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**Recapturing the Bevanite Dream?
Case Study Evaluation of Healthy Living Centres in Wales**

Interim Report to the Office of the Chief Medical Officer, Welsh
Assembly Government

Summary of progress to October 2005

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Analysis for Policy



Llywodraeth Cynulliad Cymru
Welsh Assembly Government



**Cardiff Institute of Society, Health and Ethics
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Abstract

The Healthy Living Centre's (HLC) programme was initiated in 1998 in response to the UK Government's drive to tackle inequalities and address the broader socio-economic determinants of health. Funded by the New Opportunities Fund (NOF), now the Big Lottery Fund (BLF), this programme also resonated with an emerging political adherence to 'localism' which supported the view that effective responses to such problems needed to be addressed at a local level as well as by national government. The emphasis from the start was on the development of strong local service partnerships and effective mechanisms for community engagement. Another distinctive feature of the programme was its basis in a social and 'salutogenic' model of health. Indeed HLCs draw on a concept that has its point of origin in the pre-NHS days, that health services are about health improvement in times of wellness as much as they are about health care in times of illness

The evaluation of the programme was commissioned by NOF and led by the Tavistock Institute with a range of academic partners, including Cardiff University. Additional funds for the evaluation were provided by the Welsh Assembly Government. This paper is the substance of an interim report to the Health Improvement Division (HID), which is in the Welsh Assembly Government's Public Health and Health Professions Department (PHHPD), as part of Cardiff University's agreed outputs. It enables emerging findings to be placed within Wales' distinct policy context.

Drawing of 'theories of change' evaluation this paper focuses on the way in which HLCs have theorised and developed activities to address health issues, the approaches they have developed to engage with local people or 'users' and the positioning of HLCs in an evolving local health economy. The ways in which efforts to sustain the work of the HLCs are being interpreted and operationalised are also discussed.

Keywords: health improvement, health inequalities, community engagement, sustainability, evaluation.

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EXECUTIVE SUMMARY

Introduction

- The Healthy Living Centres (HLC) programme was funded by the New Opportunities Fund, now the Big Lottery Fund, as part of the UK Government's drive to tackle inequalities in health.
- Though not initiated by the Welsh Assembly Government it parallels other area based initiatives aimed at tackling the broad determinants of health to address factors such as social exclusion and health inequality
- The importance of involving a broad range of partners was stressed as was the development of innovative ways of working to find local solutions to problems faced by different population groups.

The Evaluation

- The UK evaluation is led by the Tavistock Institute in London and involves a consortium of academic organisations including the Research Unit in Health, Behaviour and Change at Edinburgh University, the School of Social Sciences at Cardiff University, the Institute of Health Research at Lancaster University, the Institute of Public Health in Ireland, the Personal and Social Services Research Unit at the London School of Economics and the MRC Social and Public Health Sciences Unit at Glasgow University. The research team is known as the Bridge Consortium.
- On top of funding from the New Opportunities Fund (now Big Lottery Fund) the Welsh Assembly Government, through the Public Health Improvement Division, has provided additional resources to increase the number of case studies conducted and to produce a report relevant to the Welsh policy context.
- The UK evaluation consists of a two main components. Firstly, a Health Monitoring System (HMS), led by Edinburgh University, has been set up to assess the impact on the health of people who use Healthy Living Centres (HLC) and the extent to which the programme is reaching its target population. Secondly, case studies of individual HLCs have been conducted to capture in detail how they work, how they relate to

wider local policy objectives and how the programme objectives operate in relation to different local policy and cultural contexts.

- This report focuses on a second round visit to all case studies in Wales. It also draws on a policy seminar that was conducted with representatives from the Welsh Assembly Government and other national public health organisations. The UK wide HMS will be reported at the end of the evaluation period in spring 2007.

Approaches to improving health and tackling health inequalities

- HLCs embrace a holistic approach to improving health the key difference being on whether they focus on individuals and lifestyles or on the social and economic conditions under which people live. Community well being was also integral to the vision of health in HLCs with a strong emphasis on community development.
- HLC co-ordinators find it more difficult to articulate how their projects contribute to tackling inequalities in health, though their partners in local authorities or Local Health Boards could more easily see how these projects may play a role in meeting their strategic objectives in this regard.
- Activities are also shaped by different models of HLC. Whether they are virtual or a dedicated centre, whether they are completely new or based on a previous initiative and whether they concentrate on developing new approaches to health improvement or are a mechanism to bring existing initiatives and services to the target population, are all factors that have shaped the identification and development of activities.
- HLCs have developed a variety of activities aimed at improving lifestyles, providing better links to services, activities for parents and children and activities addressing social exclusion, poverty and unemployment. Activities relating to food, physical activity and children's health had more attention than was originally expected, whilst there have been few successful developments around smoking cessation. Many activities, particularly with regard to food and physical exercise, have been based on national initiatives rather than new activities developed from scratch.
- HLC co-ordinators and managers report that services and agencies are beginning to come to them to develop ideas, indicating that they can act as a magnet and an anchor through which services can be based.
- Links with primary care services are problematic in many HLCs, except where the links have been explicit from the outset.

- HLC managers and co-ordinators are having difficulty in demonstrating their successes in relation to the up-take of their activities. Providing numbers of people who have participated in activities can be misleading in demonstrating success. For instance, a large number of people may participate in a community festival supported by an HLC but a small number of people may participate on an environmental project which could have greater and more sustainable benefits in the community. It is clear, however, that some HLCs have clearly succeeded in involving large numbers of people in their activities.
- HLCs also struggle to provide evidence of impact on health. Reasons for this include the lack of funding, time or skills to conduct or commission project evaluations, the criteria of success in such initiatives are contested and the timescales for improvement may go well beyond the funding period. This also highlights the need for evaluation at the earliest opportunity in such programmes.
- HLCs have, on the whole, been more successful in attracting women than men. Some HLCs have started to explore ways in which they can engage men in activities that may benefit their health.

Building capacity for community engagement

- For community development focused HLCs, the ways in which the HLC and its partners work with the community is sometimes as important as the actual activities that they develop.
- They have worked in a variety of ways with partners, and other area based initiatives, to engage with communities and develop a set of activities that are relevant to their needs. However, the way in which both communities and partners engaged in the application process appears to have extended into the development phase of the HLC itself. If there were problems or uncertainties around roles and ownership from the outset then these appear to persist once the HLC is underway.
- For projects that are led by statutory agencies, HLCs have provided an opportunity to test new ways of engaging with communities and in developing approaches to improving health and well being.
- Projects focusing on particular places tended to use community development methods to engage with local people whilst those promoting a particular approach or

representing a distinct population group tended to be voluntary organisations and relied on their organisation's experience of working with particular groups of people.

- Some HLCs were involved in supporting local people in taking a leadership role in relation to health improvement activity. These approaches are slow to develop but examples of good practice are anticipated in the latter stages of the evaluation.

Developing Links with the Wider Health Economy/ Health Policy

- Critical to the success of the HLC programme is the extent to which the projects, and the new activities or ways of working that they have developed, are understood or taken up beyond the life of the funding period.
- In terms of national policy the Healthy Living Centres programme may have been at a disadvantage in Wales as its origins pre-date the creation of the Welsh Assembly Government. This may have impacted on the extent to which the evaluation could effectively provide learning opportunities to national and local policy makers.
- Representatives of Welsh Assembly Government and national public health organisations suggested that HLCs may well be able to contribute to the overall ambitions of the Welsh Assembly Government in developing innovative ways of tackling the determinants of health at a local level, but there was a general lack of agreement on how the effectiveness of HLCs can and should be measured. It was also felt that HLCs are trying to do something different which cannot be considered or measured alongside other kinds of intervention in the same way. In comparing different kinds of intervention it is therefore necessary to develop appropriate evaluation methods in the context of debates about acceptable forms of evidence.
- Wales needs to continue to explore effective ways of preventing ill health, promoting health and tackling persisting inequalities. This requires commitment across sectors and leadership to promote the approach at the highest level. The Healthy Living Centres programme provides opportunities for cross-divisional learning in relation to the common ground between health and community regeneration.
- There is a tension between innovation and sustainability. The HLC programme was a new idea that appears to have been lost amongst other policy innovations. This tension may be experienced at a local level with one case study already finding it difficult to find continuation funding.

- At a local level, partnerships are an important link to the wider health economy and are seen as crucial to the sustainability of activities and approaches developed by the HLCs. Partnerships were understood in different ways by the HLCs and there was a clear difference between those that provided operational links, as a means of delivering services and/or activities, and those which were strategic, providing links to wider local policy. Both kinds of links have provided a range of benefits.
- Strategic links are important as a means of ensuring that local authorities and health boards have a direct interest in the overall direction and future of the HLC. The existence of strong strategic links is no guarantee of funding commitments by commissioners in the statutory sector, even when evidence for effectiveness is strong and the approach appears to meet local strategic objectives.
- HLC co-ordinators and managers had difficulty in maintaining a balance between developing their local project and ensuring relevance to the wider objectives of the local authority and the LHB. Most HLCs were fully occupied in developing the project with little time to devote to ensuring their wider strategic relevance.
- A workshop held with some HLCs prior to selection of case studies also highlighted a lack of knowledge amongst some managers and co-ordinators of the current policy environment. Training and support on current health and regeneration policy and structures in the initial stages of a HLCs life may have been useful.
- Although greater insight into the legacy and sustainability of individual projects will be clearer by the end of the evaluation, lessons from one HLC suggest a number of key issues that may face projects as they start to consider the sustainability of their projects. These include: the fact that the task of seeking funding is highly time consuming which impacts on time given to project development; that continuation funding can be difficult to obtain; that projects may lose staff towards the end of the project funding; and that they have to prepare local people or their target groups, for the loss of a project that they may have enjoyed.
- Not all HLCs will be sustained in their current form but many will have left a legacy in terms of ways of working to improve health and well being which will be sustained beyond the programme funding.

1 Introduction: methods and data sources

Background

- 1.1 Healthy Living Centres (HLCs) draw on a concept that has its point of origin in the pre-NHS days. The concept was that health services were about health improvement in times of wellness as much as they were about health care in times of illness. By all accounts, the Tredegar Medical Aid Society in the first quarter of the 20th century, where the young Aneurin Bevan cut his teeth in health services administration, had just such a holistic approach to the business of health. However, the most famous exemplar of a ‘salutogenic’ form of health services organization, an approach that emphasizes positive health or wellbeing, was the Pioneer Health Centre, more commonly known as the Peckham Health Centre, in London which provided activities to around 950 families in the 1930s focusing on mainly preventative initiatives, using a variety of social and physical activities to prevent ill-health.
- 1.2 Healthy Living Centres are the modern equivalents of these earlier approaches to social organization. While in England in particular, the medical care agenda has continued to dominate, this has been less the case in Wales, where a number of area based strategies and policies have emerged that have been designed to address the social and economic determinants of health in particular places. The Healthy Living Centres programme, although not initiated by the Welsh Assembly Government, is part of this, encouraging a partnership approach, including lay involvement, to tackle the social and economic determinants of health and illness. They also encourage flexibility and experimentation as a means of ensuring local responsiveness. The New Opportunities Fund, now merged with the Community Fund to form the Big Lottery Fund (BLF), has provided financial support for 351 of these initiatives for up to five years across the UK, 29 of which are based in Wales.
- 1.3 An external evaluation of this programme, funded by the NOF, is being undertaken by the Bridge Consortium. The Bridge consortium is made up of a number of institutions and research centres. These include
- The Tavistock Institute (Coordinators)

- The Research Unit in Health, Behaviour and Change, Edinburgh University
- The School of Social Sciences, Cardiff University
- Institute of Health Research, Lancaster University
- The Institute of Public Health in Ireland
- The Personal and Social Services Research Unit, London School of Economics
- MRC Social and Public Health Sciences Unit, Glasgow University

1.4 In Wales, the Public Health Improvement Division, Welsh Assembly Government, has contributed funding for additional case studies which have both fed into the UK evaluation as well as providing an opportunity to produce a policy relevant report on the experiences of Healthy Living Centres in Wales. In terms of other parallel evaluations, those being undertaken for the Department of Health in England and the Scottish Executive, whilst separate with their own activities and outputs, have also fed into the evaluation undertaken by the Bridge Consortium. The Department of Health evaluation included the construction of a database of all HLCs. This drew on application forms and other business reports submitted to the NOF board as part of the process of gaining approval for funding. This database is useful as it captures the original intentions of the HLCs, providing a baseline against which subsequent developments could be compared, and providing an initial means of clustering HLCs as means of developing a sampling frame for case study work.

1.5 The objectives of the evaluation are:

- to evaluate HLC programme success in terms of the aims of the New Opportunities Fund and Healthy Living Centres themselves;
- to contribute to the evidence-base regarding successful strategies to improve health and reduce health inequalities;
- to assist HLCs and their partners to learn from overall programme experience in order to develop capacity and improve practice; and,
- to help NOF with the management and development of this programme as well as with future programme and policy development

(See Bridge Consortium 2002¹)

1.6 There are two key stands to the evaluation:

- **Health Monitoring System (HMS).** This is led by colleagues in the Research Unit in Health, Behaviour and Change at Edinburgh University and is a longitudinal study of the characteristics, health and health-related lifestyles and attitudes of a sample of over 4000 people who are using, or have used, Healthy Living Centres. It consists of a baseline survey followed by two follow-up surveys at six months and eighteen months after baseline. Response rates in Wales have been similar to those of other countries and English regions in the UK. Initial analysis on the baseline data, despite some issues with the data, indicates that the HLCs have, on the whole, attracted their target population groups (See Bridge Consortium 2005). Data from the HMS are not reported in this document.
- **Case studies.** The NOF evaluation enabled 40 case studies across the UK to be undertaken on selected projects, sampled to reflect a range of approaches. Case studies describe exemplars of HLCs drawn from the main clusters or types of HLC and the contexts in which they are operating. There have been two types of case study. *Overview Case Studies* (OCS) were undertaken over at least three days and collected detailed and rich information through analysis of documents, face-to-face (or telephone interviews) with key staff and partners, focus groups and/or informal interviews with volunteer workers and those participating in HLC activities, and observation of routine activities within the HLC. Analysis of this information provided a sampling frame for a smaller number of *Intensive Case Studies* (ICS) which were conducted around a year after the first visit. Fieldwork for these provided an opportunity to explore a number of key issues with a small group of informants. Topics for these interviews included how the HLC adapted to any key internal or external changes since the last visit, their overall orientation to health and health inequalities, their involvement of local people or users, their experience of partnership working and any plans for continuing their work after

¹ All four Bridge Consortium Annual Reports are available on the Big Lottery Fund's website www.biglotteryfund.org.uk

lottery funding comes to an end. In Wales both stages will be completed for all seven case studies.

Description of case studies in Wales

1.7 As the case studies vary greatly in approach and configuration, there was a need to agree on some criteria of selection according to type, in order to compare and contrast approaches across the UK and to ensure that particular kinds of HLC were not excluded from the analysis. Although crude the HLCs were selected across the following categories:

Umbrella: Operates as an umbrella organisation bringing together 10/15 different projects – some pre-existing – to form a diversified HLC. The HLC is essentially a catalyst for bringing a range of existing services and activities together in an accessible and integrated way.

Strong Community Development: Community development in orientation and strong community involvement. Although many incorporate community development approaches many of these HLCs tended to focus on a particular place such as a housing estate or village.

Single Focus: Single target group emphases – whether in terms of health status/illness (hypertension, mental health) or life stage and life circumstances (older persons, the homeless etc), or approach (e.g. walking, promoting exercise)

NHS linked: Strong health service links and/or are very much service/outreach oriented.

1.8 A spread of these HLC types was selected across the UK, including the 29 funded projects in Wales. The cases studies funded were too few to be captured in a single round of OCS visits but were supplemented in subsequent rounds. The three rounds of visits were conducted to reflect the rounds of funding from NOF.

Table 1.1 HLC Types selected

Welsh case studies	Umbrella	Strong Community Development	Single Focus	NHS linked
1 st round	1	1		
2 nd round			1	1
3 rd round	1	1	1	
Total 7				

- 1.9 In practice most of the HLCs could be categorised under more than one heading. For instance one of the single focused HLCs also had strong NHS links and the one that was NHS linked also had a single focus. In addition both the Umbrella HLCs also had a strong community development approach as a means of weaving different projects, services and activities into the community. Table 1.2 looks at the same headings and highlights the case studies that could be characterised under these headings at the application stage.
- 1.10 Another unexpected factor in choice of case studies was the fact the HLCs took longer than expected to set themselves up. Data collection was not possible in HLCs where staff had not yet been appointed.

Table 1.2 Case study characteristics

Case studies	Umbrella	Strong Community Development	Single Focus	NHS linked
1	√	√		
2		√		
3			√	√
4			√	
5	√	√		
6	√	√		
7			√	√

- 1.11 For the third round of case studies, since the first two rounds had covered the range, an additional set of criteria were considered in Wales including location type, lead organisation, focus, size of grant, and number of partners. In discussion with the Welsh Assembly Government's Public Health Improvement Division, one was chosen because it was led by a community based organisation; one was selected because it was in a largely rural area and another because it was led and managed by the local authority and linked to another large HLC in the borough. The Welsh Assembly Government was not informed of the identity of the HLCs selected. To provide some more detail of the HLC types selected for case studies, Table 1.3 describes all of them

under this broader range of categories. The information here is drawn from the application and does not represent changes subsequent to the operation of the HLCs.

- 1.12 It should be added that one difference between the sample of case studies and the 29 funded projects is in the lead applicants. In Wales, just over half of the lead applicants were public sector organisations (16/29) whilst five of the *case studies* are led by the voluntary sector. This is important as different issues are raised when projects are led by statutory organisation to meet their own policy objectives to improve the health of the public than when they are led by organisations that have a more specific remit or relate to a particular section of the public.

Table 1.3 Case Study Details

No	Location	Lead Applicant	Focus	Size	Partnership
1	Large estate, North Wales	Company Limited by Guarantee & Registered Charity	New building to house a range of activities appropriate to the community and aimed at tackling the determinants of health and possibly providing on-site health services. (Umbrella)	Over £500K 5 years Specific community (ward)	11 partners including the LHG/LHB, NHS Trust, LA, local college, police and an umbrella voluntary organisation.
2	Large estate, South Wales	Health Authority	A community health project aimed to reduce people's feelings of powerlessness and isolation. Will build on 5 programmes of work: community development, environmental work, nutrition, play work (4-11) and youth work (12-25) (Strong Community Development)	Over £1m 5 years Specific community (Sub ward)	12 including residents groups, the local community forum, the NHS Trust, a number of local authority departments, the local church and the police.
3	Urban/rural mix North Wales	Company Limited by Guarantee & Registered Charity	Aims to increase physical activity by setting up a Green Gym and a healthy walking programme. Links with local health services. Will train up volunteers to participate and lead in both these schemes. (NHS linked)	Over £300K 3 years Across the local authority population	14 partners ranging from community groups, other voluntary organisations, the health authority and county borough council.
4	Industrial/ post industrial urban/rural mix South Wales	Company Limited by Guarantee & Registered Charity	Tailored programmes of activity for the over 50s in three main areas: Eating for health, lifestyles (solitude, loneliness, intellectual stimulation, smoking cessation, alcohol abuse and leisure) and 'keep moving' (physical exercise). Will also identify and train volunteers to become senior health mentors. (Single focus)	Over £200K 5 years Over 50s across borough (focused on communities first areas.	9 partners – including the local college, a learning network the county borough council, health promotion (of Local Health Group), Crime and Safety Division, the NHS Trust and the university
5	South Wales – Ex-coalfield	Company limited by guarantee	Community development approach to identify specific activities and enhance community spirit. Access to health services also an issue they seek to address. (Strong Community Development)	Over £800K 5 years Sub-ward	28 (mainly voluntary sectors but also NHS trust, LHG/LHB, LA departments and local schools) . Most are represented on the lead organisation's management board.
6	South Wales – Ex coalfield	Local Authority	Bringing together of several existing activities and services. Stresses a community health development approach. Part of wider regeneration strategy. (Umbrella)	Over £500K 5 years Sub-ward 1,200 households	19 (public sector, voluntary and 1 private). Links with primary care centre.
7	North Wales – rural	Registered Charity	Aims to work with health professional to identify carers. Will provide information and support to carers identified. (NHS linked)	Over £600K 5 years, 3 counties	The three LHBs

Methodology and analysis of case study materials

- 1.13 Full details of the methods used to capture information for the case study data are outlined in earlier reports to the Bridge Consortium. The Overview Case Studies took up to three days and collected data drawn from HLC documents, individual and group interviews with key stakeholders, and observation of both specific HLC activities and of their running as a whole. Structured schedules were developed for the interviews and observation activity as well as to collect information from documents. All the data were entered, for the first round of visits, onto a database and submitted to the co-ordinating team based at the Tavistock Institute.
- 1.14 For the second and third rounds the schedules were streamlined and less structured (to allow for more open responses) and responses were again entered into a database. All data collected to date have been entered onto this database allowing responses to particular questions to be analysed across all UK case studies.
- 1.15 For *Intensive Case Studies* a flexible interview schedule was developed to interview a small number of key stakeholders 6 – 12 months after the first visit. These fulfilled two key purposes:
- To track the experiences of HLCs over time, and
 - To explore a small number of key themes in more depth, including health and inequalities, partnerships and ideas about sustainability.
- 1.16 The flexible nature of the interview schedule was to allow the exploration of ideas and themes identified from an analysis of an individual case study. Data on each case study were submitted through a matrix highlighting topic headings against headline questions to capture and assess emergent themes. Another matrix was then developed to reflect on themes emerging from the all the data but focusing on the *Intensive Case Studies* and their development in a specific national or regional context. The four *Intensive Case Studies* in Wales were submitted in this way.

Sources of data for this report

- 1.17 This report draws largely from the seven intensive cases recently conducted but also from all the original seven overview case study visits. In addition, the report begins to make links to the Health, Social Care and Well Being strategies which have provided an important local context for the development of the projects.
- 1.18 Section Four also draws on a policy seminar held with representatives and national organisations with responsibility for developing and implementing the new public health agenda. This helps to set the national policy context for the development of, and learning from, area based public health initiatives.
- 1.19 At present access is not possible to the complete data for all the UK case studies. However comparisons will be possible in relation to what has already been reported in the latest annual report submitted to the NOF. The key strength of this report is that it provides coverage of some of the themes in the light of the Welsh policy context, with a particular focus on views and experiences relating to community capacity, evaluation and sustainability. The broad chapter and theme headings from the UK annual report have been used to facilitate cross-referencing between reports.

2 Developing Activities to Improve Health and Address Health Inequalities

Key Issues

- As in the UK as a whole the HLCs in Wales are providing a wide range of activities variously addressing the environments in which people live and/or the lifestyles they adopt.
- Community-focused HLCs in particular provide a wide mix of activities which are themselves inter-related and aim to meet a number of physical, emotional and social health and well being objectives.
- It was easier for HLCs to articulate how their activities related to health improvement than how they would address health inequalities.
- Whilst in the initial applications they were required to specify what activities the HLCs planned to provide, in reality the initial focus was in building relationships of trust and in taking time to find out what kind of activities local people wanted and which were likely to work.
- Further analysis of survey and new follow-up case study data will provide a useful insight into which kind of approaches are likely to work in particular circumstances.
- However at a local level some HLCs are struggling to provide robust evidence of their effectiveness. Future programmes of a similar nature need to agree clear evaluation frameworks, to build funding for evaluation into grants and provide additional central support.

Introduction

- 2.1 It was a requirement of the HLC programme that proposed projects used a broad definition of health and initial information provided to potential applicants emphasised the need for a holistic approach to problems, working with the targeted community to develop solutions². The programme also encourages projects to address the broad determinants of health, to contribute

² New Opportunities Fund (1998) Healthy Living Centres: Information for applicants. London: NOF.

to actions that will reduce inequalities in health, and aims to be accessible to the 20 per cent most deprived people in the population. Addressing the wider factors responsible for ill health and tackling social exclusion were both considered to be particularly important in the light of current national priorities to tackle inequalities in health.

- 2.2 This section focuses on HLC activities but begins with an investigation of the underlying models or visions of health and inequality that underpinned the choice and development of these. It then goes on to examine the types of health related activity that the case studies actually undertook to respond to the health of the populations that they targeted.

Vision of health and views on health inequalities

- 2.3 HLC managers and their stakeholders were asked what they felt their vision of health was and how this informed the activities of the HLC. They were also asked a series of questions to identify the extent to which they felt that they were contributing to efforts to tackle inequalities in health.
- 2.4 In their applications and in interviews all HLCs said that they promoted a holistic vision of health but emphasised different approaches to health improvement. The key difference between the HLCs was whether they primarily focused and directed activity towards individuals or to the socio-economic conditions in which people lived. The HLCs focussing on community development, in particular, aimed to transform social relationships and/or the economic opportunities for people living in the area. Where the focus is on community development approaches HLC co-ordinators and managers felt that approaches that build on social cohesion and/or develop social capital potentially create the capacity for residents to both bring about change in their material circumstance and contribute to well being in itself.

ILLUSTRATIVE EXAMPLE ONE: HEALTH AS COMMUNITY WELL BEING

The vision of health with which this HLC operates is focused on community level well being and they aim to improve the quality of life for people living on the estate as a whole. Through this they try to tackle both the material constraints to health improvement, such as unemployment, and psycho-social determinants such as lack of self esteem at an individual level and apathy at a community level.

A key focus at the beginning was to win the confidence of local people and provide activities that stemmed from locally defined needs and solutions. In addition, information and advice drop-ins were housed in the centre which was newly built using NOF funds.

Promoting the building as a community facility offering activities to a wide range of people is seen as a means of combating a deep-seated sense of apathy that permeates the estate. However, the HLC manager feels that there is now an opportunity to build in some more directly health-based activities, particularly for young people.

Lifestyle changes have been encouraged but not forced as the emphasis is on what is acceptable to local people. The HLC has tried to promote itself as embodying a health promoting ethos by, for instance, ensuring that children using the building (e.g. in the crèche, Kidsclub or through other activities) are provided with, and therefore introduced to, healthy foods.

They see many of the activities as having a multiplicity of community and individual level health promoting functions. For instance, an allotment scheme has the potential to bring different population groups in the area together and, in particular, improving intergenerational relationships; people's skills and readiness for employment; and access to fruit and vegetables for local people.

2.5 Other HLCs focused more on individual behaviour change. One HLC defined their vision of health in terms of the promotion of 'Active Ageing', an approach that is being driven by a national older persons' voluntary organisation. They emphasize a positive view of ageing and try to encourage this view and approach amongst older people themselves. The activities that have been developed have sprung from recognition that older people need opportunities to keep their bodies and minds active and their core efforts have been directed at developing a range of physical activity programmes as well as healthy eating demonstrations.

2.6 Getting HLCs to understand and articulate their role in relation to tackling health inequalities was more difficult. This was a finding that was also

highlighted in separate report on HLCs in Scotland.³ These difficulties may have been because for some applicants and HLC managers or co-ordinators, the projects were directed at population groups already experiencing deprivation or exclusion. In reaching these groups, therefore, they felt they were not already fulfilling the programme's aim of addressing inequalities in health. The HLC programme was partly built on the assumption that national efforts to tackle inequality and social exclusion required a targeted programme, aimed at the 20 per cent most deprived, and that 'local' approaches in these areas are part of the national solution. Project partners on the other hand, particularly if they represented a wider constituency such as the Local Authority Board, often had a broader view of the role of Healthy Living Centres. In these cases, where the activities of the HLCs were known by local government officers, the projects were reported as playing a key strategic role in their efforts to tackle inequalities in health.

- 2.7 An exchange between a HLC lead and a local government officer with remit to develop the Health, Social Care and Well Being Strategy, was illuminating in this regard. In this interview, when asked to what extent they felt they were in the business of tackling health inequalities, the HLC lead said that they had never really given it much thought. The local government officer, on the other hand had a much keener interest in the role that the HLC played in a wider brief to tackle the causes and consequences of inequality in the county:

Yes it does [play a role in tackling inequalities in health] I guess you would have to analyse it to identify it in that way rather than being explicit at the very start ...I guess in terms of the fact that you [the HLC] are looking to reach out to people in their own communities. We [the local authority] know that there are health inequalities in the [most deprived] regions [of the county], so just making services available to people in those areas is tackling some of those inequalities.

Local Authority partner

³ Research Unit in Health, Behaviour and Change, School of Clinical Sciences and Community Health (2005) Evaluating Healthy Living Centres in Scotland: lessons for policy, practice and research. Edinburgh: RUHBC.
http://www.chs.med.ed.ac.uk/ruhbc/research/pdf/finding_docs/findings10.pdf

- 2.8 In a similar case the HLC has a remit to promote walking amongst sedentary populations in the local authority area. Although the co-ordinator does not feel that they have a specific role in tackling inequalities in health they have deliberately set out to make links with area-based initiatives that are reaching disadvantaged groups such as Communities First and Surestart. However the partner representing the local authority sees the scheme strategically in developing new approaches to increasing physical activity rates in population groups within the county who traditionally have felt excluded from activities which have attracted the middle-class paying public.
- 2.9 A rather different example was where the HLC co-ordinator suggested that they have a remit for tackling the roots causes of ill health in the more deprived areas of the estate in which they are working, but also that they have a role in improving connections between the least and most deprived areas within the estate. However, in this case the co-ordinator felt that they also had a key role in demonstrating new ways of working which could be rolled out across other areas in the local authority. The co-ordinator in this case was fully aware of the HLC's role in responding directly to local concerns and, at the same time, understands the project's value in being a test-bed for developing innovative ideas. Viewed from the perspective of the local Health, Social Care and Well Being Strategy, Healthy Living Centres, in this authority, are seen as a deliberate endorsement of community health development as an approach that will achieve sustainable changes in health and well being and in tackling issues of health inequity in particular. This explicit synergy between project and local government strategic aims and objectives is probably due to the fact that the HLC was initially led by the Health Authority, subsequently the LHB, as part of a commitment to test and utilise community health development approaches. This case study probably came closest to a dovetailing of project and local strategic objectives.

HLC models and health improvement activities

- 2.10 On the whole the activities planned and developed appear to reflect the way in which health is understood in relation to the populations they target. However, for HLCs that have a strong community development focus, the

process of engagement with local people is the foundation for developing activities. If the activities that are developed have come through a process of dialogue or consultation with local people or the groups they were targeting, it was felt that they were more likely to take these up. This process of engagement was felt to be an important activity in itself in that it was felt to forge relationships of trust. In four of the case studies the original focus was almost entirely based on improving relationships and opportunities at a sub-ward level. A key problem for the HLCs in developing the bids in the first place was making them explicit enough to demonstrate what the projects would provide for local people in terms of health improvement activities, and being open and flexible enough to be able to respond to the needs, ideas and solutions which were defined by the communities themselves. One HLC board chair, who had taken a lead in writing the bid, articulated this dilemma at an early visit:

What we have is a very wide remit. There is also an element that the HLC is still going through a developmental phase because we built up a theoretical framework of the issues that needed addressing within the estate...But that has got to be converted into reality and part of converting that into reality is allowing the HLC to respond to what is happening within the estate. The changes that have occurred over the past two months are hugely pleasing, partly because of the services that have come in but I can't honestly say to you whether we are currently, say, providing anti smoking services though it is clearly an aspiration that we will be able to provide such services.

Board Chair

2.11 This explains the reluctance of some HLCs to be precise in their applications as to which activities would be developed, as the *raison d'etre* was to develop ideas that were articulated by local people themselves. A key criterion for success in these cases is the development of new ideas and projects from local people and flexibility in the way in which they respond to ideas from the community. These ideas have emerged in different ways:

- Through an approach by a resident to HLC staff. An example of this way of developing activities includes the development of a family drug support group by a resident who had experience of coping with a family member with a drug addiction problem.

- Through the natural development of projects themselves. One HLC tried to develop physical activities for under 16s, starting with a pilot project providing circuit training. This did not work well but the idea resulted in street dance classes and a cheer leading group emerging. They now regularly perform at local football matches.
- Through subsequent community consultations. One HLC identified an interest in setting up a community food co-op locally through a participatory community mapping exercise. Another HLC identified local concerns about the state of the local environment and a number of environmental projects were set up as a consequence.
- Through assertive outreach approaches. An example of this was efforts by one HLC to get young men involved in health related activities. A male member of staff talked to young men in the area and free sessions at a local gym were organised.

2.12 Although case studies were selected against four potential HLC models, three potential types of HLCs can be discerned through examination of the data. Different types of HLC impose particular opportunities and constraints in terms of the activities that are likely to develop. They also raise different issues with regard to sustainability, which may be clearer towards the end of the programme funding. It should be emphasized, however, that there are grey areas between all types of HLC. In addition there is a certain amount of drift between models. So, for example a project could set out to be virtual, but end up with a focus on one building which becomes synonymous with the HLC.

2.13 Indeed, the first key difference between HLCs is between those that are largely associated with a building which have become known as a *Healthy Living Centre* and have set up activities which were associated with that building and those which are virtual, operating in ways that link people, services and/or activities, without relying on an actual base.

ILLUSTRATIVE EXAMPLE TWO: A VIRTUAL HLC

This HLC is located in an area which has a good history of partnership working and a number of community based facilities and organisations, including a community centre that provides training and access to advice and information.

The HLC describes itself as virtual as, although it has a building in which to base its staff, they try to operate throughout the local estate in places that are already being used by local people, such as the local church and primary schools. At the same time, they try to revitalise local spaces that were previously underused, such as play areas for young children.

Five broad and interlinked programmes of work around community development, the environment, nutrition, young children and young people have been developed. Although there is a programme of work specifically geared to community development, all programmes are underpinned by the approach. This allows for specific ideas from local people to be articulated and, if possible, developed.

When the funding runs out activities will already have been developed in the community and their sustainability will not be dependent on the existence of a particular building.

ILLUSTRATIVE EXAMPLE THREE: A HLC WITH A PHYSICAL BASE

The HLC provides a new resource in an area which otherwise has few local facilities, services or experience of community based activity.

A new building was built with HLC programme funds, providing an IT suite, child-care facilities, meeting rooms, a kitchen and potential café facilities and office facilities.

This facility provides a new local focus; a place for local people to meet and a starting point for developing a range of activities for people who have never been involved in community based activities before.

The HLC started by piloting ideas for educational, social and physical activities and housed a number of support services. Gradually new ideas for activities emerged and initial pilots were either rejected or adapted in ways that were more acceptable to local people.

The building is now heavily used on evenings and weekends as well as week days. They are hoping to find more space to support the activities that they want to deliver.

- 2.14 A second difference is between HLCs that are completely new entities, starting from scratch with a new legal status and new financial systems, and those which enable an existing organisation, usually a voluntary or community organisation, to access resources allowing them to bend existing activities, or experiment with new activities, geared towards the health improvement agenda. Indeed, the voluntary sector led HLCs generally had had experience of fundraising and the HLC programme provided an opportunity to develop and sustain the work of the organisation.
- 2.15 Although six out of the seven case studies claimed, at the first visit, to be a new project which was not based on an existing initiative, on closer inspection four of them could be said to have utilised the funding opportunity to provide a health and well being component or slant to their existing portfolio. The activities that were developed were therefore consistent with the organisation's objectives and ethos and benefited from the organisation's existing financial, legal and management systems. In one case the HLC funds were not so much used for the development of activities as in providing mechanisms, through primary care and other services, to identify carers who have previously been isolated, giving them the training and support that their organisation already provides to their target group. In such cases the HLC branding has not established an identity which is independent of the organisations leading the projects.
- 2.16 A third difference between HLCs in the case studies is between those projects that have largely developed and led the delivery of activities and those which have seen their role as being a catalyst to ensure that existing services and activities are made accessible to their target population in an integrated way. In this case there was usually some overlap between the HLCs, with most claiming a combination of activities run by staff or volunteers and activities which were identified as needed and run by local partners. The balance of HLC and partner run activities may be an important one when considering sustainability issues after the NOF funding has ended.

Types of HLC activity

2.17 This section focuses on the particular types of activities that HLCs have developed or facilitated. Although we look at them in relation to different levels of individual and community based activity, in reality most are seen to have impacted on health in a number of different ways and on different levels. The establishment of community food co-ops can, for example, provide an attractive social meeting point for the local community (addressing social isolation issues), promote healthy eating (behavioural issues), and provide employment and training for local people (addressing poverty and employment issues).

Activities addressing individual lifestyle, behaviours and capacities

2.18 All HLCs developed activities relating to individual lifestyles, behaviours and capacities. However, some are keen to improve lifestyles in the context of local and structural social and economic barriers. Different approaches to food and nutrition were interesting in this regard with some focusing more on education and raising awareness of the need to eat a healthy diet and others focusing on providing opportunities to eat well or providing better access to cheaper healthy food. Three of the four community-focused HLCs⁴, have set up food co-ops, two of which have won national volunteer awards. Interviews suggest that these are popular, possibly because they have both a social and economic element to them. Both food co-ops and luncheon clubs were seen as opportunities to develop and cement friendships as well as provide access to healthy, affordable food.

2.19 Cookery classes with both adults and children have also proved popular and in one HLC, requested by children themselves. Accredited food and hygiene courses have been undertaken by local volunteers who have taken up activities that involve handling food. This has also provided an opportunity for HLCs to highlight issues regarding healthy eating.

⁴ Since this report was drafted the fourth HLC has set up a community food co-op as part of the Welsh Assembly Government Community Food Co-ops pilot. In this case a number of food co-ops have been rolled out across the county with support from the Local Health Board's community nutritionist.

ILLUSTRATIVE EXAMPLE FOUR: DEVELOPMENT OF A LUNCHEON CLUB

In this HLC the luncheon club developed from a cookery course as some of those who were involved thought it would be good to take their skills forward and provide food for older residents on a weekly basis. Before setting it up they completed food hygiene training courses.

Menus are suggested by the members and each person pays £2 for a main meal and a pudding. The lunch during the research visit was cold roast pork and ham with new potatoes, boiled egg, cheese, fresh mixed salad, coleslaw, bread and pickles. Pudding was tinned peaches with ice-cream.

Talking to the 16 residents who had lunch that day it was apparent that everyone enjoyed the occasion. A key factor in its success appears to be the fact that it is not led by a member of staff.

As a way of tackling social isolation and providing an opportunity to eat well cheaply it was an idea that seemed to work well. The HLC also puts on exercise classes and some of the women who belong to the luncheon also participate in these. The luncheon club seems to provide a pathway to other HLC activities. The group also saves money for trips and other special events.

One participant reported that she owed her life to the luncheon club and the other activities that she has since joined. Previously she had a drinking and drug problem, sleeping all day until 5.30 pm and watching television all night. She said that she was overwhelmed by people's friendship and support and felt that she did not need the alcohol and drugs and more. She felt that she had something to live for. She reported that her son, a heavy drug user, has been impressed by the change in her and is now actively seeking help for himself.

2.20 Activities that focused on diet and physical activity were a theme in six of the seven case studies, providing a platform for rolling out national initiatives at a local level. These included:

- Food co-ops (Wales Community Food Co-operatives pilot)
- Gentle exercise for the over 50s (Extend classes)
- Green Gym (British Conservation Trust Volunteers)
- Walking the way to health (National scheme – some national funds from NOF)

2.21 Some of these have their own networks and have been evaluated. The Extend programme of gentle exercise which runs its own training programme had not,

at the time of writing this report, been evaluated but has been promoted in England and Wales to improve mobility and fitness levels in older people. The reason provided was that any evaluation of an intervention directed at older people is fraught with difficulties associated with the expected natural physical deterioration of this population group. Given the popularity of luncheon clubs throughout the UK further investigation of how they operate and for whom they work and in what settings may be useful.

- 2.22 Sexual health was also a major theme in HLCs where young people's needs were being addressed. On the whole HLCs made links with youth organisations and youth workers to develop awareness-raising, and individual support in this area.
- 2.23 Smoking cessation was highlighted in a number of bids, particularly those led by health (now LHBs) or local authorities. However, it is not a core area of work in any of the case studies though some have taken advantage of existing smoking cessation counsellors or services available in their area. In two of the case study HLCs smoking cessation initiatives were being shelved for a while. In one the co-ordinator reported that despite services being available, there had been no take-up and little interest generally. In the other HLC it was felt that the classes provided by the local health services were inappropriate and, according to HLC staff, were badly received by the client group. Perhaps because there are services available locally, there has been little innovation to develop new approaches to smoking cessation.

Addressing the lack of appropriate local services

- 2.24 HLCs have also used their links to other agencies to bring their services closer to their target population or made new connections between people and services. Community focused HLCs have used and developed their connections with services and other agencies to house services which would otherwise be inaccessible to local people. One case study has been successful in housing the mental health team once a week. Previously, failure to attend appointments had been an issue for local people who had diagnosed mental health problems. However, the distance that clients have to travel was a

barrier, requiring a couple of bus journeys if they have no access to a car.

Appointment rates have improved considerably as a result. Lack of access to services in the area was an issue for all HLCs that were focused on a particular village or estate.

2.25 Another role for HLCs is advocacy in that they can highlight and make a case for new services or developments in the area. One HLC board member reported that they used their interactions with young people to advocate for a youth shelter. Whilst it could have happened anyway it was felt that the HLC gave impetus and legitimacy for that provision.

2.26 HLCs that are not focused on a particular area have also developed innovative ways of linking people to services, or using local services as a mechanism to provide the target population with new opportunities to improve their health or well being.

ILLUSTRATIVE EXAMPLE FIVE: LINKING CARERS TO SUPPORT THROUGH PRIMARY CARE

One of the case studies is specifically focused on identifying and linking carers to services and other sources of support. As the HLC covered a wide area, a key role of the five health link workers supported by Lottery funds, is to raise awareness within primary care teams about the needs of carers. They also provide a simple form which is used to identify carers and then to refer them to the carers' organisation leading the HLC.

ILLUSTRATIVE EXAMPLE SIX: LINKING HEALTH SERVICE PATIENTS TO LOCAL WALKING SCHEMES

A HLC which promotes a walking scheme and a green gym is able to link activities to a number of health care services. The HLC provides community based options for health care and rehabilitation. For instance they have trained cardiac rehabilitation nurse to become walk leaders and patients are referred to a walking programme as part of their recovery. Similar links have been made with mental health services.

This HLC also made connections to other health initiatives, including a fruit and vegetable scheme funded by the Welsh Assembly Government. After four walks are completed a participant is entitled to a £5 voucher for fruit and vegetables. Though this particular fruit and vegetable scheme has finished they have replaced it with a similar scheme which has a different funding source.

- 2.27 An interesting development, as HLCs progressed is that they reported that organisations are now directly approaching them, as they provide a mechanism to provide services locally. This indicates that HLCs have a potential to act as a magnet and an anchor through which services can be based. One service provider, a health visitor, reported that she found this useful, both in terms of reaching clients and in making connections with other agencies and services at a local level.
- 2.28 However, there could be tensions between being seen as a link to health services and in tackling the main social and economic causes of ill health. One HLC has made a conscious choice not to give the impression that they were providing a GP service in order to get away from the local impression that health was solely related to NHS services. In this case links to primary care were more via health visitor and midwife support to woman in the context of other support activities for parents. There is currently still no access to a GP on this large estate but the HLC does not, at this stage, consider this a priority.
- 2.29 Other HLCs do want to link up with primary care practices but the experience of making these links is, on the whole, highly problematic. One HLC has tried a number of avenues to connect to local practices:

We've tried through the Local Health Board, tried through health promotion, tried through every route that you can think of... We've written letters on behalf of the HLC, we've been in there to see them personally. We've been in there to see the health visitor, given her information and it still hasn't got anywhere... We've had the chair of the LHB come here for something and K said to him look there is a problem with GPs and he said 'Oh Ok, no problem I'll tackle that and sort it out'. Five days later at various meeting with people high up from the LHB – they said 'all right we'll sort it out, but nothing ever changes.'

Board Member

Activities for parents and children

- 2.30 Something approximating a life-course approach has been adopted in some community focused HLCs who have built up a range of activities directed at

children, pregnant mothers and parents. In one case study the amount of time dedicated to children and parents was a surprise. In another area two programmes of work were specifically targeted at children and young people, based on a needs assessment and community profile in preparation for the HLC bid.

- 2.31 Although the first HLC above reported that it was local demand that generated the unanticipated amount of work directed at children and their parents, there may be other contributory factors, such as the existing links with Surestart, the fact that child-care for adults using the HLC is needed and because money for play-schemes is relatively easy to obtain. However, given that the proportion of households with children on this estate is relatively high, the focus on this group is felt to have had effects beyond the children themselves to family and household members and the community itself. The latter case study cited above has invested in specific programmes of work directed at children and young people as a mechanism to avoid potential problems in the future and the potential ‘time bomb’ of chronic ill health and early death that cumulative disadvantage from childhood brings.

Addressing social exclusion, poverty and unemployment

- 2.32 HLCs identified sections of their community which were considered to be excluded or ‘hard-to-reach’. The HLC programme was seen by the programme designers as a mechanism to address issues of social exclusion at a local level. HLCs have developed a certain amount of knowledge and skill in reaching and/or attracting people who they felt would not normally participate in health related activities. Most HLC managers and co-ordinators stressed the need to recognise where different groups of people were starting from and not to expect everyone to take up local activities and service just because they were now available. HLCs were felt to have an advantage over the mainstream statutory sectors in that they could develop close dialogical relationships with many of their target groups yet have the power to turn ideas into real projects or activities.

ILLUSTRATIVE EXAMPLE SEVEN: WORKING WITH YOUNG PEOPLE EXCLUDED FROM SCHOOL

An early example of the flexible ways in which HLCs have tried to work is in a community focused HLC where a number of young people on the exclusion list had started to become interested in what was going on in the new HLC.

Taking advantage of the connection that was being made, HLC staff talked with them about the projects or activities that they may be interested in. They responded by saying that they would like to grow plants – cannabis! The HLC board member reported of the staff, “They didn’t just say ‘you can’t do this’. They said ‘think about this. How are you going to get funding for this?’”

In working with the young people the business plan changed from one about growing cannabis to gardening scheme which included growing vegetables. They did the planning and were given some land and an allotment project is now running. The board member commented, ‘I was impressed how [the young people] dealt with it and that they did think it through, because I must admit I did think these kids will never be bothered.’

2.33 As well as aiming to reach vulnerable or socially excluded groups, the structural features of disadvantage are also of concern to some HLCs. Unemployment and poverty related issues were two of the most frequently mentioned by HLCs when they identified the issues which are causing ill health in their communities. However, in addressing disadvantage HLCs have responded in different ways. Those focusing on older people and carers focus on ways of reaching the target groups and trying to overcome obstacles, including lack of income, transport and mobility, in providing access to activities which would impact on their health and well being. Both of these operate across large geographical areas, are virtual and attempt to locate activities in places that are accessible. In one of the HLCs, ‘gentle exercise’ classes are organised in sheltered accommodation units. Although both HLCs offer welfare/benefits advice and support, the emphasis is largely on improving the lifestyles and well being of vulnerable individuals.

2.34 All HLCs have activities that offer opportunities to change lifestyles. However, four of the community focused HLCs have also developed activities aimed at changing the social and physical environment in which people live and provide opportunities to develop skills and find employment. As reported above, one HLC had an entire programme of work devoted to environmental

projects with local people across the area. They also had a specific programme of work focusing on community development, although this approach informed all areas of work. A community newsletter and input into a community festival were seen by the managers and board members as two mechanisms that would bring all parts of the target area together, affluent and deprived.

2.35 Another HLC have provided an IT suite and a have number of meeting rooms which are suitable for training events and course. The HLC therefore provides a base for a range of training programmes, some of them accredited for possible future employment, and have a deliberate policy to employ local people onto the staff of the HLC, particularly the play-scheme.

2.36 Access to cheap fresh food and to leisure activities are also seen as activities which address poverty or at least address some of the barriers to health that poverty creates. The analysis of the Health Monitoring System has already indicated that HLCs would appear to be attracting the poorer residents in the areas in which the projects are situated (Bridge Consortium 2005).⁵

Evidence of the 'effectiveness' of HLC activities?

Limits of current approaches to evaluation

2.37 All projects provide monitoring data on an annual basis to the NOF. Although there is an opportunity to present case study material, the data focus on the numbers of people taking up HLC activities, and there is some concern that there are limits to using these data as evidence of the effectiveness of particular projects.

⁵ Bridge Consortium (2005) *Evaluation of the Health Living Centres Programme. Fourth Annual Report*. London: Big Lottery Fund
http://www.biglotteryfund.org.uk/generic_downloads?publications=true&status=doc&doctype=Evaluation&docid=67240®ioncode=uk&doctitle=Healthy%20living%20centres%20year%20four%20report

- 2.38 By way of example, in one HLC two major programmes of work operated in very different ways, with different groups of people and very different assumptions about what needs to be done. One of the programmes reaches out to anyone living in the county, though trying specifically to reach sedentary and particular ‘at risk’ groups, to encourage them to take up a range of walks that have been developed. The other specifically targets very vulnerable groups and provides quite intensive support and training, with the aim of creating a small sustainable group of people to work on environment projects. The person leading this component of the HLC’s work felt that evidence of effectiveness could not be judged in terms of numbers of people involved in the activities but should assess the progress made by the individuals themselves and the group as a whole. The project lead expressed frustration with measures that equated the number of people involved with success.
- 2.39 HLC managers and co-ordinators also suggested that focusing on numbers was fairly meaningless. For instance, one HLC employed a Community Development Worker to engage with community groups, support the local community festival and the regular publication of a community newsletter. It would be quite possible to say that most, if not all, of the local population had therefore been involved to some extent in HLC activities. This raises a number of questions as to who is benefiting, to what extent and how, which such monitoring fails to address. In three case studies the HLC has been embraced as part of the wider work of the organisation. Lottery funds allowed their organisation to ‘bend’ their existing work towards health and well being and provide links to other aspects of their work. This again makes counting people who have taken up HLC activities difficult and there may yet be a different set of questions that need to be asked in terms of the value that lottery money has provided in enabling the organisation to build, or improve, their health improvement work.
- 2.40 A major weakness in the programme has been the lack of evaluation support for individual projects. Only one of the case studies, and three of the twenty-nine of the HLCs in Wales, had earmarked funds for an independent

evaluation of their project.⁶ Most are now recognising that as their funding comes to an end they will need to provide evidence of effectiveness to potential commissioners and funding organisations. Most are now planning or have commissioned evaluations but they are without a baseline and are being undertaken with limited resources. In two cases the evaluations have been opportunistic with students undertaking limited evaluation as a part of their course assignments. It should be recognised that HLCs need adequate and appropriate resources and expertise to undertake evaluations appropriate to the aims, mechanisms and contexts that they work in.

- 2.41 An additional problem is the complexity of the schemes themselves and what they set out to achieve. As has been seen, some HLCs focus on the social and economic conditions for ill health by transforming local relationships or instilling a sense of pride in the area. As one HLC argued, these relationships take years to change, are difficult to capture through evaluation tools that are not resource intensive and it would take even longer to see any health benefits that show up in traditional health statistics.

I think that NOF would say that we're trying to achieve health improvement, but I think that in terms of the bid that's just impossible. It's a young estate so how do you show in 5 years time that you have reduced coronary heart disease? So I think that we are providing the opportunity for better health really, which is around broader skills development, self esteem, relationships and specific skills around food

HLC project partner

- 2.42 In addition there was a reluctance to collect certain kinds of information and concerns that collecting data could be seen as intrusive, disturbing relationships of trust that the HLC had been careful to nurture. This was thought to be particularly relevant for the collection of data relating to the impact on physical health:

⁶ Two of the case studies had made initial agreements but these had not been secured as intended. In both cases it was thought that a local university department could secure funds for an evaluation but arrangements fell through following the funding awarded to the HLCs. In one of these, some funding was found to conduct a baseline health and well being survey. Additional funds are required to conduct a follow-up survey.

What we are not doing is going out and taking people's blood pressure and weight because, one I see that as invasive and it's more likely to put people off than encourage people to [take exercise]. Now we made a conscious decision at the beginning that we were not going to weigh people and measure people. Now we have organised some health events where we have had sports science students come down and cardiac rehab people come down and we've got the blood pressure and the cholesterol testing and all that sort of thing. But not as a regular thing.

HLC lead

- 2.43 This resistance also extended to collecting routine monitoring data for NOF as well as for the Health Monitoring System:

There has been resistance to filling in the monitoring stuff even if we send volunteers who will do it for people. But this is the big thing with the NOF we've got to have all of this evidence collected and yet older people, nobody probably wants to fill it in themselves, and older people without their glasses, with their arm in a sling or whatever and no pen, you know. It becomes a much bigger task if somebody is frail and elderly whereas if they are younger they are used to doing things in school and just scribbling in the odd answer.

HLC lead

Take up of activities

- 2.44 Nonetheless, in some cases, the numbers of people taking up HLC activities provides valuable and relevant evidence and, when appropriate, have been impressive, exceeding original targets. The success in attracting walkers to one scheme has already been highlighted. One HLC far exceeded the target of 400 people within the first 6 months coming to use the HLC's facilities. In fact 1,200 different people from the area used the HLC building at least once. This represents 40 per cent of the population. This HLC was discussing how they could devise a system whereby they could tell how many were visiting on a one-off basis and how many were using the building more frequently and for what. As a measure of progress, a major difficulty for this HLC during the second evaluation visit was in managing the demands for time and space.

- 2.45 In terms of gender, initial analysis of the Health Monitoring Survey, reported in the Fourth Annual Report⁷, supports the experience of the Welsh case

⁷ Bridge Consortium (2005) *Evaluation of the Health Living Centres Programme. Fourth Annual Report*. London: Big Lottery Fund

studies that, on the whole, it is largely women who are getting involved in both the activities and in volunteering. Asked why it was difficult to get men involved, staff and volunteers speculated that both the staffing and the nature of the activities themselves could be perceived as female dominated and that this could be intimidating for men.

- 2.46 A discussion with a co-ordinator and two local partners, on a second case study visit to the HLC, speculated that women become more involved because word-of-mouth mechanisms work more effectively in networks of women than they do with men. This was felt particularly to be the case if children were involved as if they could see that their children were well cared for, and that they could also benefit from the HLC's facilities, the word would spread amongst their friends.
- 2.47 Despite this general pattern, one HLC appeared not to have difficulties in attracting men to a walking project. In this case monitoring figures revealed an over-representation of women and the project team adapted their marketing to men. Observation of two walks revealed that some men accompanied their wives on walks which strengthened the social nature of the walks with couples, and not just individuals, forming friendships. The walks also linked into the local cardiac rehabilitation unit where there would automatically have been men who were encouraged and supported by cardiac rehabilitation nurses to go on guided walks as part of their recovery. However, it may also be that walking is felt to be an acceptable and enjoyable activity for men and therefore more likely to be successful in targeting men and women.
- 2.48 Other community-based HLCs feel that there is local spatial variation in the take-up of HLC activities. These experiences reflect knowledge about particular residential areas being territorial and may therefore be specific to the social geography and history of a particular area. One HLC has attempted to avoid this by being a virtual project which works throughout the neighbourhood, although the project has also inherited a large building in which the staff are housed and because of convenience and size of the building

have tended to base a number of activities there. As a consequence the building may have become unintentionally associated with the HLC and seen as 'for' particular parts of the estate.

- 2.49 It is possible that the location of HLCs may also be important when taking local feelings of ownership into consideration. One HLC is situated on the main road entering an estate, which may have avoided any tendency to associate the project with any particular resident group. However, in this case divisions were perceived to exist between the 'ordinary' and 'good' people living in the community and those 'elements', in this case drug users, who were seen as making life difficult for everyone else. The HLC staff and partners were keenly aware of the tensions inherent in their normative role in being both acceptable and responsive to the community as a whole, and supporting particular groups of people with particular needs, who may find their exclusion from society reinforced rather than reduced by the HLC.

Evidence of impact on health and wellbeing

Activities and their relation to the evidence base

- 2.50 In the absence of impact data from the HLCs themselves at this stage, evidence of the impact or potential impact, has to be seen in terms of the achievement of 'interim' or indicative measures. One useful approach to demonstrate the extent to which the programme has been effective is to assess the kinds of activities and approaches undertaken by the HLCs in relation to what is known in the existing evidence base.
- 2.51 Department of Health guidance on health and neighbourhood renewal highlights⁸ the difficulty in tracing the impact of a local strategy to reduce, for instance, coronary heart disease rates and that these changes may not be evident for years. The guidance does, however, state that if an intervention is successful in moving people to a lower risk category, through a change in

⁸ Department of Health and Neighbourhood Renewal (2002) Health and Neighbourhood Renewal. Guidance from the Department of Health and the Neighbourhood Renewal Unit. London: DH and NRU.

behaviour, then that can be considered as sufficient in demonstrating evidence of effectiveness. For some projects aiming at providing a specific activity involving, say physical exercise, this may be easier to demonstrate. The walking scheme, for instance, was successful in attracting 5,000 walkers in 2003 and was on target for 6,000 in 2004. Similarly a project that attempts to increase the percentage rate of carers that have access to health care and other forms of training support could equally be said to be reducing the health risks to a known vulnerable group. Analysis of the Health Monitoring Survey (HMS) will provide UK wide results on the extent to which regular HLC users changed specific health related behaviours. Data will be available in the final evaluation provided by the Bridge Consortium.

- 2.52 Many HLCs are providing a complex net of resources and services which cannot easily be measured in terms of their effectiveness. In addition many have created links and new ways of working with other local interventions and their effectiveness may be in the form of the synergy that is created between a range of community based initiatives. In some cases the HLC may be the catalyst for this but it would be difficult to provide evidence that shows the added impact of their own contribution.
- 2.53 Current and recent research on community cohesion and social connections⁹ suggest the importance of building on these to improve health. Furthermore there may be neighbourhood effects beyond those who use a service. One HLC reported anecdotal evidence that people now wanted to move into the area and there was a growing sense of pride locally. However, as highlighted earlier, individual HLCs lack the resources and expertise to undertake local well being surveys at baseline and follow-up. One HLC was successful in obtaining funds for an extensive health and well being survey but, as yet, it is not clear whether there will be funds for a follow-up.
- 2.54 One problem in demonstrating the impact on health is the tension that HLCs have to balance different forms of health related approaches even though this

⁹ Kawachi I, & Berkman L. (2000) Social Cohesion, Social Capital, and Health. In: Kawachi I, Berkman L, eds. *Social Epidemiology*. New York: Oxford University Press

may mean abandoning some activities for which there is evidence of effectiveness to tackle other issues. This is particularly the case with community focused HLCs that emphasize the need to build community relationships. One HLC abandoned a smoking cessation initiative because there was no interest from the local community.

ILLUSTRATIVE EXAMPLE EIGHT: BALANCING HEALTH OBJECTIVES

Interviews were conducted with two volunteers who were considered to be the life-blood of the HLC and responsible for ensuring the running of many aspects of the HLC's work. They felt that there were personal benefits for them too, thoroughly enjoying the social opportunities and feeling of satisfaction that volunteering provided. Being involved with food related activities also provided opportunities to access training and develop skills in preparing healthy meals.

However, both smoked heavily, had suffered serious smoking related illnesses and claimed to have close friends who had died as a result of heavy smoking. They knew the dangers but were not prepared to give up. The HLC does not impose a smoking ban in the building. Despite not being prepared to stop smoking, it could be argued that their health and well being in other respects has been enhanced and that they have also had an impact on the well being of others.

2.55 The NHS Centre for Reviews and Dissemination looked at the evidence from systematic reviews which were relevant to implementing the wider public health agenda, suggesting that there is some evidence for the effectiveness of generic approaches. Many features of these are embedded in the approaches used by the HLCs. For instance, it is suggested that participative rather than didactic approaches are likely to be more effective and there is evidence in the literature that participative approaches encourage sustainability in providing more appropriate services that are better received in local communities.¹⁰ It is important to highlight that this approach challenges an exclusive focus on lifestyle and behavioural approaches – being responsive to the community may mean, to a certain extent accepting that they may smoke, drink, and eat chips¹¹ It may also mean balancing the needs of one segment of the

¹⁰ NHS Centre for Reviews and Dissemination (2000) *Evidence from systematic reviews relevant to implementing the "wider public health agenda"*. York: NHS Centre for Reviews and Dissemination (CRD).

¹¹ Popay Bennett, S. Popay, J. Thompson, C. Williams, G. Gatrell, A. Bostock, L. (2003) "Beyond 'Beer, Fags and Chips'? Exploring Lay Understandings of Social Inequalities in Health." *Sociology of Health and Illness* 25, pp 1-23

population against the other and recognising that some will embrace a HLC while others feel excluded.

- 2.56 In terms of approaches that appear to work a strong message has been that the take-up is good or better when the HLC is not directly promoted as an activity that is good for 'health', but rather as something which people will enjoy, particularly for social reasons:

What we have found here is that the way to interest people is not to say that this is going to be good for your health. It is going to say 'this is going to be enjoyable'. ... They are not really interested to know that their health is improving. It sort of registers and 'oh, that's good' but it's a by-the-way. So the way you sell it to them has to be 'this is social, this is enjoyable', that angle. So you have to play down, if you like, the health benefits.

Lead Applicant

- 2.57 As suggested above the social aspects promoted are not just a way of encouraging participation but are an important part of improving health and well being. Not only did people report that individuals involved in these activities improved in terms of their confidence but they also formed friendships and new social connections. Newly formed groups, such as luncheon clubs, dance classes, co-op volunteers, walking groups, and so on would often develop their own momentum – organising trips, parties and other linked activities. However, supporting this approach and recognising its value sat uneasily with more medical approaches to evaluating the impact of the projects. One HLC lead worker felt that they were under pressure both from the NOF and by their independent evaluator (who they had commissioned), to demonstrate direct health impact as measured through improvements such as reduced blood pressure, reduced prescription rates and so on. As well as betraying a trust that develops between HLC staff and local people and/or users, such approaches to monitoring and evaluation fail to capture the kind of improvements in health that they feel are more important:

Which is why, I think, on the odd occasions when we've had medical health checks that is almost contrary to our philosophy for this project. And yet [the evaluator] thinks that we ought to be having those all the way through and in everything. It sort of medicalises it doesn't it. And

then, our older people... to them having a medical check up is about being ill and not being healthy.

Lead applicant

- 2.58 In one HLC the need to develop relationships of trust and improving the social conditions for people living in the area were sometimes at odds with the need to tackle important health risks in the community. Local fears that the HLC will become a drug support centre or needle exchange have meant that the project has to delay original intentions to tackle the problem of drug use in any obvious way and a request to hold a facility to dispose of used needles at the HLC was rejected by local people in a vote at their Association meeting.

3 Building capacity for community engagement

Key Issues

- HLCs in Wales use a variety of approaches to engage with local people, though community engagement has not been a priority for all projects.
- The way in which HLC lead applicants and their partners engaged with communities in the application phase provided an important platform for implementing the projects once funded.
- Respondents in all HLCs felt that in some way their approaches, or their position in the local health economy, placed them closer to the lives of the people with whom they worked.
- HLCs could therefore be seen as providing potential mechanisms through which public agencies can better tailor their services to different population groups living in different circumstances.
- HLCs experienced some difficulties in engaging with particular population groups and continue to develop new ideas and approaches to reach them.
- Whilst respondents in HLCs would sometimes attribute these difficulties to deficits in the communities themselves, apathy being the most widely used term used to describe people who did not get involved directly in the HLC or the activities provided, they were also keenly aware of their own need to develop more skilful approaches. Similarly, traditional approaches to service delivery were sometimes criticised in terms of their lack of sensitivity to people's lives.
- Further analysis of case studies across the UK, for the final report, will provide insights into approaches that appear to be successful.
- These insights may provide lessons as to how public agencies may themselves develop their own capacities to engage with communities either directly or in partnership with other organisations, particularly the voluntary sector.

Introduction

- 3.1 A key component in the development of the HLC programme was the involvement of users and local people in establishing projects. In practice the ways in which community engagement has been interpreted and operationalised is very different in each project. Where the HLCs had an intention to deliver a specific set of tasks or activities, such as developing protocols to identify unsupported carers, to identify and support guided walks, or to provide exercise classes to older people, then community engagement was rarely more than at the level of consultation. For others the intention was to work with local people to identify and tackle the causes of ill-health. In these cases the ways in which the HLC and its partners work with the community is sometimes as important as the actual activities that they develop.
- 3.2 In fact the process of engagement in some cases studies is a key activity in itself as their approach to tackling health issues locally has been in transforming social relationships – either within the target community itself and/or between local residents and key public agencies. Indeed one key distinction that could be made between HLCs are between those that provide *instrumental leadership* in delivering a set of pre-described activities and those which offer *transformative leadership* in changing and developing relationships¹²
- 3.3 This section looks at capacity in terms of enabling local people and partners from a range of sectors to work in an integrated way to tackle health problems and to develop a sustainable approach to health improvement.

Levels of Community Capacity Prior to the Establishment of the HLCs

- 3.4 One of the questions that the first visit to case studies explored was the extent to which community capacity was evident before the establishment of HLCs. For projects not focused on a particular place but on a single population group or approach, this question made little sense to respondents. All of these were

¹² Burns J. M. (1978) *Leadership*. New York: Harper and Row

voluntary sector led HLCs who, on the whole, already claim to have a user focused organisational ethos. Two of these highlighted that users were represented on the management structures of the organisation and felt that they were representing users, or potential users in the development of the bid.

- 3.5 In the other four case studies, respondents were able to reflect on the extent to which there had been previous opportunities for local people to get involved. All four community focused case studies were in areas of deprivation although two of these were not in *Communities First* areas. In one case it was felt that they had missed out on *Communities First* funding because of boundary changes and in the other, it was felt that the high density of children skewed health and deprivation indicators which meant that the problems around child poverty and health were not captured in traditional measures of deprivation. All, however, were in areas that were deprived relative to other populations of Wales and therefore the subject of a number of regeneration or other area-based interventions relating to health, particularly Surestart and Homestart schemes. In two of the case studies the local church is a contributor to the development of community based activity. In one, the local church has secured funds to develop a community centre potentially offering, it was thought, similar activities to that of the HLC.
- 3.6 Three of the four case studies felt that previous activities in the area had failed to engage with local people and one of the reasons for the HLC application was to tackle the apathy that accompanies successive waves of regeneration with no evidence of improvement. Involving local people in improving the opportunities for good health was seen as an important chance to approach health improvement along the principles of community health development. For local statutory partners the NOF funding provided an opportunity for new ways of working with local people in the area. The fourth community based HLC was led by a community based organisation that had become a charitable trust, and saw the NOF money as an opportunity to build health and well being into the community work that they had already established in the local area. This HLC has had success in obtaining funds to support a wide range of activities and could be seen as a model for how newly created HLCs would like to develop. The fact that local capacity already existed placed them in a

strong position to develop activities that were likely to be acceptable to other local people. Given its strong position regarding community engagement it will be interesting to explore how, and the extent to which, local people embrace the health improvement agenda over a longer period of time.

- 3.7 Regardless of whether there were opportunities for community engagement beforehand, an experience that appears to be common across all HLCs is that the way in which both communities and partners engage in the application process appears to extend into the development phase of the HLC itself. If there were problems or uncertainties around roles and ownership from the outset then these appear to persist. For this reason the application process could be a crucial indicator of the nature and strength of both community and partnership involvement. For one HLC the opportunity to involve local people in the application process was itself an exercise in building capacity in the relationship between local people and the professional partners who wrote the bid. Asked about outcomes from the application process itself one respondent answered:

Huge outcomes in terms of partnership working. For local residents who were involved they felt that they were doing something about what was perceived to be a sink estate. They grew in terms of their aspirations and outlook. Relationships between the police and the estate have been enhanced. Also the relationship between the council and the estate has improved.

Board Chair

- 3.8 Conversely one lead applicant who struggled to engage with other partners in the application process found that they were still struggling to get partners fully involved in the HLC as the project matured.

At one point I convened a meeting ...inviting all the partners to come to say that we were going to share out the tasks. They didn't turn out. So the partners that have gone forward in the bid are the ones who actually contributed something to the development of the bid. There were a lot of organisations that wanted to have their name on it, but if we wanted some statistical data or an opinion, they were all just too busy...The other organisations just talk, talk, talk and say they want to get their names on things but they do absolutely nothing.

Lead applicant

- 3.9 Access to the complete case study data set will provide an opportunity to assess the extent to which the pattern of engagement in the application process is replicated elsewhere across the UK.

Community Capacity - What HLCs Aimed to Achieve and How

- 3.10 We look here first at those HLCs that focus on specific communities, followed by those whose focus is on a particular population group or area of activity. Emerging models of lay health work which have evolved from some HLCs across Wales are then examined.

Community focused HLCs

- 3.11 All case studies that focus on one, or in some cases several, local communities, have a strong emphasis on community involvement. How this has interpreted and operationalised has depended on perceptions and experiences of previous approaches and activities in the area and what, in the light of these, they aimed to achieve. At this stage it is not possible to be clear about what approaches appear to work but it is evident that HLCs have different understandings of, and approaches to, community engagement.
- 3.12 Out of the 17 Welsh HLCs that could be described as community focused, 13 were established by the statutory sector (9 local authorities, 3 health authorities and 1 NHS Trust). The other four are led by companies limited by guarantee, three of which are registered charities and the other a community led organisation. One HLC in the latter group was instigated and written by a representative of the Local Health Group although it was agreed that a church led registered charity should be formally identified as the lead applicant. They, in turn, used their offices to provide legal and financial support and management for the local community to develop the HLC. The high representation of the statutory sector in leading community focused bids suggests an emerging concern to develop different ways of working with local people to meet local health objectives. This may reflect a willingness by the statutory sector to respond to the distinct approach to health improvement in Wales, focusing on the determinants of health, evident in early policy

documents and statements by the then Minister for Health and Social Services, Jane Hutt¹³.

- 3.13 Two of the projects are led by community based organisations, both of which are companies limited by guarantee. For more community based organisations to have been funded it is likely that they would have to have been in areas where there had been prior experience of community led activity and the experience and resources to commit to what all case studies felt to be a time consuming and resource intensive tasks. One potential criterion for the success of HLCs in engaging communities may be the extent to which they use this capacity as a platform to successfully initiate bids for further funding, lobby for resources on their own behalf or instigate other forms of social action or advocacy.
- 3.14 Below are descriptions of two quite different approaches to community engagement and the role of the HLC in creating a platform for future community based and community led activity. These are described in terms of the stakeholders perceptions of the context in which the HLC operated, their aims and perceptions of what needed to be done, the mechanisms they put in place to realise their aims, and what has been achieved in terms of community engagement to date.

ENGAGING COMMUNITIES – CASE STUDY ONE

The context

- 3.15 Based in a *Communities First* area, it was felt by the applicants at the time that there was little in terms of services, shops or social facilities. For an estate of around 3,000 people, in mainly local authority owned housing, there were only a handful of small shops, a youth centre which was protected by barbed wire and metal fencing, a small social club and a church. In terms of health facilities, there was no GP practice and no chemist. Other initiatives had been attempted but it was felt that these had failed because they had been imposed on local people rather than involving them. It was also felt that the health problems in the area stemmed from economic deprivation, the lack of skills in

¹³ Greer, S (2004) *Territorial Politics and Health Policy. UK health policy in comparative perspective*, Manchester: Manchester University Press

the area and the apathy that stems from that. There was also a keen sense that the estate had a reputation and that the people who lived there were tarnished by this. A story that was repeated by staff, partners and local people, was that if the name of the place was included in a job application, then this counted against them.

HLC aims and intentions

3.16 A small group of people from the primary care health sector felt that an approach was needed that involved local people in developing ways of improving the social and economic conditions in which they lived. As other initiatives were felt to have failed because local people were not involved, local ownership was seen to be key to the success of the HLC. During the first round of interviews it was also stressed that the ultimate aim was that the community, or a group representing the community, would eventually take ownership of the HLC. The main person that led the bid's development suggested that the HLC intended to address community and individual well being, arguing that it was about local people participating in schemes such as this. "Without that participation across the board from planning to volunteering we will not be successful." It was felt that the HLC needed to be visible as a brand new centre that would be a focus for community life. This would begin to demonstrate that something had been achieved for the community and by the community.

Mechanisms

3.17 Local people were involved in the consultation from the outset, alongside the local church and a residents association which had recently been formed. A small core of people met regularly throughout the application process. Once the HLC had been funded an Association was created, involving key stakeholders and people living in the community. One of the administrative staff has a joint post in the HLC and the local residents' group (which had become more established, it was felt, as a consequence of the HLC bid). The Association meets around 4 times a year, in a new building that was built with NOF funds, and advises on the direction of the HLC. Local people have the power of veto in any decisions that are made. To build capacity in preparation for community ownership, key positions on the Association have transferred

from the professionals originally leading the bid to local people. The chair and deputy chair are now residents. At the time of the second visit residents had been offered access to a professional volunteer training course to build up the skills necessary for the sustainability of a local owned facility. It was reported that most of the activities developed came from ideas from local people themselves and in terms of staffing most of the positions are held by local people.

Key outcomes

- 3.18 It was felt that the HLC had some way to go before local people were able to run and sustain the centre. However, their meetings are still well attended by local people and they had been successful in vetoing, by means of a vote, a decision at a meeting shortly before the Intensive Case Study visit. The HLC has far exceeded its targets in attracting residents into the building and have reported a problem with managing demand. They have also been successful in attracting additional funding for other community based activities. The condition of the building after 1½ years of use is in stark contrast to other buildings in the area and has suffered little from graffiti or vandalism. A local staff member, a play-worker, said that because she now worked and lived in the community she felt that she knew the area better and could exert an influence on the behaviour of children in the area as well as in the centre. Positive media coverage was reported and comments from a meeting of the Association suggested that local people several years ago would not have anticipated the positive contribution that the HLC has made to the area.

ENGAGING COMMUNITIES – CASE STUDY TWO

The context

- 3.19 A large housing estate, largely built in the 1970s, comprising around 14, 000 residents. Much of it is social housing divided between 3 housing associations and the local council. The physical geography of the area is also reflected in its socio-economic composition, with residents living in social housing separated by a major road from wealthier residents living in privately owned homes. The population is a skewed one with a very high density of children and a lower number of middle aged and older people. Young single headed

households are over-represented as they tend to be placed in the social housing in the area. Though not a Communities First area it was felt that there were the usual problems of unemployment and low income and the attendant health problems that stem from material disadvantage. Much of the population is transient and respondents said that there were hostilities between different areas of social housing and between people living in the area of predominant social housing and those owning their own home.

HLC aims and intentions

3.20 A major thrust of the HLC was to develop a sense of collective pride in the area, paying particular attention to the social and physical well being of the children. The overall aim of the HLC was “to reduce people’s sense of isolation and powerlessness by improving self -esteem and instilling a feeling of control over their lives and living conditions”. It was felt that a community health development approach needed to underpin the way they worked. They did not want to be seen as a ‘centre’ but to play an active part in the local area itself, complementing any existing community based initiatives, of which there was an abundance. It was felt that a centre would develop a ‘face’: familiar and comfortable to some people but then systematically excluding others. The success of the project would be through the improvement of community spirit and social capital with more people engaging in activities which would be beneficial for local residents. The development of individual lifestyles would follow. The HLC aimed to improve community activity as integral to the lives of the people living there and this is a legacy they wish to leave whether or not the project in its present form exists.

The mechanisms

3.21 The partnership basis for the application was strong, having a local forum which comprised of public and voluntary sector organisations and local residents associations. The forum had commissioned a local needs assessment to inform the HLC funding application and the lead applicant was the health authority representative. Apart from identifying children’s health as a priority they decided to adopt a community health development approach to the whole estate, rather than providing specific services or therapies. Five programmes of work were identified all unpinned by community development, and they

worked closely with local community groups. They also undertook area wide activities such as revitalising the local annual community festival, undertaking a participatory mapping exercise of local needs, and setting up and distributing a community newsletter. They have provided training to support local people taking over the running of the newsletter in anticipation the loss of NOF funding in the future.

Key outcomes

- 3.22 Anticipating the loss of NOF funding, there is a sense that there has been insufficient time to change local relationships and community pride in the way that was intended. The loss of funds may mean the termination of some activities that will be felt as a loss to some local people. It was felt, as well, that most people still did not know what the HLC was and what it did. However, reflecting on the interviews conducted during the first visit to the HLC it was clear that no-one intended the project to exist in its initial form beyond the funding period and that, indeed, some of its activities and approaches could be adopted by statutory agencies or local people themselves. It is possible that a new community centre, recently launched through European funds, may take up or host some of the activities. In addition, the local council may take up some aspects of the environmental work. Core staff had been disappointed with the lack of interest from local people in taking more of a lead. Several possibilities for continued action seem realistic including the food co-operative currently run by local volunteers, the newsletter which is currently an important means of creating a sense of unity in the locality and a drugs support group set up by a local resident who felt that there was a need for local support for drugs users and their families.
- 3.23 As the above examples demonstrate, evidence of the success of community involvement has to be seen in terms of their own aims, and the extent to which the resources available are used appropriately in the particular social contexts in which the project is located. In these cases the Healthy Living Centre is a mechanism by which local people can express their aspirations as a means to change the material and social conditions in which they live. In the first case-study the resources are invested in a tangible and 'visible' centre, which are provided for the community, the ultimate aim being ownership and control by

the community. In the second example the project aimed to build these resources within local people, and the groups to which they belonged, as well as existing buildings and environments. The HLC described itself as a virtual project and its ‘invisibility’ could be seen, potentially, as a success in the same way as the ‘visibility’ of the first was crucial. Both approaches provided a potential mechanism by which the frameworks through which local people and public agencies communicate are reconstructed to address power relationships in decision making.

HLCs that promote a specific approach or advocate for a particular population group

- 3.24 The community focused HLCs were different from those which promoted a specific activity or focused on a particular population group in that they were not anchored to a particular place. Many of the HLCs in Wales fall into this second category, with projects highlighting a range of different ways to meet the needs of a particular group of people including older and young people, carers, people with mental health problems and people with learning difficulties. The only national HLC was an initiative to support the local development of walking the way to health schemes and one HLC used a walking scheme and a green gym project to promote particular approaches to health improvement.
- 3.25 Of the 12 single focused HLCs, ten were led by the voluntary sector, all but one being registered as a charity. The other two were the Countryside Council for Wales’ national Walking the Way to Heath initiative mentioned above and a youth focused HLC led by a Health Authority (now the LHB). Five of these projects were directed at older people, four of which were led by local organisations linked to a national charity, Age Concern. The representation of this charity in the HLC programme may be due to the fact that Age Concern runs ‘Active Ageing’ and ‘Ageing Well’ programmes, emphasising activities that promote the health and well being of older people and provide access to a wider network of local organisations developing this approach and a range of leaflets and ways of working. NOF funds have provided an opportunity to develop this approach locally.

- 3.26 Of the case studies that took a single focused approach, a user focus was central to the way in which the overall organisation operated. Indeed those HLCs which focused on the health of specific groups saw themselves as representing those groups in their local areas. They felt that the HLC programme funding provided local benefits in terms of linking the statutory sector to their clients or target groups in ways that could not be done by the statutory sector alone because they lacked both the expertise and the flexibility of a voluntary organisation.
- 3.27 Success in engaging with users or local people was not really seen as the key issue in these case studies, since they already felt that as organisations they had a connection to people that the statutory sector alone lack. The key issue was whether the statutory sector would recognise their role as providing a mechanism by which they could more effectively connect with local people.

Lay health work

- 3.28 One approach to engaging communities has been to identify local people who can taken on health improvement roles within their localities or peer groups. In relation to older people, one HLC, in response to a national initiative, has promoted the idea of senior health mentors who are identified as potential health champions within their own communities and who, in different ways according to local circumstances, will be trained in providing health promoting activities and sign-posting individuals to professional health or other care services. In this case study, a senior health mentor has been trained to deliver gentle exercise classes for very old residents of sheltered housing schemes. The senior health mentor also tried to use this role as a means of communicating other health messages, particularly in relation to diet. Three out of the four HLCs led by this organisation, intend to develop local versions of the senior health mentor model.
- 3.29 In other areas the idea of local health champions was identified in the bid as a means of embedding public health and health promotion ideas into the lives of people living in particular areas. In one HLC which had had many years of

community based activity, they planned to recruit and train volunteer health advocacy workers, who would develop and operate as a means of ensuring that the ideas underlying the project would be embedded in the community. In the bid documentation they reported an intention that they intended to provide a wide range of opportunities for local people to volunteer and develop skills. These could include training in play work, group work skills, counselling skills, information and guidance provision, healthy eating projects and parenting support. Appropriate training was to be given which would then cascade down to others across the organisation and into the community. Although this model has been slow to develop, interviews with volunteers revealed a willingness amongst some young volunteers to contribute to the community.

- 3.30 Case studies have also highlighted examples of individuals naturally taking up health roles in the community. In one case study a local resident became involved in various aspects of the HLCs activities as well as setting up a local support group of her own with the help of the HLC.
- 3.31 Further rounds of data collection will provide an opportunity to identify other models of lay health work, the extent to which they are felt to be successful and the degree to which the roles are sustainable. Such work will provide an important development in understanding how local people can be involved more directly in health improvement. The English White Paper, *Choosing Health* (2004), proposes to identify, train and employ NHS trainers drawn from the local community. Experience from some HLCs suggest that there may be other ways in which local people can be engaged in health related work and learning from what has been achieved may inform the development of alternative approaches. This is particularly important in the light of the Welsh Assembly Government's long-terms plan for health and health *Designed for Life* (2005)¹⁴, which stresses the need for citizen engagement in health improvement and *Making the Connections* (2004)¹⁵, which highlights the need for the development of citizen centred public services.

¹⁴ Welsh Assembly Government (2005) *Designed for Life. Creating world class health and social care for Wales in the 21st Century*, Cardiff: Welsh Assembly Government.

¹⁵ Welsh Assembly Government (2004) *Making the Connections. Delivering better services for Wales*, Cardiff: Welsh Assembly Government.

4 Developing Links with the Wider Health Economy/ Health Policy

Key Issues

- Key to sustainability plans was that HLCs, or their activities, would become established in the local health economy.
- The views of national public health policy makers and the experience of individual HLCs highlight the difficulties in demonstrating effectiveness to potential commissioners. There are difficulties in comparing such interventions alongside other health interventions. This suggests that individual projects within programmes such as these need to develop appropriate evaluation methods in the context of debates on what counts as evidence.
- There is a need to make the links between regeneration and health more explicit at the highest levels.
- There is a responsibility for programme evaluations to inform the commissioning of future national programmes. Evaluations also need to be able to inform practice so that practitioners do not constantly have to relearn and make the same mistakes.
- There appears to be an inherent tension between the desire for innovation and the requirements of sustainability. Further discussion is needed on resolving this tension.
- At a local level the experience of partnership working was largely, though not uniformly, positive. However, good links, even at strategic levels, are not a guarantee of financial commitment.
- Partnership working has brought many benefits including providing local people with access to a wider range of services and the ability of HLCs to extend the reach of their activities. There are examples of strategic partners using HLCs as an opportunity to test new approaches to health improvement.
- HLCs seem to have had some impact on building health awareness into non NHS organisations.

- There is little mention of the work of HLCs in local Health, Social Care and Well Being Strategies. However there are some notable exceptions.
- HLC managers, who are facing the end of their funding, have found the experience of sustaining their work time-consuming and stressful. Sustainability needs to be built into the planning of any future programmes.

Introduction

- 4.1 Critical to the success of the HLC programme is the extent to which the projects, new activities or ways of working created by the projects, are understood or taken up beyond the life of the funding period. This section explores the extent to which HLCs have been seen as fulfilling wider local and national policies for improving health and tackling inequalities and social exclusion. It then looks at how partnership at a local level and links to the development of local strategies, particularly the Health, Social Care and Well Being strategies, have positioned HLCs within the wider local health economy.
- 4.2 A key assumption of the HLC programme was that the work of the projects would most effectively be delivered and embedded in local practices if they worked in close partnership with other agencies related to health and regeneration. As a consequence there was a requirement that applicants set up partnership structures to manage the projects. These partnerships were expected to be broad and include the statutory, community and private sectors. Partnerships were seen as a way of ensuring that they could mobilise the interests and resources of other agencies as well as influencing the way in which other agencies worked. It was also hoped that HLCs could be a means of influencing intersectoral working in the areas in which they operated. For some HLCs, partnerships were indeed a means of extending the reach of their own activities whilst for others the core business of the project was to act as a catalyst for better partnerships and networks for health. Finally, partnerships were seen as crucial to the sustainability of projects beyond the NOF funding as partners could also influence the funding and take-up of projects in the long

term. In that sense partnerships were crucial in establishing the work of the HLCs in the wider health economy.

- 4.3 Subsequent to the data collected for this interim report, a policy seminar was conducted with key national organisations and divisions within the Assembly Government to discuss the relevance of HLCs and learning arising from the programme to national policy and practice development. This section starts with a brief summary of the key points arising from this seminar as it provides an insight into the way in which the HLC programme and similar health improvement programmes may contribute to strategic objectives in Wales.

The Healthy Living Centre Programme and National Policy

- 4.4 The Healthy Living Centres programme was first launched in the UK in January 1999. Although the programme fits with the subsequent focus on ‘the local’ in Welsh health and health care policy¹⁶ and the Welsh Assembly’s first Health and Social Services Minister was a member of the UK HLC programme development group, the programme itself was not a creation of the new Welsh Assembly Government. This may well have put the programme at a certain disadvantage against subsequent programmes such as the Sustainable Health Action Research Programme (SHARP), which benefited from monitoring, evaluation and dissemination processes, developed by the Assembly to promote learning at national and local levels. All those who participated in the policy seminar referred to above were aware of the Health Living Centre programme, but, although some had read the evaluation reports, there was still a real lack of real knowledge and understanding about what HLCs were trying to do and a lack of communication and then information about what they are doing and achieving. There are clear lessons here for evaluations of programmes and how, when and to whom learning is disseminated.

¹⁶ Greer S. (2004), *Four Way Bet: How devolution has led to four different models for the NHS*, London: The Constitution Unit

- 4.5 It is also clear from earlier chapters that HLCs themselves are only just beginning to put evaluation processes in place and may now have some real problems in demonstrating how their projects may be effective in meeting local strategic objectives. There was some discussion about how the learning could be communicated at a local level, perhaps by bringing the original partners together, to enable HLCs to demonstrate achievements. Learning at the local level as to how HLCs can contribute to local objectives is of crucial importance as Health, Social Care and Well Being strategies are the drivers for action for health improvement.
- 4.6 The issue of what counts as criteria of effectiveness was also discussed. It was felt that HLCs may well be able to contribute to the overall ambitions of the Welsh Assembly Government in developing innovative ways of tackling the determinants of health at a local level, but there was a general lack of agreement on how the effectiveness of HLCs can and should be measured. In terms of traditional health measures it was felt that they may not be able to provide measurable outcomes in the same way as other clinical interventions. One participant stressed that HLCs would need to demonstrate that they can achieve something according to some objective criteria otherwise they are unlikely to be funded by local statutory commissioners who have to balance funding something new and unproven against what is already being funded and provides known and quantifiable benefits. This was already a problem that had confronted one HLC as we describe later.
- 4.7 It was also felt that HLCs are trying to do something different which cannot be considered alongside other kinds of intervention in the same way. There was a need, as one participant stressed, for a dialogue with senior policy makers about what counts as evidence when quantitative indicators cannot be produced. It was also agreed that it is imperative that Wales finds effective ways of preventing ill health, promoting health and tackling persisting inequalities. This requires commitment across sectors and leadership to promote the approach at the highest level. It was pointed out that there is no specific health inequalities strategy in Wales to help forge that commitment,

although various initiatives do tackle inequalities. *Designed for Life*¹⁷, the overall strategy to deliver improvements in Wales by 2015, will not be assessing progress on improving health and tackling inequalities in health until 2009 and a strategy for reducing inequalities in health will not be published until 2010. The contributions that area based health initiatives may contribute to tackling inequalities in health could be lost in the absence of the evidence of what impact they have on health and inequalities.

- 4.8 Another challenge is to ensure that the link between health and regeneration becomes explicit at the highest levels in the Assembly Government as many of the HLCs and projects funded under the Assembly Government's Sustainable Health Action Research Programme (SHARP) represent approaches that do bring health and community regeneration together. Both programmes provide opportunities for cross-divisional learning.
- 4.9 Despite a great deal of uncertainty as to what HLCs have actually achieved, participants did suggest a number of ways in which learning from the HLCs could input into future developments. For instance, lessons on 'what works' and how HLCs have attracted hard-to-reach populations could be incorporated into requirements for future bids for other initiatives. Even if the HLCs themselves are not sustained, the knowledge could be passed on so that people do not constantly have to relearn. It was also suggested that it could be recommended to Ministers that they take the findings into account when issuing commissioning guidance to local authorities and local health boards. Learning could also be fed into thinking about how such initiatives should be funded in the future, such as how long certain kinds of initiatives should be funded to ensure that something is sustained into the future.
- 4.10 Finally, the balance between innovation and sustainability in major public health initiatives was discussed. The HLC programme was heralded as a new way of tackling inequalities in health and in reaching the most deprived populations in the country. However, it was pointed out that in England the

¹⁷ Welsh Assembly government (2005) *Designed for Life: creating world class health and social care for Wales in the 21st Century*. Cardiff: Welsh Assembly Government

HLCs seem to have been forgotten and they are not mentioned in *Choosing Health*¹⁸. It was felt that there is a pressure on Ministers to make their mark by coming up with something new and the HLC programme was indeed seen as an innovative approach to a new Labour government committed to tackling inequalities in health. It may be that governments need to give greater consideration to the sustainability of policies and that unless commissioners and organisations are prepared to pick up good practice and support it over a number of years, this is unlikely to happen. It was felt that the issue of sustainability needs to be considered with partners when first developing programmes such as this, providing some evidence of commitment.

How partnerships were constructed and understood

4.11 Turning back to HLCs and partnership development, the case studies showed that the idea of ‘a partnership’ was understood and formulated in different ways. Of the seven case studies in Wales only three had established formal partnership agreements and these were usually for legal and/or financial accountability reasons. This could be a lengthy process and in one case threatened the less formal partnerships that had been established prior to the bid.

I think it was hard and more complicated to set up than people thought it would be. One of the issues that I thought took a phenomenally long time to resolve, which I hadn't really thought about but in hindsight did take a lot longer than it should have done, was getting the partnership agreement sorted out. And that wasn't because it was a problem with the Health Authority or the Local Authority it was because it was a problem or an issue that was consistently raised [by local resident representatives] ... certain individuals within that forum were not happy that there were fewer resident representatives on the management group than the local authority and health authority... It wasn't contrived that way to keep the community element at a minimum. It had to be drawn up that way for legal reasons and financial accountability reasons.

HLC partner

4.12 Formalising agreements could take time and where this contributed to the unanticipated time it took HLCs to get set up. In another case a formal

¹⁸ Department of Health (2004) *Choosing Health: Making choices easier*. London: Department of Health

agreement with Local Health Boards took time, partly because of structural changes within the NHS in Wales at the time and partly because of the length of time needed to draw up agreements that satisfied all parties.

Got the funding in January 2003 but the partnership agreement was not finalised until October 2003. It was already in draft previous to that, but the NOF people were not satisfied with it. They found some weaknesses in it. So, it came backwards and forwards and it wasn't in final form until October 2003. The partnership agreement was in draft form for the 2nd stage application. We had also consulted with the LHBs; they were called something else at the time (Local Health Groups). It wasn't the best time to be setting up a project to work closely with them because they didn't know what they were doing and we were new. Even though we were getting the support lots of their personnel were not in place and it was fraught with uncertainty. You know, it was hard.

Lead applicant

- 4.13 However, the development of formal arrangements must be seen as distinct from partnership working in practice. Unless a formal agreement was in place different respondents in the same case study, when asked if partners were formal or informal, would provide different answers and it was clear that the distinction between 'formal' and 'informal' partnerships was unhelpful. More useful was the distinction between partnerships that were strategic or that were in place because they contributed to the overall management and wider purposes of the HLC and operational partnerships that were linked to the delivery of particular activities or services.
- 4.14 Most HLCs had no difficulty in establishing operational links with other services or agencies. They provided real opportunities to establish joint projects on the ground and a means of reaching different population or illness groups. One project, for instance, established partnerships with Communities First groups and National Parks as well as links with primary care, cardiac rehabilitation services, mental health groups and adolescent obesity clinics as a means of establishing walks with different groups and different places. Strategic links also enabled this HLC, with its partners, to identify other opportunities to link the activities to other initiatives in the area
- 4.15 Strategic links were viewed as crucial to the commitment to the HLC at a broader policy level. It was an indication of the extent to which public agencies bought into the approach and activities of the HLC in the long term.

In one case, strategic level buy-in to the project was never established in practice though partners were mentioned in the application.

At one point I convened a meeting ... inviting all the partners to come to say that we were going to share out the tasks. They didn't turn out. So the partners that have gone forward in the bid are the ones who actually contributed something to the development of the bid. There were a lot of organisations that wanted to have their name on it, but if we wanted some statistical data or an opinion, they were all just too busy.

Lead applicant

4.16 The lack of commitment persisted after funding was provided and the lead organisation still feels isolated and let down by lead agencies in the area even though at an operational level links have enabled them to deliver some of their activities successfully. On the whole, however, at the beginning HLCs were optimistic about their strategic links which were often reflected in governance, management and organisational structures in a variety of ways, including:

- Local authority and LHB representation at steering group meetings
- Formal partnership agreements
- Local authorities and NHS organisations as employers of HLC staff
- HLC as an employer of a Communities First co-ordinator

4.17 All these arrangements are seen as ways of ensuring that local authorities and LHBs, together with voluntary agencies and community groups, have a direct interest in the overall direction and future of the HLC. However, as some HLCs have matured or come towards the end of their funding there is some concern regarding the commitment of strategic level partners, particularly when HLCs have started to look to these partners for longer term support. Whereas strategic partners have been crucial to the broader development and direction of the HLCs they perhaps lack, on their own, the power to sustain the future of the projects in the long term. The reasons for this are explored below.

Impact of Partnership working

4.18 Although there may be limits to what partnership working can deliver in terms of sustainability, there have been some benefits in terms of bringing in new resources into an area in terms of new activities, buildings, networks and services. In addition there is some evidence that the HLC programme had an impact on the way in which other services worked to improve health at a local level.

Bringing in new resources

4.19 On the whole the HLCs and their partners have delivered the type and range of activities as planned and the fact that so many new activities have been successfully developed is in itself a measure of the success of some HLCs. In addition, as the HLC partnerships have evolved, most have significantly increased the range and reach of the activities that they originally anticipated. One HLC has links with social services and this has resulted in training activities being provided to carers on a range of health related topics. In another, links with schools and local sheltered accommodation units have provided a means of developing physical activity programmes for different age groups.

4.20 Perhaps more interesting is the extent to which the HLCs have been seen by partners as a means of testing and piloting new activities and approaches which could be used elsewhere. An example of this is the appointment of an Activities Development Officer in one HLC, employed to develop a physical activity programme in the area. In this case the Sports Council for Wales and the local authority were interested in the idea of using the estate as a pilot area. This interest originated in initial discussions between the HLC and the Communities First co-ordinator who wanted to increase physical activity in the area. HLCs reported that organisations would approach them for ideas to develop or deliver activities.

4.21 Another important impact of the HLC partnership on local communities, particularly with regard to community focused HLCs, has been their ability to bring existing resources closer to local people. In an area where there were no local services, one HLC has contributed a new building which is able to house

a range of support, advice and education services. In this case the HLC had a strong emphasis on improving skills and was able to bring in a variety of courses to local people provided by the local college and the Workers' Educational Association (WEA). The HLC also housed a new computer suite and a crèche to enable local people to participate in courses without lack of child care being a barrier. Another HLC used the building that was leased to them to house an outreach mental health clinic which had been identified as an important gap in local service provision.

- 4.22 HLCs which emphasised an environmental approach to health improvement were also able to link health related activities to different uses of the local landscape. In one HLC improvements to footpaths not only facilitated new guided walks but also ensured that local people benefited in terms of access to public space. Similarly an approach to play with children involved transforming local play parks into spaces in which many children could play for the first time. The HLC saw its role as reclaiming the play-parks for the use of local children.

Changing the culture of mainstream organisations

- 4.23 A key thrust of the HLC programme was its potential contribution to the way in which projects could influence mainstream organisations to work in different ways to tackle the causes of ill health and inequality at a local level. Given the wide range of partners that were involved with HLCs, particularly at an operational level, the programme appears to have had some success in:

- involving non-NHS partners in a programme of activity directed at improving the opportunities for health at a local level;
- involving NHS staff in working in ways not normally associated with their traditional provider roles.

- 4.24 For organisations that used the HLC programme as a means of developing health and well being as a part of the development of their own work, the funding has had a direct impact on their own organisation. This was the

situation with four out of the seven case studies and it was evident that the experience has embedded a new awareness of the broad public health agenda into their organisations in ways that had not been possible before. In one project the Director of the community organisation leading the work is funded through the programme funding and the HLC co-ordinator is funded through a separate funding stream. The organisation's Director reported that her role was "really making sure that everything that we do as an organisation is dovetailed, under a health and well being agenda". This was also true of another voluntary organisation that provided support for carers. Asked what the HLC has added it was reported that:

We've become more focused on carers' health. For instance one of the newsletters was just for information on carers' health and how they could improve it. Also all the topics we were covering at group discussions were health related mainly. All the training sessions and well being sessions all have a health slant.

HLC manager

- 4.25 For other HLCs the funding provided a way of refocusing local services towards the health and well-being agenda. Some HLCs had a direct impact on providing new ways of working with local people or clients. Midwives and health visitors in one project reported that they were able to deliver a service which was closer and more relevant to local people.

Barriers to partnership working

- 4.26 As indicated above, partnership working is not always easy and, as with community engagement, the nature and ethos of these relationships appears to be established during the application process. In other words, applicants that found it difficult to establish good partnership relationships in the bidding stage continued to experience problems later on. However, it should be stressed that this hypothesis needs to be tested against the experiences of the other case studies in the UK.
- 4.27 One key barrier to partnership working could be the lack of understanding between the voluntary and statutory sectors. This was particularly the case where the voluntary sector was leading the bid. Differences in organisational

style and ways of working were highlighted and it was felt that more work needs to be done to understand the different constraints that staff in different sectors work under. The lack of flexibility and the long timescales for getting actions and decisions approved in the statutory services has been particularly frustrating for voluntary sector partners. It was also felt that statutory partners sometimes failed to understand the resource constraints under which the voluntary sector operates. These resource constraints were felt to be particularly hard during the bidding process and, for one HLC at the end of its funding period, in developing bids for future funding. Finally it was sometimes felt that the statutory sector failed to appreciate the ‘professionalism’ of the voluntary sector. The low pay of voluntary sector staff did not, it was argued, equate with a lack of expertise and skills and it was stressed that voluntary organisations benchmark themselves against national standards for the ways in which they work. One HLC had already discussed this problem and a suggestion for shadowing of staff across the sectors had been suggested.

- 4.28 Finally, as highlighted earlier, one link that HLCs had difficulty in establishing was with primary care, particularly GP practices. One HLC said that they had tried various direct and indirect approaches from the outset, yet there had been no interest at all. The exception to this was one HLC whose main focus was to develop a means by which primary care professionals could identify carers and refer them to the HLC for support should they want it. In this case the formal partnership with the LHBs involved was crucial and one of the partners helped to develop a protocol for primary health care teams to identify carers. In this case health link workers were employed to work directly with GP practices to support the use of the protocol and raise awareness of the importance of carers’ health needs. However, it is possible that the new GMS contract, which rewards practices for work that supports carers, was also an incentive in this case.

Positioning in the wider health economy

4.29 As well as involving partners in the strategic development of HLCs, individual project managers or co-ordinators also tried to make themselves visible in the wider health economy in a variety of ways. These included:

- representing the HLC on steering groups of other area-based health or regeneration initiatives;
- accepting invitations, or lobbying, to provide an input in the development of Health, Social Care and Well Being (HSCWB) Strategies;
- linking into other borough wide health related strategies.

4.30 Most of the case studies indicated some involvement in the local consultation process for the development HSCWB strategies but HLCs themselves are not visible in these and are mentioned in only four. Only in one HSCWB was the approach undertaken by the HLCs highlighted as representing a commitment to their overall approach to health improvement but this was a notable exception. Another two strategies highlighted the value of the activities undertaken by HLC but in these cases the lead voluntary organisation was mentioned but not the fact that these activities were funded through the HLC programme.

4.31 HLC co-ordinators and managers had difficulty in maintaining a balance between developing support for a local programme and ensuring relevance to the wider objectives of the local authority and LHB. Most HLCs were fully occupied in developing the project with little time to devote to ensuring their wider strategic relevance. However, one local authority partner concerned with borough-wide regeneration policy suggested that the future of the HLC could depend on how it would fit into the local authority's wider strategic objectives. Another LHB partner felt that the HLC needed to realise that long-term financial support was likely to be limited as they could not justify funding one area, which was not even a Communities First area, when

there were so many other deprived communities that in terms of deprivation indicators had greater need for financial support.

- 4.32 One approach that provided a link to the wider regeneration agenda was the decision to place the Communities First co-ordinator under the employment of the HLC. They have found that this link provides direct access to a wider group of organisations and decision-makers within the local authority area and the arrangement allows the objectives of the HLC and the Communities First partnership to dovetail. The co-ordinator suggested that this approach also provides benefits for the Communities First co-ordinator as they could otherwise have been seen as yet another external imposition.
- 4.33 Again, a further round of visits to case studies will indicate the extent to which HLCs have made themselves visible in the local health economy. However, a workshop held with some HLCs prior to selection of case studies highlighted a lack of knowledge in some projects of the current policy agenda and environment. Training and support on current health and regeneration policy and structures in the initial stages of a HLCs life may have been useful and should be considered for future initiatives.

Beyond the programme funding: Sustaining the work of HLCs

- 4.34 As HLCs have progressed, the need to plan for the sustainability of the projects has become more urgent for those funded in the first and second rounds. For one HLC, funding was due to end two weeks after the last case study interviews. In this project it was stressed that 75 percent of the manager's time had been taken up by sustainability issues over the previous 12 months which included negotiating with the LHB and Local Authority and writing numerous bids. The manager felt that everything had been done to make a case for commissioning a key programme in the project which would have been borough wide and fulfilled local objectives. A case for the effectiveness of the approach was made using available evidence and an evaluation project conducted by a university student as part of a final year

undergraduate dissertation. Letters of support were sent from politicians from Wales and England after project users and staff promoted the value of the project. The project did not succeed in securing funding by the time the programme funds had run out, but two months later Welsh Assembly Government funding was provided to continue the project for two more years with matched funding from the Countryside Council for Wales.

- 4.35 Although all projects will be different in terms of the way in which they envisage sustainability there are a number of learning points from this HLC that are emerging and which may relate and resonate with the experiences of other projects. As they come to the end of their funding these issues may become more predominant.

Sustainability planning is time consuming

- 4.36 The HLC was proud of its professional and business-like approach to its programmes of work and had set up a funding portfolio to plan for continuation funding eighteen months prior to the finish date. As highlighted, most of the manager's time was taken up in the last 12 months trying to secure funding locally. This had a marked impact on the proportion of time available to dedicate to the project itself and in the last 6 months the project was said to have stagnated as they could not develop new activities and ideas without certainty of secure funding. Difficulties in this project will have been compounded by the fact that they only applied for, and were awarded, three years funding

One of the problems of the HLCs you spend 12 months to get it going, 18 months being really productive and then you put lid on the whole thing because you don't know if you are going to be there in 6 months time.

HLC manager

Continuation funding is difficult to secure

- 4.37 Another frustration, also reflected in a workshop conducted by the Bridge Consortium with HLC stakeholders in England, is the difficulty in securing continuation funding for innovative community based projects. In the above case study, the HLC felt that they had made a clear cut case for the

effectiveness of the project in improving health related lifestyles locally and that it should be funded locally through mainstream resources.

I understand that issue about sustainability. If projects are proven to be effective they shouldn't have to depend on continuation funding through pots – it should be mainstreamed

HLC partner

- 4.38 However, the partner recognised, reflecting the issues raised in the policy workshop, that health promotion initiatives have to compete with existing funding commitments and priorities which are felt, by commissioners, to have proven benefits to health.

Well being approaches are competing with health care services for scarce resources

- 4.39 Despite close working with the Local Authority and the Local Health Board, both represented on the steering group, reports and monitoring figures demonstrating the success and effectiveness of the project and links between these and local health and well being objectives, no local commitment to funding was provided. This may have been partly due to unfortunate timing as the HSCWB strategies were in the process of being finalised, a time of uncertainty about what could be delivered and funded at a local level.

One thing the joint partnership boards and the strategy want are fully developed action plans ready to attach to the strategy when it is adopted in December. The reality is that is all it will be is a wish list. And I don't think it's going to be more than a wish list in the near future because if we are going to do this right we need to make sure that it is not going to be a council led thing it's got to be fully inclusive and it's got to respond appropriately to the priorities... That is the situation. It's well documented. We've had a series of meetings and nobody knows.

HLC partner

- 4.40 There was a perception in this, and other HLCs, that resources were unlikely to shift from health services towards health promotion/public health interventions, including approaches developed by HLCs. This is despite the prominence of 'well being' in the strategy guidance and the stress that action to improve health and tackle inequalities should be a priority equal to the provision of effective and efficient health services. It is still too early to

assess whether the strategies will provide a lever to direct more resources to the broad public health agenda, but the feeling in this project and other HLCs was that financial deficits in the health service, and the strong lobbying power of the NHS meant this shift was unlikely to happen in the near future.

If the strategy was health and social care I would suggest that we would probably see a more co-ordinated approach to health and social care through the partnership, but because we've got this third dimension, this well being dimension the health promotion perspective is absolutely critical then. But the current providers of health and social care just don't understand it and they are suspicious of it and they suspect that what we are looking to do is try to plunder some of the existing budget to develop a health promotion strategy. There is an element of truth in that I have to say but we are talking about value for money on that health pound I think.

HLC Partner

Funding bodies place new conditions on projects

4.41 The HLC manager submitted a wide range of bids to continue the programme of work. However, each funding body imposed its own particular set of demands which would impose different restrictions on how the programme could operate. This poses risks for maintaining the fidelity of the original project as it would inevitably have to fit in with a new set of agendas. In practice this may mean that valued elements of a project could be sacrificed in favour of survival.

HLCs may have to manage the loss of the project for users/local people

4.42 Two of the four *Intensive Case Studies* reflected on the foreseeable impact of the loss of NOF funding and the loss, in both cases, of the project. In particular, stakeholders argued that the loss of the project would be felt by local people. The manager of one had a collection of letters from people who had indicated that they would greatly miss the activity and the friends that they had made in the process. In this HLC many of the clients are elderly and previously socially isolated, in which case the health losses could be wide ranging.

If you read them, the profile of our [clients] is that 75 per cent are 50 plus. Something like 65 per cent are 65 plus and the profile is that a lot of them are elderly socially isolated people and they are all writing on these forms that 'if it wasn't for the [HLC] I wouldn't go out and meet anybody'.

HLC Manager

- 4.43 In another HLC one resident had dedicated much of her time to the management of the HLC as well as getting involved in a number of the activities. During the first visit the resident had delivered a speech at a national meeting on how her involvement with the HLC had improved the quality of her life, including her health. During the second visit the resident was reflecting on the HLC coming to an end.

The thing is, and I do feel sad about it because I've worked hard myself and I know that it is all going to finish. It will be really sad to see everything that's been going on here just disappear.

Resident

- 4.44 Another loss could be in terms of jobs of HLC staff and it was stressed that where HLCs are led by the voluntary sectors their capacity to absorb them into other areas of work may be more limited than in the statutory sector.
- 4.45 Finally, a major loss may be in terms of relationships of trust facilitated by the HLCs. In one case this loss would be felt directly by the organisation in terms of the links that they had made with the other statutory services as well as with communities and volunteers. In other areas, given the HLCs role in improving relationships between public agencies and communities it is possible that if sustainability plans fail then this could have a marked effect on these relationships and the way in which community based projects are received in the future. Research on historical data for understanding inequalities in health suggested that the way in which regeneration policies are received is often shaped by the history of a community's relationship with public agencies.¹⁹

¹⁹ Mallinson S, Popay J, Elliott E et al (2003) 'Historical data for health inequalities research: a research note' *Sociology* 37: 771-780

Inherent barriers to sustainability

- 4.46 Another potential barrier to sustainability is the extent to which HLCs experience difficulties in sustaining the projects during the course of the programme funding. For some HLCs, difficulties in sustaining their work related to retaining staff. Holding onto staff could be difficult for two key linked reasons; finding people with appropriate and adequate skills to undertake HLC work and the rates of pay for such work.
- 4.47 For managers and co-ordinators of HLCs the complex nature of the projects requires broad ranging skills which would enable them to manage the programme; identify, develop, and maintain strategic and operational partnerships; engage with local communities; develop and deliver new activities; and monitor and evaluate performance. In addition, respondents highlighted the keen sense of personal and professional commitment to the ideas and values underpinning their HLCs. In asking HLC co-ordinators and managers what qualities and skills were required of staff they stressed the need for people who demonstrated particular values as well and skills. One HLC co-ordinator said that the most important job requirements were commitment to, and experience of, working with the client group, rather than qualifications. Another voluntary sector HLC lead stressed that the levels of professionalism required were extremely high and felt that this was not appreciated by the statutory sector.
- 4.48 However, whilst HLCs require staff with high levels of skill, experience and professional qualities, the voluntary sector led projects typically offer lower rates of pay compared to jobs in the statutory sector. In particular the rates of pay for Communities First co-ordinators and people employed by the Council for Voluntary Services (CVS), where similar skills were sought, were on significantly higher rates of pay. One voluntary sector led HLC had employed five different co-ordinators in the first two and a half years. During the first visit it was reported that the co-ordinator had left to take on an easier job with the CVS at much higher rates of pay. Another HLC had also lost staff who had taken on better paid jobs. The loss of co-ordinators or managers is

particularly disruptive as good leadership was considered to be crucial to the success of the HLC.

The potential legacy of HLCs

- 4.49 Not all HLCs are likely to receive funding to continue the projects in their initial form. However, the survival of HLCs is not the only criterion of their success and the idea of sustainability can be extended to changes that the projects have made and the legacy that they may have left in terms of ways of working and in the uptake of particular activities.
- 4.50 One HLC, at the time of second visit, identified elements of current activity that could be taken on by other agencies or groups in the community. For instance they had provided training to some local people in order that they may continue to write and distribute a community newsletter. Similarly some environmental projects, as well as a food co-operative, seemed likely to survive the loss of the HLC and staff. There were also discussions as to what activities may be taken over by the local authority as well as a new community centre which, quite separately and with European funding was being set up in the local area.
- 4.51 Another legacy that HLCs may leave behind is in terms of ways of working with a particular population group or community. Evidence for such changes may be clearer in subsequent visits to case studies. HLCs feel confident that they will leave their mark in some way. For example, one manager of a HLC that developed protocols for primary care teams to refer carers to appropriate sources of help and support said that if successful, the project will have left a legacy in terms of a new referral pattern. Other HLCs have facilitated new linkages between services at a local level and further investigations should be able to identify examples of where new ways of working have developed as a result of a HLC operating in the area.
- 4.52 Finally, for some applicants the HLC programme funds provided an opportunity to refocus their own work towards health and well being allowing them to experiment with different kinds of approach and activities. The

programme funding may well change the way in which these organisations approach their work in the future.

5 Conclusions

- 5.1 The Healthy Living Centres programme funded by NOF (now the BLF) has created a range of local projects that have very different management and partnership structures, aims and objectives, ways of relating to local people and users and different underlying ideas about health and inequalities. It is perhaps these differences which unite them as a set of innovative projects designed to tackle problems relating to health and their determinants in flexible and locally appropriate ways.
- 5.2 At the time of writing this report HLCs have gone beyond the initial setting up period, which for many projects took much longer than expected. They have established, as far as they can, the links they planned with partners and communities, and have identified and delivered a range of activities to their target group. Many are now aware of the need to think of ways of sustaining the projects as a whole, or particular aspects of the programmes that they have set up. For some the loss of funding may have a range of negative impacts which were unforeseen at the beginning. The investment that they have made into partnerships, staff and communities has been considerable and it is possible that those HLCs that have received the greatest proportion of their funds from NOF will experience the greatest negative impact if the assets that have been developed are lost. Examples across the UK have demonstrated that some HLCs are looking into ways of sustaining themselves as entities that are still at a distance from the constraints of the statutory sector by becoming social enterprises or community trusts. This may well turn out to be the best scenario for some HLCs in Wales, and the Support and Development Fund which is now in place, though too late for one project, should be directed at identifying different opportunities for projects to sustain themselves in the future.²⁰

²⁰ It should be highlighted that at the time of collecting data for this report the Support and Development Fund, led by, in Wales by the consultancy firm, Momenta, and delivered by the Wales Centre for Health, was in its infancy. At the time, following a short scoping study, they had begun to develop a series of training events on key collective concerns including evaluation and fund raising.

- 5.3 Another worrying finding is the lack of visibility of the programme in local policy documents and although some HLCs have provided an input into the consultation process for the first round of HSCWB strategies, apart from three LHB areas they receive no mention in these documents. The reasons for this may be that the programme has failed to make itself visible within the LHB areas or that they are seen as peripheral to the core business of local health and well being partnerships. Another reason, noted above, could be that health promotion and interventions that focus on prevention, continue to be secondary to the need to continue to place financial investments into health care services and meet NHS targets. However, it is possible that some of the ideas and approaches from the HLC have been reflected in the strategies but are not explicit. In some, the contribution of a voluntary organisation has been highlighted but not the contribution of the HLC programme funding. The next round of case study visits should establish the likelihood of funding from local mainstream resources.
- 5.4 Final reports for the UK and Wales, due in early 2007, will provide clearer insights into the future prospects of the Healthy Living Centres, and the activities, partnerships and community relationships that they have established. Additional visits to case studies, not conducted in time for this report, will be conducted. This will be followed by final telephone calls to all case study sites to focus on impacts to date and sustainability issues. The researchers based at Glasgow University will conduct a web-based survey of all HLC Managers/Co-ordinators and a parallel survey of key partners with an interest or stake in the work of individual HLCs. The integration of case study data with the Health Monitoring System (HMS), Annual Monitoring Reports and routine area data will also provide a clearer picture of the reach of HLCs and the changes that they have made to people's health and well being locally in relation to a detailed understanding of the approaches that they have used. Finally, additional resources from the Welsh Assembly Government will provide an opportunity to explore the extent to which the policy context in Wales makes a difference to the way in which HLCs and the ideas and activities generated by the programmes are taken-up at a local and national level.



Cardiff Institute of Society, Health and Ethics
Athrofa y Gymdeithas, Iechyd a Moeseg Caerdydd

Ail-ganfod Breuddwyd Bevan?

Gwerthusiad Astudiaeth Achos o Ganolfannau Byw'n Iach yng Nghymru

Adroddiad Interim i Swyddfa'r Prif Swyddog Meddygol,
Llywodraeth Cynulliad Cymru

Crynodeb o gynnydd hyd fis Hydref 2005

Eva Elliott
Gareth Williams

CRYNODEB GWEITHREDOL

Cyflwyniad

- Ariannwyd rhaglen Canolfannau Byw'n Iach gan Gronfa Cyfleoedd Newydd, Cronfa'r Loteri Fawr erbyn hyn, fel rhan o ymgyrch Llywodraeth y DU i fynd i'r afael ag anghydraddoldebau iechyd.
- Er nad Llywodraeth Cynulliad Cymru gychwynnodd y fenter, gellir ei chymharu â mentrau ardal eraill sy'n ceisio mynd i'r afael â'r rhesymau cyffredinol dros affiechyd er mwyn cywiro ffactorau megis allgáu cymdeithasol ac anghydraddoldebau iechyd
- Pwysleisiwyd pa mor bwysig oedd cynnwys amrywiaeth eang o bartneriaid a defnyddio dulliau newydd o weithio i ddatrys y problemau y mae gwahanol grwpiau o'r boblogaeth yn eu hwynebu yn lleol.

Y Gwerthusiad

- Caiff gwerthusiad y DU ei arwain gan Sefydliad Tavistock yn Llundain ac mae'n cynnwys consortiwm o sefydliadau academiaidd megis Uned Ymchwil Iechyd, Ymddygiad a Newid Prifysgol Caeredin, Ysgol Gwyddorau Cymdeithasol Prifysgol Caerdydd, Sefydliad Ymchwil Iechyd Prifysgol Caerhirfryn, Sefydliad Iechyd Cyhoeddus Iwerddon, Uned Ymchwil Gwasanaethau Personol a Chymdeithasol Ysgol Economeg Llundain (LSE) ac Uned Gwyddorau Iechyd Cyhoeddus a Chymdeithasol MRC Prifysgol Glasgow. Enw'r tîm ymchwil yw'r *Bridge Consortium*.
- Yn ogystal ag arian Cronfa Cyfleoedd Newydd (Cronfa'r Loteri Fawr erbyn hyn) mae Llywodraeth Cynulliad Cymru, drwy'r Isadran Gwella Iechyd Cyhoeddus wedi darparu adnoddau ychwanegol i gynyddu nifer yr astudiaethau achos a gynhelir ac i gynhyrchu adroddiad sy'n berthnasol yng nghyd-destun polisi Cymru.
- Mae dwy brif elfen i werthusiad y DU. Yn gyntaf, sefydlwyd System Monitro Iechyd (HMS) dan arweiniad Prifysgol Caeredin, i asesu'r effaith ar iechyd pobl sy'n defnyddio Canolfannau Byw'n Iach a'r graddau y mae'r rhaglen yn cyrraedd ei phoblogaeth darged. Yn ail, cynhaliwyd astudiaethau achos o Ganolfannau unigol i ganfod yn fanwl sut maen nhw'n gweithio, sut maen

nhw'n berthnasol i amcanion polisi lleol ehangach a sut mae amcanion y rhaglen yn gweithio mewn perthynas â gwahanol gyd-destunau polisi a diwylliant lleol.

- Mae'r adroddiad hwn yn canolbwyntio ar ail-ymweliadau â'r holl astudiaethau achos yng Nghymru. Mae hefyd yn defnyddio seminar polisi a gynhaliwyd gyda chynrychiolwyr o Lywodraeth Cynulliad Cymru a sefydliadau iechyd cyhoeddus cenedlaethol perthnasol eraill. Adroddir ar yr HMS ledled y DU ar ddiwedd y cyfnod gwerthuso yn ystod gwanwyn 2007.

Dulliau o wella iechyd a mynd i'r afael ag anghydraddoldebau iechyd

- Mae Canolfannau Byw'n Iach yn defnyddio dull holistig o wella iechyd a'r gwahaniaeth allweddol yw a ydyn nhw'n canolbwyntio ar unigolion a ffyrdd o fyw neu ar amodau byw cymdeithasol ac economaidd pobl. Roedd lles y gymuned hefyd yn hanfodol i'r weledigaeth iechyd yn y Canolfannau gyda phwyslais mawr ar ddatblygu'r gymuned.
- Mae cydgysylltwyr y Canolfannau'n ei chael hi'n anos cyfleu sut mae eu prosiectau'n cyfrannu at y gwaith o fynd i'r afael ag anghydraddoldebau iechyd er bod eu partneriaid mewn awdurdodau lleol neu Fyrddau Iechyd Lleol yn gallu gweld yn haws sut mae'r prosiectau hyn yn cyfrannu at y gwaith o gyflawni'r amcanion hyn.
- Mae'r gwahanol fodelau o Ganolfannau hefyd yn dylanwadu ar y gweithgareddau. Mae rhai yn ganolfannau penodedig neu'n rhithwir, eraill yn gwbl newydd neu wedi'u seilio ar fenter flaenorol ac eraill yn canolbwyntio ar ddatblygu dulliau newydd o wella iechyd neu'n fecanwaith ar gyfer dod â mentrau a gwasanaethau cyfredol at y boblogaeth darged, ond maent i gyd yn ffactorau sydd wedi helpu i lunio hunaniaeth a datblygiad y gweithgareddau.
- Mae'r canolfannau wedi datblygu amrywiaeth o weithgareddau ar gyfer gwella ffyrdd o fyw, darparu gwell cyswllt â gwasanaethau, gweithgareddau i rieni a phlant a gweithgareddau sy'n mynd i'r afael ag allgáu cymdeithasol, tlodi a diweithdra. Rhoddwyd mwy o sylw i weithgareddau'n ymwneud â bwyd, gweithgaredd corfforol ac iechyd plant nag a ddisgwyliid yn y lle cyntaf, a chafwyd rhai datblygiadau llwyddiannus yn ymwneud â rhoi'r gorau i ysmegu. Mae llawer o'r gweithgareddau yn enwedig o ran bwyd a

gweithgarwch corfforol wedi bod yn seiliedig ar fentrau cenedlaethol yn hytrach na gweithgareddau newydd a ddatblygwyd o'r cychwyn cyntaf.

- Mae cydgysylltwyr a rheolwyr y Canolfannau yn adrodd bod gwasanaethau ac asiantaethau yn dechrau dod atyn nhw i ddatblygu syniadau, sy'n awgrymu y gallan nhw fod yn gyfrwng atyniadol ac yn angor ar gyfer sefydlu'r gwasanaethau.
- Mae yna broblemau o ran cysylltu â gwasanaethau gofal sylfaenol mewn llawer o Ganolfannau, ac eithrio sefyllfaoedd lle mae'r cysylltiadau wedi bod yn eglur o'r cychwyn cyntaf.
- Mae rheolwyr a chydgyssylltwyr y Canolfannau'n ei chael hi'n anodd dangos eu llwyddiannau o ran y niferoedd sy'n cymryd rhan yn eu gweithgareddau. Mae dangos llwyddiant ar sail nifer y bobl sydd wedi cymryd rhan mewn gweithgaredd yn gallu bod yn gamarweiniol. Er enghraifft, mae llawer o bobl yn gallu cymryd rhan mewn gŵyl gymunedol a gefnogir gan Ganolfan ond hwyrach mai nifer fach o bobl all gymryd rhan mewn prosiect amgylcheddol er y gallai manteision y prosiect hwnnw fod yn fwy niferus a chynaliadwy yn y gymuned. Mae'n amlwg, serch hynny, fod rhai Canolfannau wedi llwyddo i gynnwys llawer iawn o bobl yn eu gweithgareddau.
- Mae Canolfannau hefyd yn cael trafferth i ddarparu tystiolaeth o'r effaith ar iechyd. Mae'r rhesymau dros hyn yn cynnwys diffyg cyllid, amser neu sgiliau i gynnal neu gomisiynu gwerthusiadau o'r prosiectau, mae anghytundeb ynghylch y meini prawf ar gyfer llwyddo mewn mentrau o'r fath ac mae'r amserlenni ar gyfer gwella yn gallu ymestyn ymhell y tu hwnt i'r cyfnod ariannu. Mae hyn hefyd yn pwysleisio'r angen am werthuso rhaglenni o'r fath cyn gynted ag y bo modd.
- Ar y cyfan, mae Canolfannau wedi llwyddo i ddenu mwy o fenywod na dynion. Mae rhai Canolfannau wedi dechrau chwilio am ffyrdd newydd o gynnwys dynion mewn gweithgareddau a allai fod o les i'w hiechyd.

Datblygu gallu ar gyfer ymgysylltu â'r gymuned

- I'r Canolfannau sy'n canolbwyntio ar ddatblygu'r gymuned, mae'r ffyrdd y mae'r Ganolfan a'i phartneriaid yn cydweithio â'r gymuned weithiau cyn bwysiced â'r gweithgareddau y maent yn eu datblygu.

- Maen nhw wedi gweithio mewn amrywiol ffyrdd gyda phartneriaid a mentrau eraill yn yr ardal i ymgysylltu â chymunedau a datblygu cyfres o weithgareddau sy'n berthnasol i'w hanghenion. Serch hynny, mae'n ymddangos bod y ffordd yr ymgysylltodd y cymunedau a'r partneriaid yn y broses ymgeisio wedi ymestyn i gyfnod datblygu'r Ganolfan ei hun. Os oedd problemau neu ansicrwydd ynghylch swyddogaethau a pherchnogaeth o'r cychwyn, ymddengys eu bod yn parhau unwaith y mae'r Ganolfan ar waith.
- O ran prosiectau a arweinir gan asiantaethau statudol, mae Canolfannau wedi darparu cyfle i dreialu ffyrdd newydd o ymgysylltu â chymunedau ac o ddatblygu dulliau o wella iechyd a lles.
- Roedd prosiectau oedd yn canolbwyntio ar leoedd arbennig yn tueddu i ddefnyddio dulliau datblygu cymunedol o ymgysylltu â phobl leol tra bo'r rhai a oedd yn hybu dull arbennig neu'n cynrychioli grŵp arbennig o'r boblogaeth yn tueddu i fod yn sefydliadau gwirfoddol ac yn dibynnu ar brofiad eu sefydliad o weithio gyda grwpiau penodol o bobl.
- Roedd rhai Canolfannau'n cefnogi pobl leol i gymryd rhan arweiniol yn y gweithgareddau i wella iechyd. Roedd datblygiad y dulliau hyn yn araf ond rhagwelir enghreifftiau o arfer da yng nghyfnodau olaf y gwerthusiad.

Datblygu Cysylltiadau â'r Polisi Iechyd / Economi Iechyd Ehangach

- Mae'r graddau y mae'r prosiectau a'r gweithgareddau newydd neu'r ffyrdd o weithio a ddatblygwyd yn cael eu deall neu eu gweithredu y tu hwnt i oes y cyfnod cyllido yn ganolog i lwyddiant rhaglen y Canolfannau Byw'n Iach.
- O ran polisi cenedlaethol, efallai fod y rhaglen Canolfannau Byw'n Iach wedi bod o dan anfantais yng Nghymru gan eu bod ar waith cyn bodolaeth Llywodraeth Cynulliad Cymru. Gall hyn fod wedi effeithio ar y graddau y gallai'r gwerthusiad fod wedi darparu cyfleoedd dysgu'n effeithiol i lunwyr polisi cenedlaethol a lleol.
- Awgrymodd cynrychiolwyr Llywodraeth Cynulliad Cymru a sefydliadau iechyd cyhoeddus cenedlaethol ei bod yn dra phosibl y gallai Canolfannau gyfrannu at ddyheadau cyffredinol Llywodraeth Cynulliad Cymru yn eu hymdrech i ddatblygu ffyrdd newydd o fynd i'r afael â'r hyn sy'n dylanwadu ar iechyd ar lefel leol, ond yn gyffredinol nid oedd cytundeb ar sut y dylid ac y gellid mesur effeithiolrwydd y Canolfannau. Teimlwyd hefyd fod

Canolfannau'n ceisio gwneud rhywbeth gwahanol na ellir ei fesur na'i ystyried yn yr un ffordd ochr yn ochr â mathau eraill o ymyriadau. Wrth gymharu gwahanol fathau o ymyriadau, mae felly'n angenrheidiol datblygu dulliau gwerthuso priodol yng nghyd-destun dadleuon am fathau derbyniol o dystiolaeth.

- Mae angen i Gymru barhau i chwilio am ffyrdd effeithiol o atal salwch, o hybu iechyd a mynd i'r afael ag anghydraddoldebau parhaus. Mae hyn yn gofyn am ymrwymiad ar draws sectorau ac arweinyddiaeth i hybu'r dull ar y lefel uchaf. Mae'r rhaglen Canolfannau Byw'n Iach yn rhoi cyfleoedd i isadrannau ddysgu pa dir sy'n gyffredin rhwng adfywio iechyd ac adfywio cymunedau.
- Mae tensiwn yn bodoli rhwng arloesed a chynaliadwyedd. Roedd y rhaglen Canolfannau Byw'n Iach yn syniad newydd sydd, yn ôl pob tebyg, wedi mynd ar goll ymhlith y datblygiadau polisi newydd eraill. Hwyrach y gwelir y tensiwn hwn ar lefel leol gydag un astudiaeth achos eisoes yn cael anhawster i ganfod cyllid pellach.
- Ar lefel leol, mae partneriaethau'n gyswllt pwysig i'r economi iechyd ehangach ac fe'u hystyrir yn hanfodol i gynaliadwyedd gweithgareddau a dulliau a ddatblygwyd gan y Canolfannau. Roedd y partneriaethau'n cael eu deall mewn amrywiol ffyrdd gan y Canolfannau ac roedd gwahaniaeth amlwg rhwng y rhai oedd yn darparu cysylltiadau gweithredol fel dull o ddarparu gwasanaethau a/neu weithgareddau, a'r rhai oedd yn strategol, ac yn darparu cysylltiadau â pholisi lleol ehangach. Mae'r ddau fath o gysylltiadau wedi darparu amrywiaeth o fanteision.
- Mae cysylltiadau strategol yn bwysig fel ffordd o sicrhau bod gan awdurdodau lleol a byrddau iechyd fuddiant uniongyrchol yng nghyfeiriad cyffredinol a dyfodol y Ganolfan. Nid yw bodolaeth cysylltiadau strategol cryf yn gwarantu ymrwymadau o ran cyllid gan gomisiynwyr yn y sector statudol, hyd yn oed pan fydd tystiolaeth gref o effeithiolrwydd a bod y dull, yn ôl pob tebyg, yn bodloni amcanion strategol lleol.
- Cafodd cydgysylltwyr a rheolwyr Canolfannau anhawster i gynnal cydbwysedd rhwng datblygu eu prosiect lleol a sicrhau perthnasedd amcanion ehangach yr awdurdod lleol a'r BILl. Roedd dwylo'r mwyafrif o Ganolfannau'n llawn gyda'r gwaith o ddatblygu'r prosiect a phrin iawn oedd yr amser ar gyfer sicrhau eu perthnasedd strategol ehangach.

- Amlygodd gweithdy a gynhaliwyd gyda rhai Canolfannau cyn dewis astudiaethau achos hefyd ddiffyg gwybodaeth ymhlith rhai rheolwyr a chydgyssylltwyr am yr amgylchedd polisi cyfredol. Hwyrach y byddai hyfforddiant a chefnogaeth ar bolisi a strwythurau iechyd ac adfywio cyfredol yng nghyfnodau cychwynnol bywyd Canolfan yn ddefnyddiol.
- Er y bydd gwell canfyddiad o ddylanwad a chynaliadwyedd y prosiectau unigol yn fwy amlwg erbyn diwedd y gwerthusiad, mae gwersi o un Ganolfan yn awgrymu nifer o faterion allweddol y gall rhai prosiectau eu hwynebu wrth iddynt ddechrau ystyried cynaliadwyedd eu prosiectau. Mae'r rhain yn cynnwys: y ffaith fod y dasg o chwilio am gyllid yn cymryd llawer o amser ac mae hyn yn effeithio ar yr amser sydd ar gael i ddatblygu'r prosiect; ei bod hi'n gallu bod yn anodd canfod cyllid parhaus; bod prosiectau'n gallu colli staff tuag at ddiwedd y cyfnod cyllido; a'u bod yn gorfod paratoi'r bobl leol neu'r grŵp targed i ddisgwyl colli'r prosiect y gallan nhw fod wedi ei fwynhau.
- Ni fydd pob Canolfan yn parhau fel y mae ar hyn o bryd ond bydd llawer wedi gadael ei hôl o ran dulliau o weithio i wella iechyd a lles a fydd yn parhau y tu hwnt i gyfnod cyllido'r rhaglen.