is affected crucially by the quality of partnership working. From the outset it was required 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". Every HLC found it necessary to devote substantial time and resources to devise and establish partnership working.

HLCs always worked as partnerships, though of very varied types. Of the six case studies:

- two community–led organisations had inputs from statutory funders
- one was a partnership between voluntary organisations
- one was made up at board level of statutory agency partners
- two others had statutory-based strategic partnership groups but devolved responsibilities to local operational partnerships comprising a wide mix of community, voluntary and statutory representatives.

Most HLCs had a governing board or committee that did not include all its partners. However the need for partnership working extended beyond strategic boards, into participation in wider partnerships on the one hand and into arrangements for delivering services in partnership on the other. Partners included community groups, voluntary groups, representatives from larger organisations, especially the NHS and local authorities (often a number of departments or sections were listed as individual partners), individual community members, and, in one HLC, several local businesses. Several areas made attempts to fit in with pre-existing partnership arrangements.

In several areas, all organisations listed in the funding bid were considered partners (though some had a limited role thereafter). In community-led HLCs, partners were considered to be those agencies which provided funding. In other instances, partners were considered to be any organisation with which the HLC worked. In some, the inclusion of new partners was an ongoing process aimed at establishing new networks.

The roles of partners included:

- financial support, or in-kind support to boost capacity and/or provide training
- support with administration and project management
- assisting with recruitment and personnel issues
- guidance on evaluation
- fundraising
- access to target groups
- referring clients
- delivering services jointly or independently
- disseminating HLC work to wider audiences.

The Phase 2 evaluation report suggests that operational, service delivery partnership working was particularly successful, although continual adjustments had to be made to take account of changes in partners' personnel. This success was often based upon practical experience and diverged from or expanded upon relationships specified in the original funding bids. "The flexibility of HLC models and the length of time spent working in partnerships facilitated robust links between statutory and community/voluntary sectors."

Example

Two HLCs which delivered mental health services had also provided training, including mental health first aid training, to a variety of community groups.

One had created a network between existing organisations delivering mental health services, to improve referrals between agencies and to encourage sharing of best practice

Another HLC had created a new team to improve links between several agencies working to maximise benefits take-up, which had led to the creation of a new referral mechanism.

The experiences of strategic partnership working were found to be more mixed. Factors which caused difficulties included:

- management resources and capacity
- varying interest from partners
- wider changes in local health organisations.

In several HLCs, resources were stretched between enhancing partnerships and delivering services and activities. In many cases the emphasis was placed on service delivery.

Partners' levels of interest and involvement sometimes declined as time went on, particularly when HLCs were considered to be operating successfully.

> *"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." (HLC Manager)*

In such instances partnership meetings were being held less often and were felt by some managers to operate mainly as feedback or reporting mechanisms. At least one saw a positive side to reducing the number of meetings, if these could be properly focused.

> *"I would rather have the commitment to meet a couple of times a year to review and plan than pretending that it's going to be anything different, and then folk don't just come to the meeting" (HLC Chair).*

Reinvigorating strategic partnerships was hard work, but could be done. In one case study, a new project coordinator coaxed a strategic group, which had been a "bit dormant", into a more active position, moving from an "overseeing role" to one based on "ensuring that there is long-term viability".

The introduction of community health partnerships and community planning partnerships caused major changes for many. The organisational status of some partners changed, as did previously established relationships. In some areas this led to declining participation and a need to refocus on building relationships. But at least one case study HLC had been able to use changes linked to the community planning process to develop a new remit for its strategic partnership, which was thought likely to help the HLC in the future.

The involvement of HLCs with their local CHPs and CPPs, and vice versa, varied greatly. It often depended on the degree of similarity in size of area and range of objectives between partnerships and their local HLCs. Different ways of adjusting to these included:

- 'Interwoven involvement' in areas where boundaries coincided sufficiently and several key individuals were partners at both levels
- HLCs whose areas were small in relation to local partnership areas but had a significant influence on local learning about either health improvement (especially if they were NHS hosted organisations) or about community involvement
- More limited involvement, with work mainly focused on operational links.

The Phase 2 report concludes that "partnership working is often defined in practice". The most fruitful relationships were not necessarily those originally envisaged. However "there was an increased recognition that HLCs, once embedded in the locality and delivering work for shared target groups, were beneficial partners within local health economies".

Features which aided partnership development:

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

Features which weakened partnership development

- 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.

(Phase I report)

Lesson for Policy and Practice

The contribution of HLC approaches to promoting mental health and well-being should be recognised and developed.

University of Edinburgh's Research Unit in Health, Behaviour and Change (RUHBC 2007)

10. Successful Project Management And Service Delivery

Although it is not the role of an evaluation to examine the day to day management of projects in detail, several themes of general interest emerge from the two reports.

Two case study HLCs benefited from funding for a pre-operational phase. Key members of staff were appointed in time to equip offices, establish partnerships networks and employment procedures, and recruit staff. In other HLCs targets for year one were unrealistic and did not take into account initial set-up pressures.

The adaptability that HLCs displayed across many of their activities extended to practical working arrangements. They were prepared to change the premises and venues that they used to meet changing demands, so that they could better accommodate services, overcome barriers to uptake or promote new methods of work. Several HLCs developed some form of social meeting space as part of their main delivery point so that people could visit them without the risk of stigma. Many also emphasised outreach work in other venues as a method of engaging local people across all of their target communities.

Several HLCs moved towards the introduction of more sessional support staff. These changes might allow them to strengthen service delivery, to pursue a variety of smaller projects, to free up staff time to allow for new development work, and to create local employment opportunities.

Changes to services were sometimes made to curtail the proliferation of activities that had been specified in initial business plans. These were widely regarded as simply a 'best guess at the time' that had been prepared during the bidding process.

The Phase one report found that the capacity and skills of HLC staff were of considerable importance to the 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" (Phase 1 report).*

In remote locations the need for training, coupled with travel requirements, stretched limited operational resources even further.

The role of HLC manager was central to each project's development. They were typically responsible for guiding service development, positioning in terms of community involvement, developing links with partners and leading thinking about sustainability However, the level of managerial resources available varied considerably.

Sometimes partners could provide part of the answer. Lead partner organisations supported some HLCs with budgetary advice, recruitment, personnel, training and fundraising procedures, and even one community-led HLC had adopted some of its funding partner's organisational structures. On the other hand, another community-led HLC developed its own procedures, based on current best practice. Another HLC found the instability of statutory agencies disruptive, due to frequent reorganisations and changes in procedures, structures and personnel.

Lesson for Policy and Practice

Evaluations should attempt to capture the indirect benefits of the intervention – such as capacity building, training of users, employment, and benefits reported by volunteers.

University of Edinburgh's Research Unit in Health, Behaviour and Change (RUHBC 2007)

Practical workshops

11. Ensuring Sustainability

When HLCs were first applied for and established, limited emphasis was given to explaining how their work might continue after the expiry of BLF funding. The Phase 2 report describes the negative impact of short term funding on organisations as, paradoxically, “a well known but neglected issue”.

But as we have seen in section 3, the future level of support for and viability of many HLCs has become a major concern and focus of activity. Not only the future of the BLF funded activities but also the additional funded projects or community activities which rely on ongoing support from HLCs are at stake, even though the policy context suggests that the approaches pioneered by HLCs should become increasingly central to health improvement activity.

Definitions of sustainability include:

- the continuation of an entire programme or parts of a programme
- the continuation of benefits or effects from a programme
- the development of community capacity to allow a programme to continue and to permit new work to be developed.

In the timescale that was available to HLCs, few would claim that communities had been so transformed that either the community groups involved or the health improvements achieved (at a whole community level) had become self-sustaining. The sustainability of HLCs has been discussed mainly in terms of whether it is possible to retain or modify the organisations or at least the activities that they have supported. “With most HLCs requiring large funding packages to continue their organisation and services, it was apparent that options among their partners and within local health economy structures were limited” (Phase 2 report).

The evaluators see the adaptability of HLCs, their efforts to shift focus as new local needs and political priorities emerge, as “a key strength of the programme, enabling HLC stakeholders to adopt positions which should aid sustainability” (Phase 2 report). HLCs were informed by the then Scottish Executive that future funding for health improvement programmes was to be distributed by local organisations such as CPPs and CHPs. Whilst future plans were based on the learning and innovation that had taken place, much attention was given to seeking to “create proposals that we know will have the support of the CHP, or other community planning partners”.

There was seldom an automatic fit with other partners’ criteria and many HLCs were looking at a need to alter their service boundaries to incorporate larger areas and, in some instances, new directions for work. But any such proposals risked losing:

- the goodwill and attendance at services built up in local communities
- the ethos of innovation and the community development approach
- the characteristic forms of service provision developed by HLCs
- the focus on vulnerable groups
- local community involvement and governance mechanisms.

The HLC partner who admitted that “what I would like to do is, less of a Healthy Living Centre, but [more] a healthy living service that covered the area” might risk getting something that lacked those features which are seen to have been successful in HLCs. According to another HLC partner, a move away from local provision:

> *“Would be a bit damaging… [as]… that’s where you get the added value, that’s where you get the trust and the credibility and the local relationships”*

There was seen to be a lack of strategic guidance about sustainability. Some attempts to overcome this were put in place through funding made available by the BLF, which led to the creation of the HLC Support Project. But at the crucial local level, many HLCs still found it difficult to get clarity about intentions from local partners or a constructive dialogue with them, especially because of the system-wide changes that partners themselves were undergoing.

Planning for sustainability could involve many changes in the way HLCs operated, but in particular involved changes in their structures, a greater focus on outcomes, and attempts to raise their profile.

Changes to structures could be in differing directions. Some community-led organisations tried to ensure that they had better links with mainstream services; though they might also seek to diversify their sources of funding, through fear of losing their capacity for flexibility and innovation. At the same time some statutory-led services moved to become independently constituted in order to attract external funding, whilst fearing that this could lead to a reduction in statutory support and competition with other voluntary organisations.

Awareness of the need to ensure future survival was a powerful force behind the growing focus on defining desired outcomes and assessing HLCs’ contributions to them (see section 5).

> *“I think part of our long-term sustainability is that we’re very clear about what our outcomes are, how we can then measure them. Then when we go to other funders or other agencies or we’re bidding for other work we’re quite clear on that” (HLC Manager).*

Stakeholders in several HLCs expressed the need to build a profile that enabled HLCs to gain recognition for their work when approaching potential funders. This might include effective use of evaluation tools. But it also involved building general awareness of the work of the organisation and its identity. HLCs sometimes struggled to establish a profile, particularly when much of their work was delivered in partnership with other organisations.

The development of Service Level Agreements and the opportunity to demonstrate contributions to Single Outcome Agreements create the potential for the success of community health initiatives to be recognised and rewarded.

When looking to sustain work towards health improvement outcomes, partners should take into account the need to preserve and build upon the specific relationships, work practices and acceptance within local communities that have been developed by the HLCs. Not only the services but also the community-based processes involved should continue to be supported and developed if outcomes are to continue to be achieved.

The learning points that we have outlined in section 2 are therefore immediately relevant to many current funding and organisational decisions.

Lesson for Policy and Practice

A variety of configurations of staff, including both dedicated project workers and sessional staff can be used to meet needs. But significant levels of staffing, skills and training of staff, and time are needed to become familiarised with communities. Professionalism of staff is very important for many HLCs.

University of Edinburgh's Research Unit in Health, Behaviour and Change (RUHBC 2007)

Lesson for Policy and Practice

The time invested by HLCs in local capacity building, the length of time taken to gain trust and 'win over' local people, and the diverse models of engagement adopted with local communities should be recognised and built upon. Such connections can be easily lost if an HLC is discontinued.

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Healthy Eating Café

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