cheX Point

'Sustainable Development' & Community Health Initiatives

The launch of the UK-wide (March 2005) and Scottish-wide (Dec. 2005) strategies on sustainable development – *securing a better quality of life for current generations, without compromising the rights of others in the world and future generations* - provide new opportunities for Community Health Initiatives (CHIs) to link their work on the ground into programmes and actions emerging from these strategies. The Scottish strategy gives a commitment *to building a sustainable future, which supports individuals, businesses, local authorities and communities to take action to change the way we use resources, plan and develop services, and seize economic opportunities that sustainable development presents. Policies and programmes are in place to affect change in key area: such as transforming the way we deal with waste, capitalising on sources of renewable energy and taking action on climate change.*

A core aim of the Scottish Strategy is to promote people's well-being, with emphasis on *good health, a decent income, meaningful work, a high quality local environment, spending time with friends and family, taking part in activities that are not linked to work – sport, culture, leisure, studying and volunteering.* As many CHIs's already carry out this type of activity, it's a good opportunity for them to join up with new players in sustainable development and explore mutual advantage in tackling health inequalities and health improvement within the context of sustainable development.

At last year's UK Public Health Association's seminar (June 2005) sustainable development and public health, several CHIs contributed their expertise on addressing issues related to 'Food and Low Income' and 'Sustainable Transport Systems', together with knowledge and expertise in social economy, procurement policies, and community engagement. This proved an excellent experience for different players to come together and share their different interests and responsibilities in relation to sustainable development.

A practical way for CHIs to directly link into the Strategy is through Future Scotland Partnership's Initiative 'Sus It Out'. This is an awareness raising activity that invites groups to evaluate their culture and how they think and act against the core principles of sustainable development i.e. living within the earth's resources limits while building social, economic and environmental justice for all. The initiative is still evolving, but once established, trained people from FSP's partner organisations (which include CHEX) will facilitate 'Sus It Out' sessions. The exercise will be supported by 'signposting' to organisations that can help groups to develop aspects of their sustainability, by networking through the Community WEBNET and by national events. Feedback from the exercise will also be linked to the development of sustainable development indicators to evaluate its local and wider.

CHEX members who are interested in becoming involved in 'Sus It OUT' and/or wish to receive copies of the UKPHA Seminar Report, please contact Tom Warrington at tom@scdc.org.uk or David Allan at David@scdc.org.uk. For general information on 'Sus It OUT', contact Damian Killeen at damian.killeen@civicforum.org.uk.

Download 'Choosing our future: Scotland's sustainable development strategy' on www.scotland.gov.uk/Topics/Environment/SustainableDevelopment.

STOP PRESS:
Sustainability of Community Health Work

At the same time as the CHEX team are traveling across Scotland to promote strategic approaches to Sustainability for both Healthy Living Centres and Community Health Initiatives, members of the staff team have also been receiving information about lack of security for the future for some projects.

Both the Lothian Community Health Projects Forum and West of Scotland Community Health Network have reported current lack of clarity about how their member organisations might secure their future. The West of Scotland Network, at their last meeting, decided to raise this matter with Health Minister Andy Kerr. They wrote to Mr. Kerr about their concerns surrounding communication with funders, commitment to Community Health Initiatives and the potential loss for communities of their services. They are currently waiting for a response to these points.

While it is important that individual organisations need to take a strategic approach to their future, there are questions about the commitment of the statutory agencies to support community development approaches to tackling health inequalities. The policy agenda has never been more supportive. However, the lived reality of organisations illustrates that in some areas there is a mismatch between policy and practice.

While local structures within Community Planning Partnerships and Community Health Partnerships are being put in place, Local Authorities and Health Boards need to consider how they will continue support for organisations who have worked successfully to address health inequalities in our most disadvantaged communities.

CHEX would be interested in the position of organisations across our network. Do you have secure commitment from statutory partners for your organisation or, like Glasgow, is the position uncertain? If you have any information on this topic that you would like to share with us we would like to hear of your experiences good or bad. Please e-mail chexadmin@scdc.org.uk or telephone 0141 248 1990.

Community-Led Health Group - 'Moves into Top Gear'

Last year, CHEX-POINT reported on the formation and remit of the Community-Led Supporting and Developing Healthy Communities Task Group. The Task Group's Chair, Mary Castles, talked optimistically about the potential for the Task Group Partners to promote and support the community-led agenda within health improvement and tackle health inequalities. As the outputs are nearing completion, CHEX-POINT is alerted to, amongst others, recommendations on Sustainability of Community-Led Activity, *Planning and Partnership Working, Building the Evidence Base and Investment in Capacity Building.* In addition to the recommendations, there are helpful tools such as a Briefing on applying the National Standards in Community Engagement into health improvement partnerships and sharing of good practice through DVD and written case studies.

Throughout the process, CHEX has welcomed the opportunity for Community Health Initiatives (CHIs) within its Network to share lessons from their health improvement work, in particular working with those people who have experienced greater exclusion, community engagement in local decision-making processes and evidencing the impact of community-led health improvement.

Over the summer months, the Task Group's Chair will meet with the Minister for Health to share progress on work to date as well as set in motion a plan of action to take the Group's final recommendations forward. The Group is also developing a portfolio of resources, which will culminate in a celebration and official launch in Autumn 2006. If you like further information on ongoing developments, please contact Janet Muir on Janet@scdc.org.uk or Lizanne Conway on Lizanne.Conway@health.scot.nhs.uk. NHS Health Scotland's Information Sheet on the Task Group's work can be downloaded on www.chex.org.uk

Task Group's outputs - Prepare for Lift-Off

Scottish Communities

Briefing on National Standards for Community Engagement

Involvement in Strategic Planning

Evidence Review

Case Studies

DVD

Scottish Executive - Social Inclusion Dept
Health Scotland
Voluntary Health Scotland
CHEX
Big Lottery Fund
Scottish Executive - Health Dept
Health Improvement Officer
COSLA
Volunteer Development Scotland
Scottish Community Diet Project
Communities Scotland
Public Health Practitioner
Health Promotion Officer
Scottish Development Centre for Mental Health
National Resource Centre for Ethnic Minority Health

CONTENTS

The Smoking Ban – Supporting the Quitters

With the much-heralded legislation banning smoking in public places finally coming into force in March, CHEXPoint takes a look at the impact of the ban on community health projects, their workforce and user groups. In the following article, Ash Scotland provide an overview of the ban and we hear from several community projects that are supporting the quitters.

The smoking ban finally came into effect calmly and quietly at 6am on Sunday 26th March. There were no fanfares or symbolic final smokes; most of Scotland was asleep when the most significant piece of public health legislation in a generation came into effect. Despite the massive public debates and the no-holds barred contest between the tobacco industry and advocates for health, the end of smoking in public places came without rebellion. At time of writing, Scotland has been smoke-free for several months and the measure has been a stunning success so far.

Smoke-free public places in Scotland marks the end of many years campaigning by ASH Scotland. The implementation may have been straightforward but that does not reflect the nature of the campaign for the new law. Every step of the way, from presenting the evidence of the damage caused by second-hand smoke to promoting successful smoking bans in places like Ireland, we had to counter the strong opposition of the tobacco industry and licensed trade who argued that going smoke-free would be a disaster. Overcoming those arguments was in large part due to making our argument about health and backing it up with the best scientific evidence available.

So far the legislation is working well in Scotland. In ASH Scotland's opinion, this is in part due to its simple and easily understood nature. Rather than the complicated compromises proposed by the tobacco industry, you simply can no longer smoke in enclosed public places in Scotland. There are a few exemptions, which

If you can't tackle me you won't get far

I'll get you!

graham@ogilviedesign.co.uk

illustration © NHS Health Scotland

were granted for reasons of humanity than fear of potential lost profits, to places like psychiatric wards. Overall, however, the law is easy to understand and implement because it is so comprehensive.

Opinion polls before implementation showed over 60% support for going smoke-free. The successful implementation and positive experience of the ban can only further increase its support. We have every reason to believe that Scotland will follow all other countries that made smoke-free legislation a great success.

Iain Brotchie,
Communications Officer, ASH Scotland

Read more about how Scotland went smoke-free with ASH Scotland's report, "The Unwelcome Guest: How Scotland Invited the Tobacco Industry to Smoke Outside" http://www.ashscotland.org.uk/ash/files/The%20Unwelcome%20Guest.pdf

Dundee Healthy Living Initiative

Dundee Healthy Living Initiative adopts a community development approach and, as is often the case when local people are asked to identify their own health needs and issues, smoking does not come top of the list. However, as the project enters its 4th year, and participants have been supported to take steps towards a healthier lifestyle in areas such as healthy eating and exercise, smoking begins to be an issue they feel more able to address.

The DHLI has recently appointed an existing member of staff as smoking co-ordinator and responsibilities to date have included piloting innovative smoking cessation activities with local people and leading a consultation on behalf of NHS Tayside on smoking in pregnancy.

DHLI nurses give smoking cessation advice at Health Information Points, which take place in shopping centres, community buildings and even in pubs, and run a range of community smoking cessation classes. Up till now, these have been requested only occasionally and success rates vary.

However, in the period leading up to the ban on smoking in public places, the DHLI prepared itself for a significant increase in requests for smoking cessation assistance. Staff reported that many local people (particularly those who were encountered in pubs) were in denial that the ban would be implemented and/or panicked that they need to stop. In addition, some of the mental health services with which the project works jointly had clients who would require intensive and ongoing support to address their smoking habits.

The project is responding to these local requests in an innovative, interactive, client-led manner and is successfully tackling the major increase in smoking cessation activity in the wake of the ban.

Sheila McMahon, Team Leader (Strategic Development) (sheila.mcmahon@dundeecity.gov.uk)

West Lothian Food Co-op Network

West Lothian Food Co-op Network (WLFCN) provides a support network for volunteers and staff working in established food co-ops throughout West Lothian. The objectives of the WLFCN are to:

- χ Purchase or collect good quality, healthy food and other supplies and sell them within the area at the lowest possible cost.

- χ Promote health by increasing awareness of the importance of food and health

- χ Access quality training, skill development and support for volunteers and to promote and publicise the benefits of community food co-ops and support he development of other such initiatives.

The WLFCN has strong links with the West Lothian Food and Health Steering Group and the West Lothian Community Planning Structure. Through its work the Network is able to influence the direction of the West Lothian Food and Health Action Plan.

Eurohealthnet Project Exchange - West lothian welcomes Belgian Visitors

As part of the Eurohealthnet Social Inclusion Programme a group from Belgium visited to see the work of the Network and two of the local food co-ops in West Lothian. This gave the opportunity to exchange practice and to talk about the different ways of tackling the same common issues. The visit went extremely well and gave local volunteers an opportunity to tell others about the difference their work makes in reducing exclusion and addressing inequalities.

"As a local resident working in our community to improve it, it is exciting to see people from other countries interested in our work." (Faye, Bridgend Food Co-op)

"We learned a lot from the Belgium visit. It was interesting to learn about another country." (Jessie, Polbeth Food Co-op)

For me, the visit gave me a chance to reflect on the work carried out locally and the benefits of involving local community's right from the start. The Belgian approach was very different in that promotion of health was, in the main implemented through core programmes. The visitors were very keen to learn more about the community development approaches used in Scotland. It was good to be able to share our experiences.

Fiona Bayne, Food and Health Development Officer (fiona.bayne@wlt.scot.nhs.uk)

Tackling Health Inequalities and Social Exclusion in Europe

In 2004 the European Union enlarged from 15 to 25 member states. It forms a political and economic area with 450 million citizens and now includes three former Soviet republics (Estonia, Latvia and Lithuania), four former satellites of the USSR (Poland, the Czech Republic, Hungary and Slovakia), a former Yugoslav republic (Slovenia) and two Mediterranean islands (Cyprus and Malta).

In joining the EU, new members were obligated to fulfil certain economic and political requirements, and adopt common rules and policies which make up the body of EU law. Although the European Social Model is firmly embedded in EU Treaties, stimulating economic growth while promoting social cohesion and maintaining high levels of social protection remains a key challenge for member states. The Joint Report on Social Inclusion (2001) identifies social exclusion as 'circumstances where people are prevented from participating fully in economic, social and civil life'. The Report also highlights the negative effects of poverty and social exclusion on levels of social cohesion and economic development.

Despite coming together within Europe, health care systems and services remain the responsibility of individual member states and the EU has limited power to impose legislative solutions in these areas. However, within the wider area of public health improvement, tackling health issues at national, regional and local level can benefit from shared learning, enhanced co-operation and partnership working between members.

In response, EU leaders agreed to apply the Open Method of Co-ordination (OMC), a process whereby member states identify aims and objectives relating to a specific policy area and incorporate them into their National Action Plans (NAPs). A number of OMC's have now been developed, including one in the area of social inclusion.

In December 2005, NHS Health Scotland and EuroHealthNet organised the conference, 'In Good Health'. This marked the culmination of the two-year project Tackling Health Inequalities and Social Exclusion in Europe: Phase II. Twelve EU partners were involved: Belgium, Latvia, Malta, Netherlands, Sweden, Italy, Spain, Germany, the Czech Republic, England, Wales and Scotland.

As part of the project, transnational exchange visits were organised. This enabled health professionals working within diverse political structures across the EU to explore common issues, identify good practice and share learning with EU partners at a deeper level than would otherwise have been possible.

Recommendations were drafted by the project partners and were amended and endorsed at the conference. The recommendations proposed key issues, strategies and approaches to be considered in relation to health improvement activity designed to address social exclusion in the EU. There is no obligation to adopt the recommendations. However, they can serve as guidelines for health and social care professionals engaging the NAPs/Inclusion process and to ensure NAPs are informed by good practice prevalent within the field. The recommendations in full can be viewed at: www.eurohealthnet.org. For further information, contact John Brown on John.Brown@health.scot.nhs.uk

What Community Health Initiatives took from the Transnational Exchange

Phoenix Community Health Project, Inverclyde

Phoenix is a community health project in Inverclyde adopting community health development approaches to health improvement.

We thought it was valuable for the visitors to see first hand the areas that we worked in and therefore took people around different areas of Greenock – highlighting the contrast in living standards and inequalities of health between those in low income areas and those in affluent areas. Enroute, we popped into different community facilities that support local people in community activity and provide health, social and recreational services. Surprisingly, Greenock enjoyed one of its rare sunny days and we were pleased to show off the place in its best light!

Back at Phoenix's base, management committee members and representatives from other local groups joined us to share information and view points about different ways of tackling health inequalities and improving health. The discussion highlighted various approaches to health improvement and we were keen to impress on our visitors the different ways of involving people, not only in activities by also decision-making that affects their lives.

The idea of a European Exchange for sharing information and good practice is sound, as well as exchanging ideas, it provides a good opportunity for an exchange of different cultural approaches. However, on this particular exchange, time was the essence! The visits were packed into a two day event, with lots of presentations and site visits, which didn't really allow enough time to thoroughly explore ideas and build relationships. We would definitely suggest that if visits remain one-way then they should be organised on a residential basis, where people have time to draw breath, give presentations, share ideas and build relationships that provide a strong basis for ongoing dialogue.

Anne Crawley, Phoenix Community Health Project (phoenix_health@btconnect.com)

REACH Community Health Project

REACH Community Health Project strictly endorses a no-smoking policy within the workplace in order to ensure other employees are working within a 'safe environment' and that their health is not put at risk as a result of passive smoking. It is imperative for Managers to prevent smoke in the workplace so not expose others to an increased chance of heart disease and other passive smoking related side effects.

REACH has recently been successful in a joint application with the Greater Glasgow NHS Board Pharmaceutical Department to Pfizer who through an educational grant have supported the setting up of a Black and Minority Ethnic (BME) Men's Smoking Cessation Clinic. Essentially this would allow clients to access a Pharmacist and undergo an interview in order to assess their readiness to stop smoking and their suitability for using Nicotine Replacement Therapy (NRT). At each visit, the client will be supplied with NRT, offered encouragement and information, have their Carbon Monoxide levels measured using a Smokeanalyser and relevant outcome data recorded.

REACH recently conducted a project on "Actively Preventing Cancer in Gorbals and Govanhill areas of Glasgow". During an information workshop with the youth, there was particular interest expressed in the information provided our interactive website on "Quitting Smoking". Engaging youth in projects on health-related issues is a priority for REACH as adolescence is a vulnerable period of transition in which lasting life-style habits are formed. Since there is a higher rate of cancer among BME groups, we have also prioritised cancer prevention.

REACH has also been successful in receiving funding from ASH Scotland to conduct research into 'BME Youth and Patterns of Tobacco Prevalence' and recently to develop an educational media based resource highlighting the dangers of tobacco use specifically targeting BME youth. A core group of 14-18 year old BME youth will be active in the creation of video and radio broadcasts that tackle the issue of smoking cessation/prevention among their peers. The project will be guided by a media producer with group work experience, who will work collaboratively with REACH's Youth Health Participation Officer. It is imperative that BME youth are consulted and informed about the harmful effects of tobacco consumption which may then deter this target group from continuing/starting to smoke.

REACH whole heartedly welcomes the Scottish Executives decision to enforce a 'No Smoking in Public Places' as Scotland has been at the bottom of the European Health League tables and this is an excellent opportunity for Scotland to improve its poor public health record.

Uzma Aslam, Assistant Manager (uzma@reachhealth.org.uk)

Stirling Health and Well-being Alliance

Stirling Health & Well-being Alliance has been a smoke free organisation for the last 15 years and promotes and provides health improvement sessions over 8 communities across the Stirlingshire area.

The Stirling Health & Well-being Alliance operates a non-smoking office and provides all community health improvement activities within existing community venues. This often means, therefore, that SHWA staff are required to work in venues with smoky atmospheres such as pubs and welfare centres. Not only is the health of workers open to compromise in such situations but an unhealthy venue flies in the face of promoting health improvement to local people. As a direct result, many people are put off taking up the health activity on offer.

With the smoking ban now in effect, we, as workers, are no longer subject to passive smoking. Therefore, venues that were previously off limits for our work because of their smoky atmosphere can now be considered, leading to greater opportunities for capacity building within communities.

In promoting the ban, we adopt a community development approach. We encourage community facilities to advertise their venues as being smoke-free and, accordingly, as being healthy places to take up community activities. This helps to allay some fears that venues would have in losing custom through the smoking ban by providing a venue open to a wider audience.

During the course of our promotional efforts, it is obvious that local people are well aware of the introduction of the ban and are conscious of the changes that the legislation has brought. However, there was undoubtedly a certain amount of trepidation for many people who feared that they would feel embarrassed within their community, especially at social events, and would feel in a minority when attending venues which do not cater for their habit.

As a result, we expect to experience an increased uptake of smoking cessation sessions and this, in turn, will have a knock-on effect i.e. an increased uptake of other health improvement opportunities that we provide, such as weight management and physical activity sessions.

Suzanne Wright, Information Resource Worker (info@shwastirling.freeserve.co.uk)

'Sharing Power - Requires a Radical Shift'

In Jan. 2006, Professor Jennie Popay, from Lancaster University presented some major challenges at a Glasgow Centre for Population Health Seminar on 'The Contribution of lay knowledge to reducing health inequalities'. CHEX-POINT followed this up by asking her assessment of current developments in joint decision-making between health professionals and lay people. Although Set within in an English context, her response has many resonances for the Scottish experience.

Community engagement has never been more popular – we have moved from 'listening to local people' during the Thatcher years to a situation today in which the public sector is required to engage communities of place and interest in a whole range of activities from planning and policy making to the governance and direct delivery of services. But is this anything more than better rhetoric - is real power being redistributed? And what needs to happen in the future to move this agenda forward?

Superficially at least there does seem to have been a change in relationships between public organisations and the people they 'serve' over the past 10 years. Legislation has placed a statutory requirement on public bodies to consult with local people on all aspects of their decision making, the NHS is to be patient led, the Healthcare Commission is working closely with the new national system of Patient and Public Involvement Forums in England in developing and implementing their standards based approach to regulation and inspection, a string of major national initiatives – Health Action Zones, Healthy Living Centres, Sure Start, New Deal for Communities, Communities leading for Health, etc – are based on the premise that they will only succeed if they develop more equal and effective relationships with the people who are the target of their work.

There is also a growing body of evidence that listening to the experiences and needs of lay people particularly those living in the most disadvantaged circumstances, involving them in the co-production of solutions to the enduring problems they face and giving disadvantaged groups the power to act collectively on their own behalf does lead to more appropriate and therefore more effective interventions to improve population health and reduce health inequalities. The success of the Healthy Communities Collaborative in reducing falls amongst older people and the myriad of successful community health projects focusing on improving the environments in which health related choices are made demonstrate the impact authentic community engagement can have at a micro level. Similarly, at a macro level the transformational potential of collective action by lay people can be seen in many quarters including for example, the impact of the woman's movement on maternity services and hospital care for children and the mental health survivors' movement. However, at the risk of gross over simplification

and without the space to go into detail it also seems clear that whilst these examples may testify to the potential contribution of community engagement to population health improvement taken together they do not represent a transformation of relationships between public bodies and lay people – we have not yet seen a radical sustainable shift in the 'way things are done' in the public sector.

Whilst recent reviews[1] of the impact of community engagement for health improvement have identified many examples of good practice they also suggest that there remain significant barriers to more effective practice. The SAFEC research funded by the Department of Health[2], for example has identified five types of barriers to more effective community engagement operating within communities and the public sector:

✗ the capacity and willingness of service users and the public to get involved

✗ the skills and competencies of public-sector staff

✗ the dominance of professional cultures and ideologies

✗ the organisational ethos and culture

✗ the dynamics of the local and national political system.

These barriers have also been identified in the formal evaluations of a number of recent high profile public health initiatives with a commitment to engage with communities at all levels[3]. There is little evidence, for example, that the strategic directions of Health Action Zones, New Deal for Communities initiatives or Sure Start schemes were or are being shaped by local communities although these initiatives do appear to have succeeded in fostering active community participation in specific health improvement projects and in the delivery of some services.

Attempts to share power and influence with communities in all these initiatives were severely constrained particularly by the demands from funding bodies for quick wins. The neglect of the principles of common purpose espoused during the opening stages of these national initiatives was experienced as a lack of respect by community participants, undermining their motivation to maintain relationships with public agencies and their staff. National evaluations of these initiatives point to deficits in the skills and competencies required for effective working with active communities within public sector organisations at a local, regional and national level including government departments. Whilst Healthy Living Centres may have avoided some of the difficulties the evaluation suggests that they have become marginalised from mainstream policy developments and that learning from their experiences has been limited[1].

Equal Dialogue

Effective community engagement is dependent on the existence of both community and organisational capacity – including values, knowledge, skills, competencies and motivation. Whilst methods for building and/or releasing community capacity have received critical attention over many years, methods to build organisational capacity for community engagement are underdeveloped. Research suggests that this will require structural and cultural changes at the organisational level as well as improvements in appropriate knowledge, skills and competencies amongst public sector employees. Resources to support appropriate organisational change are beginning to be made available, including for example, a resource pack based on the SAFEC research described above but this type of resource cannot deliver the cultural and structural changes required without a similar shift in the ways things are done by central government and the signs do not bode well. For example, the panel of 'experts' recently set up by the Secretary of State for Health to make recommendations for changes to the national system for patient and public involvement in health is entirely white, largely middle class and dominated by public sector/professional voices – little evidence of co-production or authentic engagement.

Lay people are well aware of the way in which the positional power of professional groups can be used to define agendas for action and determine solutions to problems. More importantly, however, lay people learn that nationally and locally the public sector is unwilling to truly share their positional power. Sharing power is a risky business but it is also an essential one if we are to see the fundamental changes in relationships between public bodies and citizens that are apparently on the agenda of all political parties.

Professor Jennie Popay, Lancaster University

For more information on this article please contact Janet Muir at janet@scdc.org.uk

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