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Final Report on the sustainability and legacy of Healthy Living Centres in Wales.

A report to the Department for Public Health and Health Professions

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Cardiff Institute of Society, Health & Ethics (CISHE)

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Mae CISHE yn gwneud ymchwil rhyngddisgyblaethol sy'n arloesol o ran ei methodoleg. Mae hefyd yn cydlynu'r ymchwil honno, gyda chyfraniad cryf o'r gwyddorau cymdeithasol ac ym meysydd perthynol biofeddygaeth, gwasanaethau iechyd, iechyd cyhoeddus a biofoeseg. Rydym yn gwneud ymchwil o'r radd flaenaf yn rhyngwladol ac yn ei hyrwyddo, gan roi pwyslais ar fynd i'r afael ag anghydraddoldebau iechyd a sicrhau bod ein hymchwil yn cael effaith ar bolisi ac ymarfer yng Nghymru a thu hwnt.

Abstract

Funded by the New Opportunities Fund (now known as the Big Lottery Fund or BIG) the Healthy Living Centre (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. Some 351 HLCs were funded throughout the UK, 29 of which were in Wales. Informed by a political approach to public policy which emphasised community action and cross sector networks or partnerships as mechanisms to bring about change, the programme represented an approach to health inequalities that rejected reliance on either state intervention or market mechanisms.

Following on from a UK evaluation of the programme this study focuses on the sustainability and possible legacy of the HLC programme in Wales. Informed by theories of sustainability this report draws on interviews with HLC managers or co-ordinators, local evaluation documents and a policy seminar to assess the extent to which the programme has been sustained in Wales. It looks beyond whether individual projects have continued to whether there have been changes in ways of working across sectors or engaging with the public to address perceived health priorities. Factors that promote or hinder sustainability are grouped in terms of how the HLC projects were designed, how they were implemented and managed and how they were positioned within the wider health economy. The experience, role and purposes of evaluation were also explored in relation to both attempts to make a case for sustainability and as a mechanism for capturing learning from the programme.

The paper concludes with recommendations for policy makers, commissioners of similar programmes and practioners working in community level health projects.

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Chapter One: Introduction to the Report

1.1   Background

The Healthy Living Centre Programme was launched by the New Opportunities Fund (now know as the Big Lottery Fund or BIG) in 1998 as part of the new Labour government's strategy to improve health in its broadest sense and address health inequalities. Underlying the vision for how these centres would operate was a perception that 'communities' themselves would drive improvements supported by broad partnerships between health and other public, voluntary and private organisations. The planning and launch of the HLC programme was prior to the establishment of the devolved governments of Wales, Scotland and Northern Ireland but covered the UK as a whole. As health is a devolved policy area there are specific issues about the extent to which the integrity or veracity of the project could be sustained in Wales which was developing its own health vision, strategies, structures and policies.

In 2001 the Bridge Consortium, made up of six academic organisations in England, Scotland, Wales and Northern Ireland, was commissioned by the New Opportunities Fund to undertake an evaluation of the programme (henceforth referred to as the UK programme evaluation). The Welsh Assembly Government provided additional funds to ensure that data collection was adequate to provide reports relevant to the Welsh policy context.   Recognising the diversity of projects and their focus on responsiveness to local needs and innovation the evaluation was informed by theories of change and realistic evaluation.[1] [2] This ensured that processes and changes in outcomes were grounded in an understanding of the assumptions, or theories of change, built into both the programme and projects on the ground, and the contexts in which they operated. The evaluation consisted of a number of elements including:

- Detailed case studies through time of HLCs using a sample which represented different types or models
- A health monitoring system (HMS), which captured longitudinal data on over 2000 users of HLCs,
- A survey of all HLC managers undertaken in 2006
- A review of external evaluations commissioned by local centres
- Workshops with representatives from local centres
- Analysis of the changing policy environment within which the programme has taken place.

The evaluators also made use of other sources of data including annual monitoring reports provided by centres and from parallel national evaluations. A final report was submitted to the Big Lottery Fund in January 2007.

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[1] Pawson, R (2003) 'Nothing as practical as a theory'. *Evaluation*, 9, 471-490.
[2] Pawson, R and Tilley, N (1997) *Realistic Evaluation.* London: Sage

There were two key emerging issues in the Final Report, as well as in an interim report on the HLC programme in Wales[3], which had not been adequately dealt with. Firstly, it was unclear to what extent the programme, and particular projects, activities or ways of working were likely to be sustained beyond the funded period. In early communications from the Department of Health there was a clear assumption that the programme was part of a long term approach to health improvement and addressing health inequalities[4]. Early hopes that the projects and the activities they initiated would be 'mainstreamed' looked unlikely to be realised, though there were indications that HLCs were in a good position to apply for external funding for certain aspects of their work. The second, related to the first, concerns the legacy of the projects. This goes beyond the sustainability of the programme to identify what has been left of the benefits, resources and assets that the HLCs created. There is obviously a link between sustainability and legacy, particularly if sustainability is defined in terms of the continuation of these goods. However, it is important to highlight some of the achievements of the HLCs even if they have not been continued in the way in which originally intended. Legacies are, of course, also potentially negative and it is important to learn from the potential negative effects of such programmes as well as the positive.

Underlying the issues of sustainability and legacy are a range of questions including: the extent to which HLCs were able to demonstrate their ability to address key local priorities; the extent to which Local Health Boards (LHB) and Local Authorities (LA) took up opportunities to learn from the experience and achievements of HLCs; and the extent to which the loss of funding may itself have an impact on both local communities themselves and on the local health economy.

This study focuses on the sustainability and possible legacy of the programme in Wales. Definitions and plans for sustainability were built into the UK evaluation but at the time the Final Report was submitted the situation of most HLCs was unclear. This study, being conducted solely in Wales, is important for four key reasons

- Most HLC projects in Wales were expected to come to the end of their funding by the end of 2007. This provided an opportunity to explore what the HLCs felt they had achieved and likely to sustain.

- Current case study data in Wales had only been collected for seven HLCs. Although two projects could not take part in this study, information on 27 of the 29 HLCs provides a more comprehensive picture of the experience of the programme in Wales.

- The data collected have important messages for policy makers and commissioners of community-based interventions such as HLCs. The study included a policy workshop to maximise the opportunities for learning and future development.

- The study provides an opportunity to review what is meant by sustainability in the context of community based health programmes. The study has revealed a number of ways in which sustainability has been understood and operationalised with varying degrees of success in terms of the original intentions of the applicants. Within this, respondents identified a number of facilitators and barriers in terms of how HLCs, their activities and/or ways of working could be sustained in the long term. This

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[3] All UK evaluation reports are currently available on the BIG website
See http://www.biglotteryfund.org.uk/index/evaluationandresearch-uk.htm
The interim report on HLCs in Wales, *Recapturing the Bevanite Dream,* is currently available on
http://www.cardiff.ac.uk/socsi/cishe/pages/Publications/WorkingPapers.html
[4] Department of Health (1997) Circular 97*: Letter to Chief Executives.*

report should provide a basis on which possible sustainability indicators could be developed to guide the planning of future programmes, to assess sustainability strategies in programme applications and to support ongoing sustainability strategies in the implementation of programmes.

In this report we assess the extent to which the programme has been sustained in Wales in relation what HLCs were expected to achieve (at programme and project levels) and in relation to definitions of sustainability.

1.2   The sustainability of a theory

The HLC Programme was one of the largest of its kind and was an experiment which naturally followed from Acheson's *Independent inquiry into inequalities in health*[5] which utilised a socio-ecological model of health to stress the need to address the broader social and economic determinants of ill health and their distribution in society. The HLC Programme was based on an old idea stemming from the Pioneer Centre in Peckham in the 1930's[6] and more recently the American Seniors Programme[7]. What is now known as the Peckham experiment was based on a holistic notion of health, combining nutrition, leisure and education as a mechanism to create the circumstances for good health. Although it closed in 1950, perhaps sitting uneasily in an NHS system focusing on medical services, it served as a model and inspiration for healthy living initiatives across the globe. The American Seniors Programme was one of these, aimed at older people, particularly with chronic illnesses or disabilities, providing access to health promotion activities, adult education and counselling.

As well as embodying a social and holistic model of health, both these programmes stressed the importance of local or user ownership or governance as well as responsiveness to local need.[8] This democratic ideal resonated with 'Third-Way' thinking influenced by the sociologist Anthony Giddens [9] which rejected simple market or state based solutions in favour of a dialogic democracy in which citizens are empowered to participate in seeking solutions to the problems that they face in a globalised neo-liberal economy. So the HLC Programme was an intervention that epitomised a political approach to public policy emphasising ideals of 'localism' and community action and 'empowerment' as mechanisms to bring about change. In assessing the sustainability of the programme it is important that the theories and ideas underpinning the programme are evaluated. The study provides an opportunity to assess how resilient these ideas have been, and are likely to be, in the face of political, economic and policy changes that the programme has travelled through.

1.3   Aims and objectives of the study

The overarching aim of this study is to evaluate the final phase of the HLC Programme in Wales in terms of the experience of sustainability and its likely legacy, including key achievements. The main purpose is to draw out the learning which could inform future policy and practice.

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[5] Acheson D (1998) *Independent inquiry into inequalities in health*. London: Stationery office
[6] Ashton J (1977) 'The Peckham Pioneer Health Centre: a reappraisal' *Community Health*, 8, 132-137,
[7] Krout, Cutler and Coward (1990) 'Correlates of Senior Centre participation: a national analysis' *The Gerontologist,* 30, 72-9
[8] Iliffe S (1999) 'Pioneering or engineering' *Health Matters*, 8, 14-15
[9] Giddens, Anthony (1998) *The Third Way. The Renewal of Social Democracy*. Cambridge:Polity Press

The specific objectives are follows:

- To identify the perceived achievements of the HLC projects in terms of their own aims and objectives

- To examine HLC experiences of trying to sustain the projects, their activities and/or new ways of working

- To identify the factors that shape the challenges and opportunities for sustainability

- To identify the key learning points for future policy and practice with a focus on addressing health inequalities, tackling social exclusion and informing community based health developments

- To refine the findings and recommendations through a policy workshop with key policy makers and practitioners at national and local levels

1.4   Methods

The focus of this study is the experience of sustainability and the legacy of the programme. It does not present information on impact or effectiveness as these are reported in detail elsewhere in the UK evaluation Final Report.[10] However, issues about what is considered to count as success and how this is resourced and communicated were areas for investigation as part of the efforts made to sustain individual projects.   The UK programme evaluation set up a Health Monitoring System as a means of collecting quantitative data on the impact of the programme on health and health behaviours as well as on the reach of the scheme. In this study the focus was on the experience, actions and perceptions of key people with a role in sustaining individual HLC projects. For this we gathered qualitative data to illuminate the perceptions, values and meanings of events as they appeared to key actors in running HLCs.

1.4.1 Interviews

Interviews with HLC managers or co-ordinators, conducted between March and June 2007, provided insight into experiences and perceptions of those who were most likely to be seen as responsible for driving the projects.   They therefore gave privileged 'insider' access into the inner dynamics of the projects. Interview schedules drew on those used for the UK programme evaluation. However, the main emphasis was on projects identifying their own perceptions of their achievements, drawing on available supporting evidence, and their experience of developing and implementing sustainability plans.

Interviews with HLC managers or co-ordinators were conducted either face-to- face, or by phone and due to restricted resources, most were not fully transcribed but used as a back up to detailed notes. A sample were fully transcribed to check the reliability of the notes and to check they allowed key themes to emerge. In some cases the co-ordinator was joined by another HLC staff member or, in one case, a local evaluator. This was particularly the case if a manager had not been involved with a project from the outset or if they felt that another member of staff could provide a better picture of the HLC as it operated, and was received, on the ground.

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[10] Hills et al (2007) *The Evaluation of the Big Lottery Fund Healthy Living Programme: Final Report.* Big Lottery Fund: London http://www.biglotteryfund.org.uk/er_eval_hlc_final_report.pdf

No HLCs refused to be interviewed but there were difficulties in accessing two of them. In both cases there was no longer a co-ordinator in post. In one case it was not possible to contact anyone responsible for the HLC at all and in the other, where the co-ordinator had left, it was felt that no-one could provide the insights required. Indeed, one problem faced by HLCs was the loss of key staff towards the end of project funding. Overall, twenty-five interviews took place and there was sufficient data on the two remaining HLCs where programme funding had finished such that there was no need to approach them again.

The interviews were semi-structured to ensure that specific topic areas were covered but allowing flexibility for respondents to provide as open a response as they felt necessary. The topic guide consisted of a number of subject headings under which there were a number of prompts which, though not exhaustive, ensured that the topic area was sufficiently covered from the perspective of the interviewer. Emergent themes were initially constructed independently by the two interviewers to ensure reliability. Theoretical elaboration of these themes was subsequently developed by the principal investigator.   The topic guide included questions on:

- **Understanding of health and health inequalities.**
  How these concepts were understood and operationalised through the HLC. Also, how evidence of success or effectiveness was understood, and whether they had been successful in achieving their aims and objectives.

- **Attitudes and use of evaluation**
  Whether and why they had, or had not, conducted an evaluation. The purposes of the evaluation, target audience and how it was received. Issues in providing and communicating evidence of success and other mechanisms to highlight the work of the HLC.

- **Current financial position of the HLC**
  Extent to which future funding had been secured and the main difficulties in securing this.

- **Aspects of the HLC likely to be continued**
  The likelihood that something that is called a HLC will be continued and if so the   form it would take. Post funding plans for core and other staff, buildings, activities, the use of volunteers and so on. The extent to which post funding sustainability ties up with original intentions and the extent to which this was built into the implementation and development of the HLC. Key barriers and facilitators to sustaining the HLC, activities, or ways of working as originally intended. Extent to which the HLC programme could have addressed or supported sustainability from the outset.

- **Links with wider services/ policy environment**
  Extent to which HLCs engaged with local policy development and the difference this may have made for HLC development and sustainability plans. The nature of their links to the LHB, LA, NHS Trusts and the voluntary sector and the role of this relationship in sustainability. The role of the community or HLC 'users' in sustainability plans.

- **Change/Legacy**
  The perceived legacy the HLC has/ will leave in terms of:

  - *changes for individual* (e.g. development of health related skills; ability for people to support each other, reduced social isolation; better use of health services; removal of obstacles to health and well being; development of

employment related skills; support to increase income; help to secure paid employment)

- o *changes in the local community* (e.g. links between groups in the community which were previously isolated/in conflict; community more active in terms of lobbying for local improvements; new physical and social resources established in the community (such as new places for people to meet, new activities, community café, crèche); more employment opportunities locally; the neighbourhood perceived to be safer or more attractive)

- o *changes in the capacity of other organisations to address health related issues* (e.g. by providing a physical location for their activities, changing the way in which specific organisations work, new access to administrative support, access to training, new mechanisms for consulting with the community)

- o *Partnership working* (e.g. new ways in which organisations work together on an on-going basis or through the development of new projects or activities)

- o *Quality and accessibility of* services (e.g. development of existing services or new services and improved access)

- o *Negative legacy* (e.g. extent to which there may be negative impacts for the community, partnerships or existing services due to loss of core funding)

Only seven Welsh HLCs were case studies in the UK programme evaluation. This meant that the interviewers were approaching new HLCs and had little prior knowledge of these projects, what model they represented, their geographical coverage, staffing, financing, partnership arrangements or evaluation plans. Although some information could be gathered from a central database (established by the Tavistock Institute, who led the UK programme evaluation, and funded by the Department of Health) and from original applications, some of this was out-of date or inaccurate. For HLCs that were new to the evaluators a checklist was sent to confirm some of these details.

1.4.2 Review of key documents

Key documents produced by the HLCs were reviewed to confirm original aims, objectives and expectations and to generate supporting evidence. Where possible the study has drawn on local strategic documents to establish the extent to which the work of the HLCs has been acknowledged in future plans. However, the analysis phase of the study coincided with the consultation phase of the Health, Social Care and Well-being Strategies and as these are presented in various forms at different level of detail and development, it is not certain at this stage how HLCs or their activities will be reflected in future strategy. Where possible, evaluations commissioned by HLCs were also accessed and used to assess approaches to evaluation.

1.4.3 Policy workshop

HLCs do not exist in a vacuum and in the case of the programme it was intended that they be supported by new partnership arrangements and that their sustainability would depend on

statutory agencies redirecting their efforts' to support them[11]. In the UK programme evaluation the first round of visits to case studies included interviews with key partners. However, the partners who were interviewed varied in terms of whether they were strategic or operational and were often not in a position to assess the prospects of HLCs in future local health arrangements. In 2006 key partners identified by each HLC were contacted and asked to respond to a survey but the poor response meant that the results were not included in the final report. This does not mean that they had no interest in the HLCs and may well reflect a reluctance to comment on specific projects. However, the importance of getting a strategic view of HLC is paramount in an assessment of the sustainability of HLCs as an approach to public health delivery in Wales.

In order to get a broader perspective from stakeholders in the local and national health economy a policy workshop was held in September 2007 to present the main findings to invited stakeholders across relevant Assembly Government departments, BIG, the voluntary sector in Wales, the Wales Centre for Health, the National Public Health Service plus selected individuals working at strategic levels locally. Presentations were followed by a facilitated discussion on the main learning points for policy and practice, particularly regarding implications for commissioning, the value of such programmes for addressing inequalities in health and tacking social exclusion, and the role of evaluation of such programmes in better informing future policy and practice. Views from this event are incorporated into the body of this report where relevant. The workshop was facilitated by Dione Hills, who was part of the UK evaluation, and has contributed to papers and reports on evaluating community-level programmes. Her overview of the workshop is appended to this report.

1.5 Timing of study

The timing of the study coincided with the final phase of programme funding. Although only a handful of HLCs had come to the end of programme funding by the time of the interviews, most were contemplating the end of funding by the end of the year. This means that nearly all HLCs were actively engaged with plans as to how to manage the loss of programme funding. In reality, a number were given permission to use under-spends or had found small bits of additional or core funding to continue for a short time. Experience from the UK programme evaluation, reinforced by this study, indicates that plans for sustainability are not always clear until very late on or even after programme evaluation has finished. This is because awards for external grants may not be announced until after programme funding has finished. Similarly, decisions from statutory bodies to provide funding will fit with their own commissioning cycles and do not necessarily fit with the needs of HLCs.

For instance, one HLC whose programme funding finished at the end of October 2005 only heard that they had been awarded a major grant to continue a significant stream of work two months later. The manager of another HLC whose funding came to an end in March 2006 was pessimistic about the prospect for sustainability when interviewed in September 2005. However, when re-contacted in the manager's new post in August 2006 it was reported that although the HLC as an entity no longer existed, most elements of work had been sustained in a variety of ways, including: an external grant for one major element of the work; LA commitment to fund a major activity that the HLC had piloted; volunteers to run certain activities including a food co-op and an environmental group; and the formation of a community based group, largely composed of residents, set up to raise small amounts of

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[11] Speech made by Athony Hird (Chief Executive and Project Director of *The Sunlight Centre*) at a seminar hosted by the Dept of Health on 2nd April 1998.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010504

money to improve health and well being in the area. An important theme arising from this evaluation is that sustainability is not a concern which is phased after implementation but can be identified as a latent or explicit concern from the initial application, through to implementation and beyond.

Table l: Overview of HLCs at time of the study

End of BLF funding	Numbers of HLC no longer in receipt of BLF funding (n=29)
By end of data collection (end May 2007)	9
By September 2007	13
By end of year	26

Note-numbers are cumulative with time.

However, the timing of the evaluation had provided some insight into the likely prospects of sustainability towards the end of programme funding. For instance, both HLCs highlighted above could be seen as relatively successful in sustaining their activities and, in the latter, new ways of working. The fact that the capacity to continue existed even when programme funding had finished and core staff had left was largely due to the organisational home in which they were based and strong partnership arrangements.   The ability of systems, whether they are single organisations or partnerships, is a theme which is discussed throughout this report.

1.6   Overview of report

Chapter Two will discuss definitions of sustainability and how these may be applied to the HLC Programme. It will go on to look at what kind of entities HLCs are since it is not possible to assess sustainability without understanding what it is that the programme designers thought these projects were and how they would change the local health economies and structures in which they were placed. The chapter ends by looking at what HLC respondents felt was likely to be left of the projects once programme funding had come to an end. The report then examines factors that have had a role to play in sustaining individual projects.

In Chapter Three the extent to which projects may have been designed with sustainability in mind is explored. The HLCs varied in terms of structure and orientations to health. This chapter looks at the way in which they embodied latent features which were conducive to sustainability. In particular, there is an assessment of how HLCs operating as physical centres differed in terms of their long-term prospects to those operating as virtual projects or networks.

Chapter Four identifies the active measures taken to sustain the projects. In particular we look at the role of evaluation, how it was resourced, who it was aimed at, how it was done, the extent to which it was used to demonstrate the effects of the HLCs and how it was received. Evidence from this study suggests that sustainability, and evaluation as part of sustainability planning, was not a priority in the early stages and so other factors in the way in which HLCs were set up or in the wider health system may well have played a more important role in their long term prospects.

Chapter Five looks at how HLCs were positioned in different health systems or economies and the extent to which they engaged with policy makers and strategic processes. In particular, in the Welsh context, we look at the way in which HLCs related to Communities First partnerships and the extent to which they engaged with and were visible in Health, Social Care and Well-being processes and action plans.

Chapter Six focuses on the potential legacy of the programme in Wales. The final report of the UK programme evaluation suggested that although the future of HLCs themselves were uncertain they had undoubtedly left a legacy in terms of health benefits for individuals, a proliferation of new health related activities, improvements and new physical and material resources in local communities and some changes in the way in which services are delivered. The chapter ends with a discussion of the possible negative legacy of the loss of programme funding.

Finally the report concludes by drawing the key lessons together to influence the design and set up of future community based public health programmes. Lessons are addressed to different audiences with specific recommendations targeted at policy makers, commissioners of future programmes and managers and co-ordinators of future projects.

Throughout the report material from the projects is presented in boxes to illustrate issues raised in the evaluation. These combine verbatim quotes and researchers' summaries

Chapter Two: Programme sustainability and it's relevance to healthy living centres

Key Points

- By the time the programme funding has come to an end most HLCs as entities are likely to close and their core workers moved on to other jobs or careers.
- Some elements of projects are likely to continue and those that have been based in new or existing buildings have provided an important new local resource and have been a catalyst for developing new activities.
- HLCs were set up to create new ways of responding to health inequality issues through the mobilisation of communities and through networks and partnerships. Sustainability is therefore more than whether HLCs still exist in name or if some activities continue. It concerns the sustainability of a particular way of working

2.1 Introduction

In order to assess the extent to which the HLC programme has been sustained it is necessary to establish what is meant by sustainability. An extensive literature review of the sustainability of community based public health programmes found that sustainability could be defined in 3 ways[12]. First, there are those definitions which focus on the sustainability of the health *benefits* in which case there is a need to assess the resources that are required to ensure long-term change. Second, sustainability may focus on the institutionalisation or mainstreaming of a programme in which case the assessment needs to look at the extent to which these practices are taken up and built into the routines of existing institutions. Third, sustainability is defined at the level of community change and capacity, in which case there is a need to assess the level and scope of public participation. It is also suggested that sustainability, deriving its meaning from the same root as the term sustenance, implies something that continues through time but is not necessarily contained within the same institutional structure. In order to survive, programmes need to be able to respond, adapt and change to new situations and structures to stay true to their aims (programme fidelity). Particularly with the second and third types of definitions, sustainability depends on the flexibility and willingness of political, institutional and social systems to take on, or to own, programmes (or parts of programmes).

In practice, it is difficult to know how one type of sustainability can be distinguished from another. What is clear, however, is that sustainability needs to be considered in terms of whole systems and not just, in the case of HLCs, in terms of whether an independent entity continues to exist or not. One definition of a sustained programme refers to 'a set of durable

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[12] Shediac-Rizkallah MC and Bone LR (1998) 'Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy', *Health Education Research,* 13, pp87-108

activities and resources aimed at program *(sic)*-related objectives. [13] This suggests that whether or not activities, buildings, or people remain, in order to be seen as sustained, programmes must be true to their original aims whether or not the funding which provided the original impetus for the programme exists. In terms of this programme, objectives need to be sustained through entities known as HLCs or through communities, organisations or an entire health system (which may include the public and the organisations that serve them).

At the outset of the programme, initial documents announcing funding clearly indicated that entities known as HLCs would continue to exist after lottery support with, it was hoped, input from the health sector[14] [15] and partnership agencies. Respondents in all seven original case studies in Wales, mirroring case studies in the rest of the UK, believed that their HLC would be a permanent presence in the locality rather than a time limited pilot. In the latter stages of the programme, and in order to help HLCs think about their future, four different models of funding were developed.

> **Options for future funding for Healthy Living Centres**
> - Mainstreaming – HLCs operating from the statutory sector.
> - Independent operating – the development of HLCs as self sustaining enterprises.
> - A hybrid model – with a focus on contracting services to the statutory sector, but retaining the advantages of a voluntary service model. This was seen as requiring a considerable shift in the statutory commissioning of public health and regeneration services.
> - Exit - winding up of their organisation, or some or all of their activities.
>
> Taken from Final Report for the Department of Health [16]

2.2   What is a Healthy Living Centre?

It is clear from early circulars to chief NHS and LA officers, that they expected the 'schemes' to be sustained as part of a new way of delivering health improvement beyond the funding of the programme. However, the notion of what a HLC was, and what it could be in the long term, was undefined. This lack of definition was deliberate since the emphasis was on flexibility and innovation, with a range of different models being expected to evolve, the emphasis being on 'partnerships and networks' rather than 'bricks and mortar'.[17]

Understanding sustainability therefore also begs the question: the sustainability of what? What was it that defined the programme and made the HLCs distinct? Certainly the diversity of the projects was a challenge to the UK programme evaluation team as, as illustrated later, they varied at almost every level: in terms of their orientation to health, their focus, their structure, their geographical scope, their alignment to mainstream services and their approach to community engagement. However, what could be seen as defining HLCs is their focus on innovation. Later evaluation reports considered the idea of HLCs as providing a 'platform for innovation', a concept which derives from industry and the UK Government's

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[13] Pluye, P et al (2004) 'Making public health programs last: conceptualizing sustainability', *Evaluation and Program Planning;* 27, 121-133

[14] Department of Health (1998) Circular MISC (97)83

[15] Department of Health (1999) HSC 2009/008

[16] Tavistock Institute (2005) *Final Report for the Department of Health on the Big Lottery Fund Healthy Living Centre Programme* Tavistock Centre: London

[17] Department of Health (1998) Report of a seminar held on 2 April 1998

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010504

Technology Strategy Board. An innovation platform is described as a mechanism for engaging stakeholders to seek innovative solutions to political or societal challenges[18]. Another definition of HLCs derives from the idea of a 'community anchor' in which the projects are seen as providing a focus and resource for community change. Community anchors are seen, in one Home Office report, as the basis for sustainable change within communities and builds on the UK government's adherence to community development solutions to a variety of contemporary social problems.

> *"Strong sustainable community based organisations can provide a crucial focus and support for community development and change in their neighbourhood or community. We are calling them community anchor organisations' because of the solid foundation they give to a wide variety of self help and capacity building activities in local communities, and because of their roots within their communities."*
> Home Office 2004[19]

In both ideas, HLCs could be seen as catalysts for harnessing and co-ordinating human resources around a common purpose. Visits to individual projects demonstrated that the first two or three years were often focused on establishing this platform or focus, by developing trust and ongoing forms of communication within their localities and with their partners. [20] [21] Later on, HLC respondents, usually co-ordinators or managers, felt that they had become experts in their communities which they illustrated by highlighting how other organisations would approach them for ideas of how to work with, or to access, particular community groups.[22] This begs the question as to what future sources of support or ownership would need to be present to sustain these activities. As we shall see the most difficult aspects of the HLCs to find continuation funding for were the innovative functions which involved continuous efforts to communicate, engage, co-ordinate, facilitate and activate local people and other agencies at operational and local strategic levels. However, as will be highlighted in this report, some HLCs developed ways of working throughout the funded phase, which aimed to ensure that the ways of working made possible through the programme could be sustained once this funding ceased.

In the rest of this chapter we will look at the financial position of HLCs when they were interviewed in 2007 and their view of what was likely to be left of the centres, their staff and their key assets, particularly buildings, once programme funding had come to an end. This is a starting point to assess the degree to which HLCs have been sustained either as independent entities or as ways of working in local 'systems'.

2.3   Sustaining Healthy Living Centres as an entity

For reasons given earlier, it was not entirely clear what the prospects were for HLCs, even in cases when funding was about to finish. Some HLCs had been allowed to use an under spend to allow more time to seek funding. Others were still trying to find support from partners to

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18 See for instance
http://www.berr.gov.uk/dius/innovation/technologystrategyboard/tsb/innovation_platforms/index.html
[19] Home office (2003) *Active Citizens, Strong Communities – progressing civil renewal.*
http://www.communities.gov.uk/publications/communities/activecitizensstrong
[20] Bridge Consortium (2003) *Evaluation of the New Opportunities Fund Healthy Living Centres Programme; Second Annual Report.* New Opportunities Fund: London
[21] Bridge Consortium (2003) *Evaluation of the New Opportunities Fund Healthy Living Centres Programme: Third Annual Report.* New Opportunities Fund: London
[22] Hills et al (2006) *Evaluation of theBig Lottery Fund Healthy Living Centres Programme: Fourth Annual Report.* Big Lottery Fund: London

allow the HLC, or parts of its work, to continue. In two projects, closure was imminent and as no staff were in post, there was no prospect of continuing.

As shown below, most projects at the time of being interviewed were uncertain of their future, were definitely not continuing or had closed, with seven reporting that they would definitely continue or had secured time limited funding for around a year. However, these figures mask a more complex picture.

With regard to those that were uncertain, not continuing or closed, all those that were led by the health sector (National Public Health Service or NHS Trust) came under this category. However, three of these were intended as short term projects, with plans to sustain the ideas or the activities through capacity building and the others have managed to sustain aspects of their work, with differing degrees of reported success, through volunteers, other services or independent funding.   That said, these three had also made efforts to secure funding on a more secure and coherent basis and had been unsuccessful. A LA led HLC had an uncertain future but the respondent claimed that they were still seeing it as a pilot to inform ways of working across the borough.

One project funded by the programme stood out as different from all the others. The Walking the Way to Health initiative, also funded separately in England and in Scotland, was led by the Countryside Council for Wales in partnership with the British Heart Foundation. The project was seen as a time limited pilot and it was always likely that the project might be taken up by another organisation following programme funding. It would be incorrect to say that the HLC was still in existence but the initiative is now being led, albeit in a slightly different form, by the Sports Council for Wales.

The key message here is that even where a HLC has said that they are closing, this does not necessarily mean that the project has failed to be sustained.

Table II: HLCs continuing as an entity

Lead Organisation	No. 27	Will definitely continue as HLC	Have secured time - limited funding	Uncertain	Not Continuing (includes those that have closed)
LA	7	2	2	1	2
Health	6			1	5
Independent	14	2	1	3	8

Of the four HLCs that will definitely continue, all but one will change what they do significantly as a result of reduced funding or new governance structures. The two LA led

HLCs that will continue are based in the same area and have had strong support from senior management from the county borough council and the LHB from the outset. The HLCs have a strong profile in the area and although some sustainability funds have been secured from the LA and LHB, to be considered on a year by year basis, in the long term they will have to seek additional funding. The idea is to roll out 'the model' to other areas identified through the Welsh Index of Multiple Deprivation and perhaps set up new HLCs in existing premises. However, the jobs of core staff will be changed and the emphasis will be on working across the borough. Although this HLC had a commitment to working with local people and developing the capacity of the public to lead and deliver health related action, there were some questions about the extent to which this element had succeeded.   The key message here is that where HLCs are reported to be continuing, there may be important aspects of the ways in which those centres have been set up to work that will not be sustained.

Even where HLCs felt that they had some chance of continuing, it was not always the case that they saw themselves as a HLC. There are two different types of example of this. One centre was perceived to be more of a focus for a variety of regeneration activities than a HLC. In this case programme funding formed a significant but partial component of the funding that they received. The manager felt that although they were likely to continue running the building, it was not seen as a HLC and the end of programme funding, although creating some financial difficulties, would not stop them continuing to work in the area. Another HLC was seeking funding via Communities First as the activities of both had dovetailed closely. The merged entities have become a Development Trust operating as a company limited by guarantee and the respondent reported that it was more likely to be branded as Communities First in the future and not a HLC. A number of other HLCs, particularly those led by charities, saw the programme funding as an opportunity to refocus their core work in a way that was more directly concerned with health outcomes. In these cases their activities were unlikely to be viewed externally as healthy living centre work. Although some of the activities, without funding, were likely to cease, the organisations would still exist and may, indeed, still try and provide a health focused service.

Another indicator of whether a HLC has been sustained as an entity is to reflect on, as above, what kind of entity it is and the core components that need to be sustained in order to continue. Key to what HLCs were set up to be was as a platform and a catalyst for innovation, such as: different ways of working; responding to community needs and aspirations; forging new relationships across communities or between the public and statutory agencies and so on. This work was often facilitated through core posts, whose jobs were not just to deliver activities but to facilitate these processes, networks and partnerships. We looked at the extent to which core posts were likely to be continued. No core posts were likely to continue in the same form, although in two LA led HLCs core posts were set to continue as previously pending confirmation of funding arrangements.

Table III: What will happen to core posts after programme funding?

Lead Organisation	Core post continuing in same/similar Form (n=27)	Core post Continuing in same/similar form for now	Uncertain	Not continuing Staff redeployed	Not continuing Staff likely to be made (or have been made) redundant
LA	**7**	2	1		4
Health	6			1	5
Independent	14		6	4	4

Only five HLCs had redeployed staff within the lead organisation. It could be argued that this had been a wasted opportunity given the expertise that managers hold about what works in community level interventions and the chance to facilitate organisational learning and capacity building. The benefits of intelligent redeployment, where there is a deliberate intention to pull new knowledge and skills back into the organisation, are highlighted in the illustrative example below.

> **Developing organisational capacity through redeployment**
> In one health organisation the manager was redeployed back into the organisation six months before the HLC eventually closed as a separate entity. As the health organisation was also the lead applicant, the manager was able to work with the HLC until the end to ensure that as much of the work that had been developed could be sustained. In addition, the respondent was able in this new role, to apply models of working which were developed in the HLC to other population groups.

Thirteen HLCs were likely, or had already, made core staff redundant and respondents reported particular difficulties in getting funding for core staff posts, which it was felt, are essential for organisation and innovation. However, in one HLC it was reported that some newly created posts could have a co-ordinating role in that they will be responsible for maintaining partnerships and perhaps getting new activities underway. Nonetheless in most cases it was felt that without core funding the essence of the HLC would no longer thrive and even those activities and capacities that had been developed could suffer without a driving force or source of support to sustain them.

> *We can train however many people we like but there has to be a driving force for agencies to put it on the agenda, so without us pushing them [the organisations] to put [the public health issue] on their agenda, they might stop doing it again.*

CS08

One risk, as programme funding comes to an end, is that core staff will leave the initiative early in order to ensure their place in the labour market or to develop their career. Although this had happened, or was about to happen, in a number of cases, some respondents had stayed, or were prepared to stay, with the projects until the end. This indicates the levels of commitment that this kind of work inspires and early interviews in the UK programme evaluation indicated that personal qualities and commitment were often considered to be more important than formal qualifications. However, it also highlights the inherent insecurity built into time-limited community based initiatives and some consideration could be given to how staff careers can be supported in the longer term, particularly where the lead organisation has mature human resource arrangements.

2.4 Buildings and bases

HLCs that were physical centres had a valuable asset, in terms of their building, to maintain or transfer. Indeed, in these cases the HLC's branding or identity were synonymous with the HLC. Its visibility was its strength and its 'Achilles heel' as the loss of a building as a community resource would, it was felt, be a visible symbol of the programme's failure in that area. The advantages and disadvantages of having a physical centre for sustainability are discussed in the next chapter. At the time of interview all physical centres and some hub and spoke models (see chapter 3) had still retained some ownership and control over the building or the building has or will be transferred to an organisation committed to maintaining it for community use – though not always directed towards the original objectives of the HLC.

In other cases the HLC had an administrative base in a GP centre, LHB offices, a school or the administrative offices of the lead organisation. In these cases the HLC did not remain in control and ownership was usually returned to the lead organisation. Where HLCs had invested in improvements, through renovations or new equipment (such as gym, kitchen and IT facilities) and was no longer in control, the building was usually left as a legacy asset for local communities to use or distributed amongst partners agencies (particularly with regard to office equipment).

2.5 Conclusion

By the time the programme funding has come to an end most HLCs as entities are likely to close and their core workers moved on to other jobs or careers. However, as the introductory discussion on sustainability suggests, this does not mean that the elements of the programme have not been sustained. Those HLCs that operated as buildings, particularly those that operated as a physical centre, had significantly changed the use of a pre-existing building or were the catalyst for bringing new activities and services into the community. All of these are considered to be community facilities which are in some sense 'owned' and controlled by community groups. Many HLCs have, or attempted to, sustain much of the work they set up in terms of ensuring that some activities continued and that community groups were self sustaining.

In the next three chapters, three groups of factors will be explored to assess the extent to which they may have played a part in sustaining the programme. In other words we are interested in the extent to which communities and health systems were, or are likely, to continue elements of the programme towards the same objectives, despite the loss of the HLC and programme funding. Pluye et al (2004)[23] reject the ideas of sustainability being a final

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[23] Pluye et al (2004) op. cit

stage of a programme which follows implementation. The stage model of sustainability does not consider how sustainability must be prepared for in advance or the extent to which wider organisational and social structures need to be taken into account.

First, we look at the way in which the HLCs were set up and the extent to which they were 'designed for sustainability'. Second, we assess the way in which key stakeholders worked, or failed to work, to sustain the projects throughout the implementation process, including an exploration of evaluation and how it was regarded, resourced and utilised. Third, we look at factors that impacted on the prospects for the HLC in the outside world and the extent to which HLCs were seen as part of wider political and policy processes.

Chapter Three: Healthy Living Centres in Wales: Designed for Sustainability?

Key points

- How projects were planned from the outset made a different to their prospects for sustainability.
- Particular features of HLCs presented their own risks and benefits in terms of their likelihood of being sustained.
- Physical centres risked losing financial support beyond programme funding and could have a negative effect on the community should that resource be lost. Virtual HLCs risked losing the collective commitment of partners once core funding had finished.
- Other design factors which need to be considered in terms of sustainability are how the area or geographical scope is defined, how the vision of health and orientation to health inequalities is defined and positioned, and how community engagement and community capacity building is understood.
- There is no definitive model but it is suggested that a number of questions need to be asked by applicants and commissioners in assessing whether projects in a programme like HLCs are likely to be sustainable.
- These questions include: Has the model for sustainability been fully discussed and negotiated with relevant communities and partner agencies? Are the roles and expectations of different stakeholders clearly understood and agreed? Is the vision of health clearly understood and accepted by stakeholders? Is there a shared idea of how the programme or project will be sustained, with whose or what resources, in the future? Who will be responsible for sustaining any capital assets and what conditions will be imposed?

3.1   Introduction

In this chapter we will describe the extent to which the way in which projects were set up, their design and orientation, facilitated the opportunities for sustainability. The UK programme evaluation identified a number of ways in which projects varied in terms of whether they were set up as physical centres or virtual networks, their orientation in terms of health and addressing health inequalities, project leadership, geographical scope and focus. This chapter therefore looks both at what we have learnt about the advantages and disadvantages in relation to different models and orientations and the extent to which sustainability was built into the setting up of the projects. What is being assessed are the latent theories of sustainability of the project designers and the extent to which these are now thought to have been successful.

3.2   Models – physical centres v virtual networks

Given the emphasis on diversity and innovation, identifying emerging types of HLC model was challenging. There were three broad categories of HLC that seemed to emerge: those that saw themselves as a physical centre, providing a distinct and visible focus for activity; hub and spoke models which do have a physical base in which some activities may take place but activities are generally scattered in other settings around the area; and network or umbrella organisations where the HLC acts as virtual catalyst to bring together a number of existing or new activities. Other HLCs saw themselves as not fitting into the last category but were more similar to the network or umbrella model as they saw themselves as virtual.

Table IV: HLC Models

Structure	Number (n=27)
A. **Physical centre** – where there is one main physical centre in which most activities take place	6
B. **Hub and spoke** – one main centre with activities also taking place in a number of locations	4
C. **A network or umbrella organisation** – where most activities are delivered in different locations, by a number of partner organisations	8
D. **Other –** please give details	9 • Improvement of existing day care service with activities bought in on a sessional basis. • The HLC has its office space in a school, a physical presence for young people who want to access the HLC. They also run some sessions there. Many activities go on in the estate. • Based in two places and activities happen in a variety of different places e.g. Church hall, local schools and community centres • We run 5 HLCs in rural village halls/community centres around the county. The 6th is managed by another organisation. • We are a service within a service. Everything that the lead organisation does is linked in to everything else that we do. • There are 9 members of the HLC team with different members dealing with different activities. Some activities are delivered by HLC staff and sometimes external specialists are brought in for certain programmes.

3.2.1 Physical centres and 'hub and spoke' models

The difference between these types is not clear cut as nearly all HLCs that described themselves as a physical centre had some activities that were based outside the building. The difference was largely one of perspective and scale depending on how central the building was in terms of the identity and purpose of the scheme.

In Wales all those that were described as a physical centre (model A) were based in a specific estate or locality. Although one of these was, in principle, a resource for anyone in the LA area, it was felt in practice and effect to be a community resource for a particular housing estate. One was atypical in that the HLC was a strand of activity, with people with mental and/or physical disabilities, in a community café in a new community centre which was funded separately[24]. The rest of these were completely new buildings or represented significant renovation to an existing building or buildings. The capital spend on one of these was from separate European funds with NOF funds primarily directed at revenue costs. With regard to two of these buildings there was a condition of NOF funding that the building would remain a facility for community use with financial penalties imposed if there was a failure to comply.

All 'hub and spoke' HLCs (Model B) made use of existing buildings with some funds for minor renovation or refurbishment. Those described as representing a hub and spoke usually had some physical presence as a HLC but saw these as primarily administrative bases with a minority of activities actually taking part in the building. One was described in the application as being a virtual project, rather than a centre, but because they were housed in a large building, provided in kind by a former housing association, were able to provide activities and community resources on site, as well as activities throughout the estate.

The advantage of having a building as the focus for the HLC was felt to be that it was a tangible and visual symbol to the community of a public commitment to their area which, it was reported, helped to forge a sense of community ownership. In one estate there were very few public or community facilities, with the HLC building becoming a prominent feature in terms of the physical landscape and increasing in significance as a social and practical resource as the number and range of activities and services increased. In another HLC, respondents said that the building had been key to the setting up of new community based and community run activities. Without the building these groups would not have been set up and there would be practical difficulties in being able to function in the future should the building no longer be available as a community facility. Another HLC, which had used funds to renovate a derelict building into an architecturally impressive and functional community resource, uses the building both to facilitate activities for the local community as well as accommodating seminars, workshops and meetings for outside bodies including statutory agencies. In terms of implementation this could be seen as facilitating the development of social capital, not just horizontally within the community itself but vertically between the community and the public agencies that represent the key local service and policy decision makers. In terms of sustainability, one definition that was built into some HLC applications related to the transfer of responsibilities and functions for HLC governance and the delivery of activities to community members. Physical centres appeared, at the very least, to generate interest in communities and provided a mechanism to support involvement at a variety of levels.

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[24] The issues raised about A and B type models are not relevant to this HLC, since they had no control over the future of the community centre itself.

Interviews also hinted that a building generates obligations by statutory partners to ensure that the building continues to be resourced. A number of reasons were given. Firstly because the building may be used, as it was in all of these HLCs, as a base for existing services to disadvantaged communities. These services range from regular outreach clinics or advice surgeries to the housing of permanent library resources. Secondly, it provides a base for communicating with, or accessing, a local population. Although other HLCs also stressed that an important aspect of developing maturity was that they came to be seen as experts on, and providing a pathway to, their population group, having a building had added benefits in terms of providing a 'real' place to meet local residents in a physical space felt to be acceptable to them. More controversially, a new building which is no longer being managed risks losing the support of the community and can become a liability for statutory agencies. In one case, the HLC manager was confident that the organisation would have continuing managerial responsibility for the community building as this would be the cheapest option for the LA in terms of maintaining the building and ensuring that existing services continued to be housed there.

Finally, those HLCs that were based within a physical centre, as the main focus and base for activities, were aware that the building was an economic asset. For instance, there were advantages in terms of the potential to raise funds through renting rooms and hosting events. These HLCs initially took a cautious approach to raising funds through room charges and this strategy was not at first seriously considered as a central strategy for sustainability. As projects come to the end of their HLC funding the advantages of charging for space, for some, has come to be considered a key component of sustainability plans. However, in one HLC, where the manager, the Chair of the Board and a resident member of the Board were interviewed, it was recognised that the HLC could become an 'office block' and simply a base for the statutory services. In this scenario the HLC may be sustained in name and as a physical presence but its integrity as a 'community owned' entity, which was at the core of what they felt the HLC was, would cease to exist.

Perceived strengths of having a physical centre

Physical centre
- The fact that there is a physical building provides a new focus for the community. They can offer a variety of activities across the community. The fact that the local community has been involved from the beginning and has seen the benefits is one reason why the building has not suffered from vandalism.

Hub and spoke
- It also brings services into the building, making them more accessible to local people. Previously, for instance, residents would have to take a bus journey there and back to access the services of the mental health team. People were not turning up for appointments. Now they have 100% attendance because they are based there. The people who use the service say that they appreciate that.

However, as the above point illustrates, these very advantages have their own risks. Centre managers were, and still are, aware of the fact that there are no guarantees that statutory funds will be provided to sustain buildings and core running costs (including costs of core staff). Although HLC managers were confident that buildings would remain in community use there was less confidence that the original HLC objectives could be sustained, particularly without funding for core staff. The impact in terms of the loss of trust and 'respect' by the community was, in the opinion of one HLC manager, a significant risk. The investment of resources in such a visible asset both generated community commitment and risked setting

something up that could be felt as a loss, leaving a site that could become a parallel symbol of 'abandonment'.

> *This place has never ever been vandalised. If you look at the place across the road they have got all steel wire, razor wire, left around it. It still gets vandalised, it still gets graffitied. The thing this place has always had is that pretty much every extended family on the estate has contact with it in one way or another: through using something that is here, or using some sort of drop-in function or even working here in the past. Certainly, most youngsters, and this is just a stab in the dark, I guess that of all the kids under 21, about 80-85% are getting some use out of the place...so the place gets respected.… But if the shutters go down the respect goes too. The centre is more than just a provider of services; it is a visible symbol of the whole regeneration process. If you let it close then you are just sticking 2 fingers up at them – then the tiles would come off the roof and the place would get a good kicking. So we couldn't let it happen.*
>
> Manager CS22

Another disadvantage of this model, as one manager of a hub and spoke HLC reflected, is that it may act as a disincentive to using existing venues. In this HLC the original idea was that they would have located different staff all around the estate with the intention that they would access as wide a geographical range of residents as possible. However, the provision of a building large enough to host meetings, training sessions and other events, meant that there was a perception that the HLC was aimed at people living in the immediate vicinity. This was problematic in an estate which was already characterised in terms of its territorialism.

Other issues relating to the localism inherent in the idea of the HLC programme are discussed elsewhere. However, the visibly localised nature of HLCs based on a building may also have created disadvantages in terms of how they were viewed strategically. First round interviews with strategic partners as part of the UK evaluation suggested that there may be problems in HLCs being supported by mainstream funding if they were targeted at residents living in a particular area.

> *I think in terms of obtaining funding from statutory providers I think that it is highly unlikely …I think that there is also difficulty with supporting [the HLC] in that community and not providing an equivalent [elsewhere] It is quite difficult isn't it for a local authority or health authority to say we are putting money into this but we are not doing something equal somewhere else*
>
> Statutory partner (interviewed 2004) CS16

In another HLC, a statutory partner felt that the HLC would have to position itself carefully if support was likely to come from statutory sources. In particular it would need to demonstrate its value against wider objectives for regeneration within the county borough council. This suggests that the kind of relationship that HLCs have with wider strategic partners is crucial if their very local focus is to be seen to have strategic value. Finally, HLCs with a physical centre were seen using up human resources in terms of time and energy. This was particularly the case with new capital projects where negotiating with architects, builders and solicitors diverted time away from project development and sustainability planning. In one HLC a new building was not opened until the penultimate year of lottery funding. Even in HLCs based in existing buildings, concerns about maintenance absorbed the attention of managers in ways that had not been anticipated.

3.2.2 Virtual Healthy Living Centres

These include all HLCs without an identifiable physical centre as a focus for the organisation and delivery of activities. A number of different sub-models operate within this category and there are aspects of some of these which may have contributed to whether they were likely to be sustainable or not. Primarily, the advantage of virtual HLCs were seen as allowing flexibility and focusing on building the capacity of existing human and physical resources. One early concern was that physical centres would develop 'a face' which was acceptable to some residents but not others, thereby reproducing, or recreating, new forms of social exclusion. Applicants responded to the idea that HLCs were not necessarily 'bricks and mortar' but networks and/or partnerships. HLCs based in rural areas provided opportunities to develop outreach work or identify local hubs, in towns or villages, through which a range of activities could occur. Virtual HLCs were a particularly useful model for those wanting to facilitate new ways of working with a specific population group, or to develop a particular health intervention, across one or more LA areas.

Virtual HLCs were also seen as mechanisms for LAs to develop ways of working or piloting programmes of work with partners across a number of localities. The key advantage was that they focused on the use of existing physical and human resources which were likely to outlive the funding period. Some felt that rather than energies being directed to maintaining buildings, they could focus their attention directly on the development of relationships and skills across a large network of health and community development workers and residents. The focus was often on capacity building and change within both communities and services.

Example of a virtual network

The centre is virtual, referred to as a network, which supports, stimulates and helps develop health projects and health capacity in 22 areas across the county. This includes all Communities First areas, plus several other deprived wards. The projects involve four development workers, who each have designated areas, and their role is to:

- Engage with the community development worker to try and identify needs that could be addressed by the HLC

- Try to address these needs, by passing them back to the health promotion department, passing them on to the LHB, or preparing and developing courses to address these needs

- Work with Communities First health and wellbeing groups to try and help build their capacity through signposting, help with funding, finding out about training etc.

The disadvantage of virtual networks was that in many cases this left HLCs without a tangible resource or core to which partners were committed. As we shall see in a later chapter many of these HLCs may have left a legacy in terms of a generation of new activities, new ways of working, and improved facilities, but there was some doubt as to whether these

changes could be sustained as a coherent collective endeavour directed towards common objectives.

3.3   Geographical scope

HLCs operated within different geographical spaces. In the main, decisions as to at what scale they operated were shaped by the perceived needs of the target population and the nature of the lead applicant, rather than concerns about sustainability. Different scales of operation meant that HLCs related to different health economies which, in turn offered different challenges and opportunities. As Table V illustrates, HLCs varied from very local projects, through to those operating within or across LA or LHB areas or at national level.

Table V: Geographical boundaries of HLC

Geographical boundaries coincide with	Number (n=27)
Housing estate	8
Two or more localities in LA/LHB area	10
Across one LA/LHB area	6
Two or more LA/LHB areas	2
National	1

3.3.1 Locally focused HLCs

Locally focused projects based on a particular, socially meaningful place or housing estate were more likely to have a community development orientation and were usually the most successful in generating and developing interest and commitment among groups of local people. These were most likely to have built a core of volunteers prepared to take a role in the governance of the HLC and a leadership role in delivering and developing further activities. This also applied to some HLCs that worked in two or more localities. The more that HLC staff resources were dispersed across different areas, the less likely they were to report successful community engagement. Where community ownership was seen as driving sustainability beyond programme funding then the lack of constant, visible on-site human or physical resources was a barrier.

The risk of highly localised HLCs also have to be recognised, such as work not being aligned to the wider strategic objectives and priorities of the area. Since health and well-being resources are driven by LA wide Health, Social Care and Well-being strategies, there is a tension between the development of area wide local strategies and developments that emphasise localised bottom-up approaches to health improvement. However, the idea that community led developments could be sustained without public funding was felt to be naïve in areas of deprivation. In one HLC, focused on a housing estate, the manager felt that they had been highly successful in motivating local people to participate in health related activity but it was felt that it was not realistic to expect these people to take responsibility for local improvements without public money:

> *This phrase they keep using with us is 'capacity building' which has its place. Well what I keep emphasising every time I'm reporting back is that where we are up to now is not about capacity building but about capacity maintenance with regard to this place and what it represents… This business about sustainability – it is a chimera. What makes the police sustainable is that they get public funding. It is never going to be a business. I know it is fashionable to use business terminology but at the end of the day we are a public service… If tax paying representatives think that we are worth*

funding then we will be, if not then we'll pack up our bags and go. If we are worth funding, don't tell us to raise our own income in a place like this.

CS21

Another HLC operating in various localities across the LA was not so successful in mobilising local people, but as it was led and steered by corporate leads in the LA and LHB, it forged an alignment between policy level objectives and activities at a very local level. The model has since had financial support and is being rolled out in other areas of deprivation in the county.

3.3.2 Cross county initiatives

Six HLCs operated across a particular LA/LHB area. Four of these were led by voluntary sector organisations and two by LAs. Although seemingly the best placed to sustain the HLC programme in terms of their potential to forge an alignment with Health, Social Care and Well-being objectives, most have had considerable difficulty. The voluntary sector led initiatives had particular difficulty in winning support from their local statutory organisations. In one of these the partnership broke down completely and the steering group had to be suspended. In another, despite having statutory partners who were very supportive, there was no financial support given to the organisation to continue the work. The latter was eventually successful in winning a further two years of external funding for a major stream of their work. This may well be related to historical difficulties in sustaining voluntary and statutory partnerships where there may be an expectation that the voluntary sector will find its own sources of funding for the activities that they develop.

The LA led HLCs are both likely to close though they have been successful in getting some activities up and running. Both suffered high turnover in terms of core staff and changes in partnerships and there appears to have been a lack of commitment to sustain those partnerships where they do exist. In neither case is the loss of the HLC likely to be particularly visible as they both focused on developing cross borough programmes of activity rather than new resources or relationships with local people.

3.3.3 Two or more local authority areas

Two HLCs worked across three LA areas. Although very different, both experienced similar problems in terms of having to work in different areas with varying strategic priorities and partners. In one the original sustainability plan was for the three managers to secure funding from their LHBs and for the HLCs' services to be fully mainstreamed rather than keep a separate project. It was reported that there have been several difficulties around being three separate projects that are all part of one HLC as it was felt that no statutory organisation could appreciate the value of the whole.

3.4   Focus

HLCs varied in terms of focus.   Fourteen addressed a broad range of issues within one or more neighbourhoods. In these cases there was a tension between responding to issues which were seen to be a priority by local people, but not necessarily the LA or the LHB and those that had developed programmes of activity which were of most concern to the local statutory organisations. The advantage of the first approach is that it was in line with efforts to ensure that the projects were seen to be locally owned and driven. The advantage of the second

approach was that they were more likely to be seen as meeting strategic objectives, particularly when Health, Social Care and Well-being Strategies were being developed.

Table VI: Focus of HLC

Primary Focus	Number (n=27)
Focused on particular population groups	10
Focused specifically on physical activity	3
Addresses a broad range of issues within a particular (or number of) neighbourhood/s.	14

Ten HLCs focused on particular population groups, five of them on the health and well being of older age groups. Other groups included people with mental health problems, people with mental or physical disabilities and young people, particularly with regard to sexual health. Sustainability in terms of mainstream support tended to be seen in terms of whether the group was seen locally as a priority or not. Eight of these HLCs were led by voluntary organisations and it was felt that the extent to which the group they championed was a priority locally determined whether they received funding or not. None of these had received mainstream funding at the time but what HLC funding has done in many of these organisations is develop a greater awareness of health issues within their own organisation and had consequently changed the way in which they worked.

Three HLCs focused specifically on physical activity, two with a focus on walking (one national and one as a major part of their local programme). In both cases support for walking schemes has received significant attention, perhaps because the Walking the Way to Health Scheme has received funding in Wales, England and Scotland. The Walking the Way to Health scheme nationally was also taken up to support smaller walking schemes at a local level, which many HLCs took advantage of. Responsibility for the national scheme moved to the Sports Council for Wales and the local scheme was extended to the adjacent county with two years extra funding.

3.5 Orientation to health/inequalities

A key objective of the HLC programme was to generate new ideas and action to address inequalities in health, by targeting 'areas and groups that represent the most disadvantaged sectors of the population' and reduce 'differences between individuals and improve the health of the worst off in society'. [25] The way in which the programme was to achieve this aim was through local innovation through the mobilisation of the ideas and resources of the public (*communities)* and new partnerships between the voluntary and statutory sectors. Project applications were given scope to address inequality in ways that were considered to be locally appropriate and, not surprisingly, there was also some diversity in terms of how health inequality was understood and addressed at project level. The UK programme evaluation set out to assess the ways in which HLCs interpreted the concept of health inequalities. In practice most respondents found it difficult to articulate how they sought to address inequalities as distinct from improving the health of the populations with which they were engaged. In addition, early workshops and interviews tried to enable respondents to articulate the 'theories of change' that underpinned their activities. The UK evaluation final

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[25] New Opportunities Fund (1998) *Information to applicants for the Healthy Living Centre Programme*

report [26] presented a table of the key issues articulated in relation to approaches to health inequalities identified in the literature.

TableVI: theories of change and health inequalities clusters (taken from Hills et al 2007)

Key issues identified in theory of change	Health inequalities cluster
1. Focus on specific health issues	A behavioural explanation
2. Lack of access to information 3. Lack of interest and confidence	A service accessibility explanation
4. Lack of uptake of conventional services	A service appropriateness explanation
5. Social isolation and social exclusion	A social exclusion/social capital explanation A community participation/involvement explanation
6. Underlying poverty and unemployment	A poverty and income explanation An environmental explanation

In terms of sustainability, there were two key original orientations that are relevant; whether there was a focus on healthy lifestyles, behaviour and information or some attempt to address broader determinants or consequences of health inequality, such as social exclusion, poverty, employment and poor environmental quality. In addition, some HLCs in their original bids aimed to build social capital, social cohesion or social networks and these were seen as mechanisms to address both these orientations. A concern with soft skills, such as communication and emotional dispositions (e.g. self confidence and self esteem) was also seen early on as an important mechanism to facilitate change as well as being important health outcomes in themselves. Another cross-cutting theme was the need to engage with hard-to-reach groups which HLC respondents felt was implicit in the work that they were doing, whether they were working with carers, young people, older people, people with mental or physical difficulties or economically deprived communities.

The scenario with regard to sustainability is a complex one but approaches to health and addressing inequalities appeared to determine how they were seen by statutory agencies and the extent to which strategic partnerships felt they had a home for such activity. A key barrier to mainstream funding for health related activity of this sort where the boundaries between health and community regeneration are not clear is the extent to which there is perceived to be a 'home' for this kind of work. For some HLCs a lack of productive engagement with LHBs or local health services meant that HLCs tended to brand themselves as environmental, economic development or community regeneration entities seeking funding from alternative mainstream sources to those of health. However, where the bridges between health promotion and community development or regeneration were to some degree established (evident in two LA/LHB areas) then the holistic model had a better chance of being supported (usually though partnership working) beyond programme funding. HLCs, or their activities, also had a better chance of survival if directly linked to local policy objectives.

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[26] Hills et al (2007) op cit

3.6   Orientation to community engagement

A condition of programme funding was that applicants consulted with their communities or target group in some way and that these groups were involved in the running of the HLCs. However, there were wide differences in the way in which projects orientated themselves towards community engagement as a component of their work. Most voluntary organisations, particularly ones that represented a specific population group, felt that by their nature they were representing the needs and aspirations of their group. For instance, they had already had users involved on their own Boards of Trustees or management group, existed to serve the group they represented, and had extensive knowledge of what needs had to be addressed. For other projects, particularly those working on a broad range of issues within specific localities, the process of working with communities was an objective in itself. For a number of HLCs sustainability was premised on the idea that communities would themselves take over the governance of the projects and/or lead key areas of health activity after programme resources had been withdrawn. The aim, for these HLCs, was to build capacity within communities and to establish the mechanisms whereby they are able to define and address their own health problems. This reflects a shift whereby the 'centre of gravity' in health promotion resides in the community itself. [27]

Community engagement was built into the design of projects in a number of ways; in the overall steering of the projects, through ongoing mechanisms of dialogue or consultation, through the availability of accredited training schemes and through the development of peer health mentors or advocates. In developing the bids case studies in the UK programme evaluation highlighted extensive consultation which had taken place with local people through existing community groups, community consultation events and needs assessment surveys or community audits. The development of bids therefore provided an opportunity to test the extent and readiness for participation. In the first annual report[28], HLC leads and stakeholders reported that the time lag between submitting the bid and being awarded the grant, and then the long process of setting up legal and financial processes and appointing staff, meant that much of the momentum that had been developed in engaging with communities had been lost.

In the next chapter we will asses the extent to which factors in the implementation of HLCs influenced sustainability and in relation to community engagement the process was considered to be one of continual trial and error. As a model of sustainability, the shift to community ownership was felt to be the most problematic. Community ownership as a model for sustainability was in line with the original aspirations of the programme. It has the advantage of not depending on the chances of attracting new external grants or on the commitment of services to mainstream new activities. It also recognises and harnesses the positive resources of the public, rather than seeing people as passive consumers of existing services and resources. Indeed as a legacy of the programme (see Chapter 6) there have been some changes in terms of setting up some new groups and people who are willing to take a leadership role in their communities. However, on the whole HLCs were disappointed in the extent of willingness of communities to take on a leadership role and become the basis through which HLCs could be sustained.

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[27] Shediac- Rizkallah and Bone (1998) op. cit
[28] Bridge Consortium (2002) *New Opportunities Fund Healthy Living Centres Programme: First Annual Report.*

3.7 Conclusion

This chapter shows the ways in which sustainability was built into the models that were set up. This goes beyond assumptions that eventually HLCs will be mainstreamed or would attract further independent funding. Different models and orientations had latent features which made them more or less likely to be sustained as they had intended. All have had different risks and benefits in terms of their consequences for sustainability. There is also no model which is right or wrong. The chapter raises a number of questions that need to be asked to assess whether projects in a programme like HLCs are likely to be sustainable. For instance, has the model for sustainability been fully discussed and negotiated with relevant communities and partner agencies? Are the roles and expectations of different stakeholders clearly understood and agreed? Is the vision of health clearly understood and accepted by stakeholders? Is there a shared idea of how the programme or project will be sustained, with whose or what resources, in the future? Who will be responsible for sustaining any capital assets and what conditions will be imposed? These are questions which need to be considered at an early stage of the planning process and cannot be left towards the end when making arrangements for end of programme funding.

Chapter 4: Implementing sustainability: developing capacity and plans for sustainability

Key Points

- Data in this evaluation confirmed that sustainability planning was not generally considered to be a priority until the final 24 months of the projects.

- Evaluation was thought to play an important role in making the case for sustainability but interviews indicated that the role of evaluation was generally not properly considered.

- Many HLCs lacked a mechanism or forum to consider sustainability options at an early enough stage. This sometimes resulted in projects fizzling out with staff leaving before the end of the funded period rather than a planned sustainability or exit plan.

- Underlying the lack of planning, however, was a clear lack of support to conduct evaluation with staff lacking the time or skills to consider this properly.

- In addition there appeared to be little agreement between HLC managers and stakeholders, who may have had a role in providing future support, as to what would count as success.

- It would appear that evaluation in itself made little difference to the sustainability of projects. The context in which evaluation was developed and interpreted seemed to be of greater value.

4.1 Introduction

The previous chapter looked at the initial set up, structure and design of HLCs and the implications that different models had for sustainability. This ignores the fact that HLCs were driven by people and organisations throughout the process in trying to make them work and promote their ways of working or activities as part of a new way of delivering public health. Another way of saying this is that is focuses on structures rather than agency. This chapter looks at the how HLC managers conceptualised sustainability themselves and actively built it into the development of the projects. Case studies demonstrated that there was, on the whole, a lack of active planning for sustainability until fairly late into the projects with HLC managers largely focused on getting the projects up and running in the first two years and then developing the projects and activities. Many respondents, reflecting on how the current position of HLC projects tied in with original intentions, also felt some of the initial assumptions were naïve. In particular the idea that the ways of working and activities of HLC would be taken up by partner organisations, mainstream services or communities themselves, was felt to be flawed. Another key theme was the way in which HLC leads felt that they were victims of the wider policy environment for which these projects do not have a natural home and, like many other health promotion interventions, are not seen to be a key local priority.

Local evaluation is also discussed, as this was a potential sustainability tool to demonstrate to funding bodies, partners and statutory services, the extent to which the projects had been effective.   However, there was no agreed understanding of the nature or purposes of evaluation or shared experience as to how evaluation was resourced and used. Although there was a requirement for HLCs to evaluate their progress not all projects conducted an evaluation and those that did commissioned them fairly late into the funded period. The research reveals many different ideas about what evaluation is, how it should be used and who it should be aimed at.   Furthermore, it was evident that there was a perceived lack of resources, human and financial, in conducting evaluations. In particular there was a concern that outcomes such as improved well being or improved confidence in the community were difficult to measure and likely to be questioned by potential funders in the statutory sector as priority health impacts.

4.2 Managing sustainability

Respondents were asked about the extent to which they felt sustainability was taken forward in the projects, how it was done and who was responsible. Reflecting the lack of evidence on planning for sustainability in the early stages of the UK evaluation, programme respondents on the whole felt that there was little actually done to facilitate sustainability for various reasons: first because they felt that ideas about sustainability were built into the model (however naïve – see previous chapter); second that they were overwhelmed by the necessity of establishing the initiative, getting activities going and ensuring momentum; third that project partners lost interest or had disengaged from the process; and fourth that priorities in the wider world of health and/or regeneration were ever changing and it was therefore impossible to control the destiny of the HLC. However, those that had not planned to remain as a HLC did set up a range of measures, though not always satisfactorily from the perspective of the project mangers, to ensure that some of the outcomes or ways of working could be sustained in the future.

It was clear, however, that sustainability was not a priority for managers/co-coordinators, HLC Boards or their partners in the early stages. There had been an expectation initially that projects would be funded by a mix of mainstream resources or securing independent funding for some aspects of their work. However, there was little incentive to develop fundraising plans in the early stages of the programme as it was felt that the financial situation may be different several years down the line. Some HLCs talked about initial intentions to set up planning, sustainability or fundraising groups but these often did not come into being until the last 18 months of funding.   Particularly vulnerable were HLCs led by voluntary organisations who felt that they were at a particular disadvantage in providing a secure financial basis for continuing their work.

> *You can't build in the financial security can you? Because the organisations that are putting in the bid are not financially secure themselves. And voluntary sector funding is never permanent. Actually, I think that's probably quite an important point; just how insecure the voluntary organisations are in themselves, let alone in sustaining a project.*
>
> *CS02*

In four HLCs, multi-agency steering, management or advisory groups also had a remit to consider sustainability, and in all of these the continuation of the project was of interest to all the partners involved. In one case a multi-agency panel, chaired by a stakeholder not involved in the HLC, was set up to consider how the project should be positioned post-

funding, to listen to on-going feed-back from the implementation and to consider the findings of the evaluation. In this particular case measures to secure funding were successful, with the support of panel members, before the evaluation results were clear. In this case, with panel members keen to ensure the project was supported and in a position to make representations on behalf of the initiative, funding was secured. In the other HLCs the manager reported that multi-agency partners who were on the management group worked hard to support the bids for future funding and, for particular areas of work, helped to gain support from their own organisations to fund or support future activity. In the latter case the bid itself was supported by a pre-existing partnership and all the statutory agencies had some line management responsibilities for staff. In both these cases partners had some interest, and influence, in finding funding for future activity.

One problem for a number of HLCs is the lack of a strong partnership to share responsibility for sustainability. Reflecting on how this affected sustainability plans at the time of interview, one co-ordinator felt that some terms and conditions could have been built into the bid to ensure other agencies could continue the work, before the funding was provided. Another HLC manager felt that another problem they faced was that statutory partners, even within the health service, had very different agendas and that the HLC was not a priority in terms of the everyday work of their partners. Managers were also asked about the role of partners in their HLC and most highlighted that partners were largely involved at an operational level, in delivering services, often in a personal capacity, rather that at a strategic level. This had a number of consequences. Firstly, the strength and resilience of partnerships were weak – if a partner left their job then that person may not be replaced by the organisation. Secondly, operational partners have little influence in the strategic direction of the HLC itself. Thirdly, there is less likely to be a connection between local strategy development and the role of the HLC within that. Operational partnerships were valuable in getting the projects established and developing activities but were unhelpful in providing support for sustainability management.

Another facilitating factor was having someone dedicated to writing grant applications, or negotiating with statutory partners for mainstream funding. This role was important for HLCs to have any chance in sustaining their work. In a previous report to the Welsh Assembly Government, one project manager reported that in the final 18 months of the project 75% of their time was spent in fundraising activities to sustain the project. This work included writing grant applications, negotiating with project partners, lobbying health leads and national politicians, and overseeing and marketing a project evaluation. However, good fundraising and negotiating skills seem to be a necessary but not sufficient condition of continuation funding. Multiple grant applications were submitted in the full knowledge that few or none would be funded. Another risk was that managers were unable to focus on fundraising while fully engaging in project development and maintenance of the HLCs' other key functions.

4.3   Transferring skills and activities to services and communities

Another approach to sustainability was the transfer of skills and capacities to other health or community workers to take on new ways of working or leadership roles. HLCs have been particularly conscious of the need to look for ways in which the capacities of people and organisations can be strengthened to take on new roles. This usually took the form of providing training to local people or service providers.

Sustaining change in service provision

HLC staff reported that as they were told that theirs was a strictly time limited project they decided to direct their efforts into training to ensure that there was a sustainable workforce to work with the young people on a priority public health concern. They targeted people who work in schools and people who work with young people. Through this work, staff established a need for a consistent training pack and subsequently created a resource pack containing useful information for teachers working with years five to eleven. Having put together these schemes of work, they have tried to identify key people who would remain after the HLC project finishes.

CS08

With regard to building community capacity, a range of training opportunities were offered apart from skills that would benefit individuals. These included training that would lead to community members leading activities themselves, training to become health mentors or advocates as well as training to become professional volunteers. This was coupled with encouragement and support for community members to take on community leadership roles, particularly in terms of the governance of HLCs themselves. In some cases local people did take on responsibility for the running of particular activities and some of these are still running since programme funding ceased. Particularly successful have been some food co-ops, environmental groups, walking groups and dance or exercise groups. The success of community food co-ops and walking groups may partly be due to the fact that they are supported by national programmes. Dance and exercise groups have largely been sustained by small charges to users who pay to keep on an instructor. In all of these, success was also perceived to be due to the social dimension of these activities where friendships were formed and new networks created.

Methods used to sustain HLC activity in communities
The manager felt that the HLC was about empowering people and enabling them to realise their skills. They would find support for people if they wanted it. In other areas they facilitated a development that was identified as needed and then left residents to take it forward in their own way. The most obvious example of this is the food co-op where the HLC helped in the early stages with the logistics in getting it set up but now it is entirely resident led. The manager felt that this has had a marked impact on increasing the confidence of some people and in utilising and developing their skills. Occasionally there were issues the HLC were asked to help with so they were always there as a source of help when and if needed. The community nutritionist is still working in the area and is a useful link to groups in the community as well as a source of ongoing support now that the HLC itself does not exist.

CS25

Although HLCs did point to successes in ensuring that communities or organisations were able to continue particular activities, it was this aspect of sustainability which disappointed managers the most. Assumptions that communities or other service providers, for different reasons, would be ready to take over aspects of the HLC were often felt to be naïve or over-ambitious. With regard to community roles in taking up leadership positions in health or regeneration, it was felt that it was asking too much of the public to take this on without

considerable ongoing investment and support. There were different ways in which this perceived failure was articulated. For some, it was seen as the lack of individuals with the 'necessary drive and leadership', for others it was unrealistic expectations of the public without having the time to build up their confidence, experience and skills, whilst others pointed to the statutory agencies themselves and the inability to respond and support people who were trying to take on these roles.

HLC co-ordinators and managers believed that it was wrong to assume that communities, particularly in areas of deprivation, would readily take on leadership roles without additional on-going resources. Furthermore, community engagement was seen to be a continuous endeavour and not one which comes to an end after a certain period. Practical concerns around insurance and access to ongoing training were also raised in terms of people who had become involved in leading activities but may be reluctant to do so in the future without an organisation willing to take on some of the responsibility for financial risk, ongoing recruitment and training and development. Where projects reported that volunteers were leading activities there was a fear that they would not be able, in some cases, to continue without the support and resources the HLC offered. Other project leads felt that not enough had been done to test the likelihood that the model of community participation was likely to work:

> *It was supposed to be a sustainable project, it was supposed to be three years, within which time four community health groups were set up with the support of doctors surgeries, health workers, local councils, local people, but it hasn't worked this way because of the lack of volunteers, the usual problems you've got; they don't want to take on the responsibility but they do want to be involved. I mean it's taken us four years for us to get to a stage where we're thinking about possibly suggesting that they go out on their own, so we haven't had as much support as anticipated.*
>
> CS04

On top of the difficulties in sustaining the ways of working in services and communities it was felt that the efforts of HLCs in building the relationships required to develop capacity in the first place would be wasted.

Difficulties in sustaining programmes in communities

The original concept for sustainability at the conception of the HLC project was that services would become embedded in the local community and with local agencies enabling them to continue. However, staff had also been hopeful of sustaining funding to extend the HLC project. Without funding for core staff posts, there will not be a coordinator or anybody to establish new projects and reach out to other marginalised groups. Whilst other agencies may continue some aspects of the HLC's work, the trusting relationship staff have built up with young people will be lost.

'I'm quite hopeful that a lot of the work will continue in one form or other, but I think there are some things that will be lost; the relationship the staff has built and Sheila and Beth *(not their real names)* have worked closely with groups as well and I think they'll be sorely missed. I think, you know five years is quite a long time and people do get to know each other really well and to be accepted as a part of *[the area]* and things so I think it will be missed, and also just someone there to push issues forward really,'

CS14

4.4 Conducting evaluation

4.4.1 What evaluation was undertaken

A potential tool for sustainability is evaluation to demonstrate that original aims and objectives have been met, that an intervention works or to highlight gaps or additional opportunities which may require funding. Evaluation also provides opportunities for organisations, partnerships or systems to learn about what works. Applicants were required to outline plans for evaluation and, indeed, most of the HLCs were undertaking some kind of monitoring or evaluation of their activities through a range of methods including baseline and follow-up questionnaires or telephone interviews, post activities evaluation sheets and case study vignettes. These were often used as part of their requirement to submit an Annual Monitoring Report to the funders. However, a key concern from managers that emerged towards the end of programme funding was the lack of evaluation that could demonstrate the impact that they had made on health and relevant determinants. Out of the 27 HLCs whose information was collected as part of this study, 18 had commissioned external evaluations. Of these:

- 11 had only started to put evaluation processes in place from year 3 (or half way though the funded period) or later.
- 4 were conducted in the final year.
- 7 were conducted by external consultants, 6 by undergraduate or post-graduate students, 3 by university departments and 2 by an evaluation officer employed by the lead organisation.
- Apart from evaluations that were conducted at no cost as part of a student study, costs ranged between £1,000 and £50,000, with the vast majority being less than £5,000.

Of the 9 HLCs that had not commissioned external evaluations:

- 1 had commissioned a base-line well-being survey of the local housing estate but had been unable to secure funding for follow-up. In addition changes in core staff meant that there was no organisational memory of a survey having taken place.
- 1 was in its 3rd Year at the time of interview and considering an evaluation
- 3 in their fifth year of funding thought a final evaluation may yet be undertaken
- 1 thought that they were being evaluated anyway
- 1 thought that the annual monitoring reports for the funders was the evaluation
- 2 were undertaking fairly comprehensive internal evaluations as an alternative

As it can be seen above, most evaluations that were undertaken were conducted fairly late on in project development. The reasons for conducting evaluations varied, with most wanting to make the case for future funding. In addition, evaluation was undertaken to assess and demonstrate that they had met their targets to project partners and/or stakeholders, or for developmental purposes to improve the work being undertaken. Similarly, evaluations had different audiences including external funders, existing partnerships or stakeholders, who may be able to fund or part-fund the HLC in the future and staff working in the HLC.

Difficulties in conducting local evaluation
The original bid stated that the University X would undertake an evaluation, but in year three it could not be established who agreed to do this. The HLC employed one postgraduate and one undergraduate student from University X to undertake the evaluation, supported by the LHB. The evaluation was unable to identify health outcomes as no measures were put in place at the beginning of the project to provide baseline measures to which later measures could be compared. The evaluation officers asked people to think back to how they were

before the project and compare this to how they felt after taking part in activities. These retrospective programmes have been used for each of the programmes to see how health and behaviour had changed over the course of the activities. Although these retrospective measures were not ideal, staff felt it was the only way they could evaluate the health impact of the project without baseline measures. The exception to this was the physical activity programme, where people were identified through a health needs assessment. Everybody who was referred onto the scheme was initially screened by the GP before referral and then screened by the HLC to record measures such as BMI, circumference measurement and blood pressure, so they could see a before and after picture. However, this also had a drawback in that it did not provide an indication of improvements in emotional wellbeing and confidence.

CS07

Some internal evaluation was undertaken by nearly all HLCs with staff finding it useful to assess the reach of their activities, how well specific activities were being received, how they could be improved and whether they were worth continuing. They also used them as a way of communicating and updating project partners, local people and other agencies on the progress of their work. One advantage of internal evaluation was felt to be that it is conducted by someone who knows and understands the project. Methods used to undertake internal evaluations of specific activities were user satisfaction forms, follow-up questionnaires or phone calls, individual testimonies (or stories about how individuals had benefited) and health checks (such as blood pressure and weight), though health checks were sometimes seen as intrusive and as failing to highlight more important health changes.

Internal Evaluations

These individual evaluations have been very useful for the HLC as they provide an extra opportunity to talk to people about their needs and interests, and to discuss whether the HLC programme has been able to meet this. The evaluations also examine the quality of the programme to consider whether it is fit for purpose and consider the benefits people gain from the activities. The HLC coordinator feels that BIG have been quite rigorous in their evaluation of HLC programmes and these evaluations are necessary for obtaining funding, whilst also providing HLC staff with a lot of useful information that will help them with future projects and future bids. The HLC has conducted a health needs assessment in local comprehensive schools, talking to all children in the area about what the HLC does and what things they would like or need to support them and this has directly influenced how the HLC works.

CS16

4.4.2 The purposes of evaluation

Asked how evaluation was used and who it was aimed at, it was clear that evaluation appeared to matter in different ways as the projects developed. Initially evaluation was largely seen as an internal developmental tool to inform HLC staff and partners how the project was developing and to ensure that they were meeting their own, and the funders, requirements. Monitoring information was submitted to the funders but also used to assess who was benefiting from the projects. In at least two cases monitoring information highlighted population groups that they were failing to engage with and enabled the HLCs to refocus their activities.

Evaluation was also used as a communication tool as a means of demonstrating the value of their work to people in the wider policy environment, to local people and/or, in some cases to other HLCs. As a communication device, HLC managers and staff expected feed back but were often disappointed when they heard nothing. In a small number of HLCs, however,

evaluation was used in a more interactive way. For instance, in a HLC with a multi-agency advisory group members were described as ongoing 'translators' of the emerging results. In this case evaluation was a process and a mode of communication rather than just a final report and efforts to make a case for further funding with partners were made before final results were published. Evaluation was also seen as an opportunity for the lead organisation to learn how such interventions work as well as learning about the use of evaluation, particularly in relation to health impact in their (non-health) work. Another respondent also reported that the evaluations were useful as a mechanism to engage key local officers about the work of the HLC and its relevance to their own work:

> *I certainly used them, when I came into post I used them when I had meetings with head of regeneration, local authority figures health board figures, I made sure they had copies and that we were pointing those key officers to that documentation so they could see that it was something that had been well planned and wasn't just something we were doing simply because the community said so but there was actually a reason behind it as well, and it was actually being productive.*
>
> CS21

However, on the whole there was a lack of a two way dialogue with mainstream organisations and final reports were often just sent to LHBs and LAs, relying on feedback rather than interaction.

Another respondent felt frustrated at the lack of advice on the purpose of evaluation when brought in to conduct an evaluation half way through project development:

> *I was totally left to my own devices so I felt the most important use in evaluation would be to help the project so I did it with that in mind really as to how we could improve the project, so I didn't look at the original aims and objectives I looked at what was happening currently and what we could learn…like…it was more of a…to kind of map what was happening and who we were reaching at the moment really and then to set up the monitoring systems in place so we could measure against that, so I basically took it, I just decided myself really that it would be…well I did have meetings with the management board as well…they weren't a lot of guidance to be honest so I just decided yeah that it would be aimed at us.*
>
> CS17

For most projects, it was not until the final two years that managers looked to evaluation as a mechanism to demonstrate the impact that the schemes had made on health. Independent evaluation was seen as important in providing credibility to the findings and because HLCs did not have the time or skills to conduct evaluations themselves. In two cases there had been an intention to build external evaluation from the outset but they, with academic partners, had failed to secure the funding required. Considering evaluation late into project development meant that there was no baseline to demonstrate change which some managers felt was a distinct disadvantage in evaluating any impact that they may have made. Lack of resources also meant that evaluations were commissioned 'on the cheap' in some cases taking advantage of the availability of local students who were able to undertake evaluation as a part of their studies. A small number of HLCs used support and development funds to access grants of up to £5k to undertake small scale evaluations to make the case for sustainability.

Responsibility for undertaking and learning from the evaluation was not always clear. In projects led by LAs and/or health organisations the projects were often seen as opportunities to learn how different approaches to health could work as a model for working in other geographical areas in the future. This is relevant in terms of sustaining and developing the ways of working in an organisation beyond programme funding. However, there was little

evidence that anyone apart from the managers or specific HLC staff was taking responsibility for how evaluation would be used strategically and therefore how evaluation could be used purposively to inform future work. In one HLC the respondent reported that the scheme was originally intended as a pilot to roll out across the borough yet they felt that it was left up to them to guess what kind of data lead officers needed to make that decision.

> *It is really difficult to assess impact in terms of the kind of data that the Local Health Board or Trusts or Local Authority might see as being really relevant to them so... I think it took my interpretation, it took sometime for the team to discuss and work through finding out a particular method in evaluation.*
>
> <div align="right">CS21</div>

4.4.3 Measuring and assessing health impact

As well as conducting evaluation late into the projects and with a lack of resources, managers reported other difficulties in identifying appropriate methods of capturing health impact. Some felt that there was a pressure to demonstrate changes in health that would not be seen for many years and that it was unfair to demonstrate impact on key health priorities when the focus was on the individual and the wider determinants of health.

> *I think it is impact they want, they do want to see how we have affected health, which is hard to measure in this short period of time, it takes a lot longer than that. Obviously we've got case studies and lots of anecdotal evidence but those above don't always recognise the qualitative things, so that's been quite difficult.*
>
> <div align="right">CS05</div>

HLCs were meant to be holistic in their approach to health and inequalities with a focus on improving well-being rather than just changing health behaviour. In her address to a seminar funded by the Department of Health in 1998, the then Minister for Public Health, Tessa Jowell, said

> *And what I really hope is that the centres will have a rounded vision which encompasses the psychological dimensions of health – which seeks to work with local agencies to alleviate the problems which feed a mentality of despair and which tries to build self confidence, self esteem and self reliance which is the bed-rock of good health [29].*

HLCs on the whole responded to this challenge and, indeed, improvements in well being were, for staff and managers, the most striking impacts of the schemes. However, demonstrating those impacts, and identifying methods that would capture those changes was felt to be particularly challenging:

> *It's quite difficult with the befriending, if it's made a real impact on someone's life, and I think that is the case with a lot of people who were befriended, it's not always recorded or quantified in the chart of figures that say how often they went to the dentist, so those softer outcomes, one of the things she's (evaluator) done is to go through interviews, interview everyone who was involved to see what's come out of it.*
>
> <div align="right">CS02</div>

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[29] Department of Health (1998) Healthy living centres report of a seminar held on 2 April 1998
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010504

I don't know how you can evaluate that feeling of wellbeing; that you go out on Thursday afternoon and listen to a talk with your friends, and you go home and you feel much better, you feel brighter and more alive and part of the world. I don't know how you grasp that and demonstrate it.

CS03

In addition, it was felt that the ways in which changes occurred were complex where the pathways to change are not immediately obvious. They felt that the traditional methods of evaluation could not capture that complexity and there was a fear methods such as vignettes or testimonies would be regarded as anecdotal and not seen as robust.

For example, there was one person who said 'I went to [town name] and bought some clothes'….. but what she actually didn't say in the questionnaire was that she was actually a size thirty in clothes, she was really ashamed of her weight, she had a lot of sexual abuse as a child, which is why she put on the weight, and she was actually agoraphobic. So we did a lot of home visits beforehand, we actually got her to go to a cooking group…. She then started to lose weight, she joined the 'X' scheme in a local centre, she actually took the bus to [town name] by herself, which was a huge life-changing thing for her, and she actually bought some size fourteen clothes, which for her was fantastic, but none of that is actually recorded.

CS21

Some people think community development is wishy-washy and that we're just a little project, but it's a lot more than that and the impact you do have on the community is difficult to measure.

CS05

The lack of skills in using evaluation tools extended to most other areas of health change too. It was relatively easy to monitor who was using HLC services but not how people were benefiting, particularly those not directly involved with activities, such as when examining the broad impact of neighbourhood improvements or health related skills among wider family members. In addition, some HLCs felt that they had made an impact on preventing ill health or accidents and reducing pressure on the NHS but apart from occasional stories told about individuals they felt unable to capture the extent to which they had impacted on prevention adequately and convincingly in an evaluation. Where HLCs were involved in building the capacity of the public and health and/or regeneration, there was some concern about how capacity building would be measured and assessed and how individual projects impacted together and synergistically on particular communities.

Problems in evaluating impact

Prevention

The co-ordinator felt that they should have had more experience in, on the one hand demonstrating how people had moved on in their lives as a result of the healthy living centre and, secondly been able to present valid and reliable statistics on the extent of change. For instance she felt that the Eat and Exchange had made big differences to some people's lives (e.g. off drugs, into training and perhaps employment) but did not know how they could best demonstrate this. She feels that they have made an impact on falls prevention – but how can they show this?

CS20

Capacity building

At this stage, the coordinator is unsure how capacity building can be measured and how they will be able to demonstrate the improvements that have been made. The coordinator feels that there may be a critical mass of people with certain skills who are crucial to sustaining a project such as this, and the evaluation would need to consider what prerequisites are essential for a community health project to work.

CS09

Individual Well Being

It has been difficult to quantify what the HLC does and the changes it has made; staff are able to see the changes it has made in peoples lives, but this seems anecdotal when presenting it to possible funders. As people often use the HLC for a variety of activities, it is difficult to provide statistics on user figures, as this does not provide an accurate representation of the benefits. The HLCs own evaluation included chats with users, which provided qualitative feedback on how people have benefited from the HLC.

CS14

Finally, the nature of HLC work in engaging with communities appeared, in some cases, to impact on how and to what extent they felt they could use evaluation. First, it was felt that people living in deprived areas were over evaluated and would not be happy for over intrusive methods to be used. Second, that data collection itself impacted on how they delivered their work and third, that there were therefore, in come cases, concerns about confidentiality. In the policy seminar, held as part of the evaluation, a HLC representative felt that there needed to be clarity about what evaluation is, what it is for and what its value is for community, statutory and academic stakeholders before it can be undertaken with any degree of success.

> *I mean one of the reasons HLCs have been so successful is because they literally work within their community and use that sort of community language. When you look at the medical model it is so much more academic and when you try and put that into the community it is very difficult for the community to actually play and to buy into evaluating. When you are using a softer approach you are more likely to feed into an evaluation but when you are using SF[30] criteria it is just so complex and it frightens the sort of everyday people off and they don't want to be involved in great big long questionnaires and I think there needs to be a happy medium of getting the key information that is required by LHBs or local authorities to sustain or to be able to continue a project in some way in the future after the initial funding. And I think we've got to get some (happy) medium to ensure that people will actually feed into that evaluation.*

HLC representative (policy seminar)

Conflict between evaluation and HLC objectives
Their own external evaluation report highlighted the informality of the HLC staff as an important factor in encouraging people to access the project, but this informality made it particularly difficult to build in measures of health impact. Subsequently

[30] Referring to the SF-36 which is a well known questionnaire used in surveys to measure self assessed health status. SF stands for 'short form' and 36 refers the number of questions asked. The original questionnaire was developed in the USA and had many more questions.

staff were conscious not to formalise their relationship with the community through taking health measures.

This is an area of deprivation that has been researched and questioned and interviewed a lot, and one of the positive things to come out of the evaluation was that we are so informal, so we consciously moved away from that…… we moved away from a paper and pen sort of approach.

CS05

It has been particularly difficult to evaluate the impact of the sexual health programme because of confidentiality issues, but to try and ensure they got some feedback from beneficiaries, staff developed a system where people were given a certificate once they completed an evaluation form, however, they were still only able to access less than 1% of people involved in the programme.

CS07

4.4.4 Did evaluation make a difference?

Where evaluations have been undertaken there was very little evidence that they have had an impact on whether the HLC received further funding or not. Managers reported that they felt that monitoring and evaluation figures were sometimes useful in putting together a case for external funding but in these cases the evidence they used was to fund something new rather than continuation funding. HLC staff had to manage a tension in the effort to sustain their work by repacking what had already been done as new whilst retaining as much as they felt could work as possible.

In terms of mainstreaming the core activities of HLCs, even when evaluations were reported as being 'well received', they appeared to carry little weight as far as continuation funding was concerned.

Everybody thinks that this is a marvellous model, you know, this is held as a model of excellence, it's a fantastic project, we're still waiting for the money. What's so frustrating is that we tick so many boxes, you read all these strategies, all these action plans, the recommendations in reports, and all these commissioned national research and evaluation things, and there are so many that we tick all the boxes, we're doing everything that we're being told needs to be done but the money isn't forthcoming.

CS01

Evaluation: does it make a difference?
An evaluation of the pilot project (first year) was a requirement of the BIG funding, and from this they set the base line of what targets would be. The administrator was unsure whether the mid-term evaluation was part of the bid, but this was partly used to consider exit strategies and evaluate the project in terms of whether it worked and whether or not it should continue. The final evaluation aimed to look at the project as a whole. The mid-term evaluation was given to everyone who was involved in the project (partners, steering group etc) and at this stage it was hoped that another agency would pick up the work of the project once funding ended. The evaluations were quite well received but did not persuade people to continue the work.

CS02

Another issue raised by one HLC was that evaluation to justify further funding is one thing but evaluation also needs to be used to inform implementation if, in their case, it is taken over

by another organisation and secondly, how it may be rolled out across other service areas, geographical areas or population groups if seen as a model to be developed. This HLC was particularly concerned that certain recommendations regarding how the initiative could be successfully implemented would be ignored and that they had not 'sweated and toiled for 4 years and made all these efforts for nothing'. It is beyond the scope of this evaluation to assess how health systems learn from evaluation to sustain or develop intervention work from evaluations but it appears from concerns raised by HLC managers and co-ordinators that this is likely to be limited for community based initiatives such as this.

In conclusion, it appears that local evaluation in itself has had minimal influence on the sustainability of HLCs. However, caution must be applied as evaluations may have a life that goes well beyond the point at which findings are received and fed back. What appears to have been more crucial is the context in which evaluation is developed, discussed and applied. Where partners who have the power to influence changes have been involved in evaluation processes then there appears to be a better chance that HLCs or the activities to which they attach value will be sustained.   In the absence of such partnership structures, the extent to which managers or co-ordinators are able to use evaluation to develop new forms of engagement with influential stakeholders may influence sustainability outcomes.

4.5   Other ways of demonstrating success

The above section suggests that evaluation in itself has had a minimal influence on whether HLCs or activities have been sustained or not but that it is the form in which the work of the HLCs were communicated that made the difference.   We also asked respondents to talk about other ways in which they had tried to communicate the work and achievements of HLCs to help secure funding for future work. Towards the end of project funding, mangers and co-ordinators reported a number of ways to draw attention to the work of their schemes. These included attending conferences and meetings, press coverage, lobbying politicians and writing articles for journals. DVDs were found to be particularly useful in demonstrating the human impact of their work. In addition some HLCs facilitated meetings or events where 'users' of HLCs could provide verbal testimonies of how their lives had been affected.

Demonstrating Success
Apart from the evaluation report, staff tried to demonstrate the success of the project using patients' testimonies, an article in the Nursing Times about the green gym, and a short documentary in HTV news. The HLC as a whole has won two awards from the Trust, and the previous mental health worker won an award for his work with mothers with post-natal depression. Staff have also given talks to other areas about the success of the scheme.

CS10

Apart from the evaluation reports, the coordinator feels that they can demonstrate the success of the project by asking people to visit and experience them first hand. The coordinator also invites written feedback from clients, their carers and families so they can describe the impact that the project has had on their lives. She feels that the visual methods such as the DVD and photographs have been particularly effective in demonstrating success.

CS11

It has been difficult to provide figures for the Local Health Board to demonstrate success, but four HLC users met with the director of the Local Health Board to tell their personal stories of the affect the HLC has had on their lives, and it would be impossible to quantify this.

CS16

It is not possible to say whether any of these other approaches worked in attracting funding and, as most HLCs were in the final year of funding, many of these were being tried at the time of interview. However, there is little evidence that any of these are a better substitute for sustainability planning and structures established early on in projects. Evaluation is not simply a mechanism to demonstrate effectiveness; it is also a mechanism for learning about ways of working. Sustainability can also be seen as the capacity of organisations and partnerships to learn from their investments in interventions as a way of informing how they may apply lessons about 'what works' in different contexts in the future.

4.6   Conclusion

Evidence from the UK programme evaluation highlighted that sustainability planning was not generally considered to be a priority until the final 24 months of the projects. This picture was confirmed in this more detailed and timely assessment of HLCs in Wales. Interviews revealed that the role of evaluation was not properly considered and there was a lack of a particular structure or forum to consider sustainability options. This sometimes resulted in projects fizzling out with staff leaving before the end of the funded period rather than a planned sustainability or exit plan. Underlying the lack of planning, however, was a clear lack of support to conduct evaluation with staff lacking the time or skills to consider this properly. In addition there was little evidence of local agreement as to what would count as success. Managers reported that in many cases, impact on well being, for instance, would not be considered a priority outcome. Overall, it would appear that evaluation in itself made little difference to the sustainability of projects. The context in which evaluation was developed and interpreted seemed to be of greater value.

Chapter 5: Healthy Living Centres and the policy environment

Key points

- The future prospects of HLCs are determined in part by factors beyond the control of projects which are to do with the wider local and national health economy.
- Structural changes to the planning, commissioning and delivery of health services posed challenges for HLC managers. HLCs led by voluntary organisations found it particular challenging to 'read' the policy environment.
- HLCs led by local authorities with health organisations were in a better position to ensure links between projects and their overall Health, Social Care and Well-being objectives.
- Interviews suggested that much of the learning held in HLC projects will have been, or will get, lost. There was some evidence of HLC managers using their experience and applying it to different geographical areas and population groups.
- There is an issue about how, and whether, the lessons from programme evaluations are learned and by whom
- Future programmes may like to consider ways in which project staff could be supported to become policy savvy as well as identifying ways in which local policy makers and commissioners could learn from the achievements of such initiatives

5.1   Introduction

Literature on the sustainability of community based initiatives suggests that factors in the broader political and economic environment also impact on sustainability. The best efforts at sustaining the work of HLCs could be frustrated by factors in the wider policy environment beyond the control of project leads and managers themselves. A key issue with regard to the positioning of HLCs as a part of public health strategies and policies in Wales is that the HLC programme was developed and announced prior to the establishment of the National Assembly for Wales. Early circulars from the Department of Health [31] [32] were aimed at English Health Authorities, NHS Trusts, Local Authorities and Voluntary Organisations. There was a therefore a potential misalignment between HLC programme objectives and the emerging Welsh policy framework. At the very least there was no intrinsic national ownership of the programme and this may have shaped future ministers' responsibilities for the development of the programme and individual projects. There is more of a case to suggest that there was some accountability for the HLC programme in England. Although the New Opportunities Fund was were tasked with leading the programme, as part of their new 'good causes' remit, the programme was specifically highlighted in the first White Paper *Saving Lives: Our Healthier Nation*[33] and the health inequalities strategy launched as part of *Tackling Health Inequalities: A Programme for Action* in 2003.

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[31] Department of Health (1998) Circular MISC (97)83
[32] Department of Health (1999) HSC 2009/008
[33] Department of Health (1999) *Saving Lives: Our Healthier Nation* Stationery Office: London

Restructuring of the health system in Wales, including the abolition of the Health Authorities and creation of Local Health Groups and subsequent LHBs, meant that local health strategies became more significant for how HLCs could be positioned in local health systems or economies. Applications for funding were made prior to restructuring which meant that applicants had to re-engage with new sets of partners particularly with regard to health organisations. Where health organisations led applications, the officer took the project to their new location, in most cases as part of the National Public Health Service, but generally the same officers retained overall responsibility. In the meantime HLC leads, who were not part of the health service had to reconnect with new systems and often new people in their LHB. The requirement to undertake health needs assessments and develop and implement Health, Social Care and Well-being Strategies provided an opportunity for HLCs to play a part in realising local health objectives but presented a challenge, particularly to voluntary sector led projects, to make sense of the new policy environment and forge the appropriate relationships.

Another key issue was the positioning of HLCs in terms of their fit in the health and regeneration agenda. As a programme that was intended to be holistic in its approach, addressing the wider determinants of health and mobilising community resources, there are clear overlaps with community regeneration plans and activities. From the outset there was an expectation that projects in Wales would work with Communities First partnerships where possible. However, the extent to which this has happened has been varied and this has also had an impact on the extent to which HLCs have been seen as aligning with local regeneration plans.

This chapter will look at other factors in the national and local environment which may have impacted on the extent to which the work of HLCs was sustained or not. Local partners and stakeholders were not interviewed as part of this final phase evaluation but the analysis will draw on discussions in the policy seminar to explore some of these issues from a wider policy perspective.

5.2 HLCs and their positioning in health systems

As highlighted above, the HLC programme was introduced before the National Assembly for Wales (latterly the Assembly Government) was established, as well as significant change in the organisation of the NHS in Wales. However, there was a strong policy rhetoric around the priority of public health, particularly in relation to addressing the wider determinants of health and inequalities in health [34] [35] Commentators on devolution and its impact on health policy and organisation have noted the strong emphasis on localism and the development of structures which are not driven by national targets but by structures which were flexible to respond to the needs of the twenty- two LA and LHB areas. Other national documents such as *Better Health, Better Wales* [36] and *Well Being in Wales* [37] stressed the need for health to be recognised in all policy areas. There has also been a strong emphasis on 'active communities' and public involvement in public service delivery and development which is reflected in its community regeneration programme, *Communities First,* and in the more recent *Beecham Report* (2006) in terms of developing a strategic approach to developing citizen centred

[34] Greer S (2004) *Four Way Bet: how devolution has led to four different models for the NHS.* London: University College London Constitution Unit.
[35] Blackman T, Elliott E et al (2006) 'Performance Assessment and Wicked Problems: the Case of Health Inequalities', *Public Policy and Administration,* 21 pp 66-80
[36] Welsh Office (1998) Better Health, Better Wales, Cm 2922. Cardiff: The Stationery Office
[37] Welsh Assembly Government (2003) Well Being in Wales: A consultation document. Cardiff: Welsh Assembly Government

services. Therefore, the environment would appear to be conducive to a HLC programme which was meant to embody many of the principles heralded by the new Welsh administration.

In reality, the experience at the local level was fragmented. Although many HLCs were consulted as part of the needs assessment and subsequent Health, Social Care and Well-being Strategy for their locality, few felt that their work was recognised as a means of meeting local priorities and objectives. As highlighted in the UK programme evaluation final report[38], a supportive local statutory environment was felt to have a number of benefits in terms of the development of local service agreements for some activities, in-kind support from staff to apply for external grants and agreement to provide some resources to continue the HLC in some form. This was more likely to happen where the projects were led by a statutory organisation where there was considered to be a strong partnership between sectors that had a commitment to the inequalities or/and community health development agenda. Even where HLCs were unlikely, or did not plan, to exist after programme funding, a supportive and thriving Health, Social Care and Well-being partnership or Board was seen as a lever for building on some activities or capacity building work developed by the HLC. HLCs in areas with a strong health promotion team supporting the work of the projects also benefited by profiling the work with their LHB and in terms of developing new ways of working beyond the area or scope of the HLC itself.

However, strong supportive links are not a guarantee for future funding and ongoing support. One LA manager reported that the project has good links with local policy development and led, for example, the health and well being aspect for the Communities First partnership in their area, which provided the opportunity for conducting a health needs assessment. It was reported that staff have also been liaising with people in the LHB about how to use the health needs assessment to inform Health, Social Care and Well-being strategies. There are representatives from the LHB and LA on the partnership board and staff are managed by LA employees. Through these links, people have been publicising the work of the HLC and this has led to opportunities for HLC staff to give presentations about the project. This had not, at the time of interview and when contacted a couple of weeks before funding was due to come to an end, given rise to any funding opportunities.

> **Advantages of a supportive local statutory environment**
> Through having a base with the health promotion team, the HLC has strong links with the LHB and the LA is represented on the advisory board. The coordinator feels that the main link with the LA has been to ensure they know what the HLC has been doing so they can link their policies in with this. The HLC work has helped to inform policy development in the area and helped other agencies develop effective ways of working with local communities.
>
> *It's a bottom up approach, we've given them the skills and they're now in complete ownership of it, even though it was us who developed it.*
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> CS09
>
> The Health, Social Care and Well-being Coordinator is represented on the HLC partnership board and the HLC manager is represented on other boards throughout the borough relating to health and social work. The HLC also links to the local Voluntary Alliance, who are closely intertwined with the LA, to run community groups with

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[38] Hill et al (2007) op. cit

> community area representatives, and this information feeds up before it becomes policy. Locally they have also recently developed a new group to promote health and healthy lifestyles within the area, so staff are hoping this will be leverage for them as they help to fulfil these objectives through the work of the HLC project.
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> CS07

Another factor affecting sustainability reported by HLC staff was the view that the financial position of the statutory sector, particularly LHBs, limited the availability of resources. Many believed, though this was not backed up by evidence, that LHB funding was being used to deal with the financial deficit in NHS Trusts and with Trust Chief Executives having to meet targets on waiting times. In this context expectations that HLCs and their activities would be mainstreamed were felt to be unrealistic. Particularly at risk were HLCs, or aspects of their work, that were seen to be new activities or services, as opposed to new ways of delivering existing services, as there was considered to be few resources to commit to what were considered new ideas or initiatives.

The extent to which HLCs were seen locally as part of the Communities First agenda was also important for establishing the projects within local regeneration plans and activities. Projects worked with Communities First in a number of ways, by hosting local Communities First partnership meetings, representation on each other's advisory or partnership groups, leading the health sub-group, and joint working and capacity building. In one case the HLC staff and the Communities First co-ordinator were all employed by a registered charity which was a company limited by guarantee. The HLC co-ordinator line managed the Communities First co-ordinator and presented a report to all meetings of the HLC Association. Throughout the development of the project the work of Communities First and the HLC was difficult to disentangle. The relationship provided mutual benefits in terms of access to different kinds of resources and assets. Since programme funding came to an end the project has been led by Communities First and is a Development Trust operating as a company limited by guarantee. Although the HLC branding is unlikely to survive, the manager is hopeful that they will be able to keep the building and maintain it for community use as well as building on the joint work that has developed over the years.

A problem, however, where projects were seen as 'regeneration' or not 'health' was in engaging health leads to support the projects and had failed to secure any substantial funding or in-kind support. In another case it was felt that the LHB was unsupportive of both Communities First and the community level work that they undertook. Indeed, as highlighted earlier, the HLC programme has to some extent suffered from the lack of a 'home' within existing organisational structures. Where Communities First, health promotion and the HLC were felt to work well at an operational level, it was sometimes felt that they lacked an integrated approach at the strategic level. Another issue for HLC managers was that LA or LHB support for HLCs was not the same as support for what the communities want to see developed. It was the approach to engaging with communities that they were trying to sustain and not just the activities.

> Although the LA were the lead organisation I still feel that they are a long way off from securing the initiative in the way in which resonates with what communities want rather than fitting in with the LA's agenda.
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> CS21

Relevant here is a question that was asked at a policy seminar with people who had an interest in the future of the programme from a policy or academic perspective. It was asked that if we see these projects as things which are mobilising community resources and bringing together community resources, where is the locus of responsibility to support that sort of work? One participant argued that it ought to be in local government since the multiplicity of health determinants are under their control. However, this begs the question as to where in the LA. One participant argued that it can work but it depends on fit, and identifying an appropriate home within existing organisational structures. The example was provided of a Community Involvement Unit in Salford which is nested within the local strategic partnership and, after 5 years in existence, is now just about institutionalised and seen as part of the local strategic partnership team. However, as highlighted by the quote above there may still be issues about the willingness and capacity to support the work that is felt to be community led.

Another risk if these initiatives are positioned within LA structures is that health is positioned within the social services department. In relation to the prospects of the broad public health agenda, addressed by interventions such as HLCs, this was thought to be no better that being tied to health services. The best strategic position, it was argued by one participant, was close to the Chief Executive's Office and the most important relationship that exists is the one between the Public Health Director and the Chief Executive of the LA. It was felt that although we probably have the cross-cutting structures in place at the local level, the terrain is extremely complex, even for the people who work within it. If HLC managers are going to find themselves in any organisational or strategic home they need some anchor point or person who can tell them where they are, and where in the structure or the strategic plan, they fit. However, HLC managers were never appointed to have these kinds of skills, they were appointed to run HLCs. Some suggested that there is a need for resources and support in future programmes for individual projects to ensure that they have an appropriate anchor point within local systems.

In relation to the links that were established between HLCs and Health, Social Care and Well-being Strategies, it was pointed out that the very people within health promotion who may have helped to write the original bids may also be the same people who were fundamental in developing the local Health, Social Care and Well-being Strategy. For other HLCs there may not have been that home that could have taken them forward, since there was a fundamental disconnection between what they were doing and local strategic health development. Both the local locus and the nature of a project's connections to it are crucial. It was also mentioned that what may be thought of as 'homes' at the beginning of such programmes, such as Local Health Alliances, may no longer exist as these kinds of developments are also fragile.

> *Healthy Living Centres found themselves without a home but the home that they were in, and we all thought was going to last, like local health alliances also found themselves politically out of favour. So that locus where you thought you could get all these people together and the point that was trying to unite all these different initiatives actually was destabilised further along, so things didn't work out…. So I think that that is important learning for us as well.*
>
> Policy seminar participant

Finding a home – shifting priorities
The HLC coordinator feels that there has not been enough support, for example, when the partnership board was drawn up six years ago the individuals who signed may have been committed to supporting the HLC but they have now moved on and the

The seminar also addressed the issue of where such a programme would be supported at a national policy level. For some projects it may depend on having support from a specific policy area and a link was made to the Assembly Government funded Sustainable Health Action Research Programme (SHARP). [39] Some projects benefited from having the support of the then Minister for Education and therefore that policy area. However, at a national level, it was reported that there have been difficulties in getting other policy areas interested in the broad public health agenda within the Welsh Assembly Government, and that leadership is needed to get other policy leads to buy into this area of work.

5.3 Learning in health systems

Another issue raised in interviews was the concern that the learning of what works would disappear with the closure of projects and the loss of staff. This issue is relevant to sustainability as one way in which ways of working can be sustained in organisations is through organisational learning. There were examples hinted at earlier that some organisations had developed new ways of working as a consequence of the HLC projects. Factors which supported organisational learning were the relocation of HLC staff within the lead organisation, capacity building and training for service providers, development of training manuals or resources, and joint events across partnership organisations.

Learning from Healthy Living Centres
The manager is now a Health Promotion Specialist in the LHB's Public Health Team but works across the local authority area. Some of her work is with a Communities First area on the other side of the county and she can apply her knowledge of the activities and approach in the HLC to the work being undertaken there. In relation to the community food work she is encouraging residents and partners to link up and learn from people involved in the HLC's food co-op.

CS25

The issue of organisational learning and, in particular, partnership learning, was also discussed at the policy seminar and there was some concern that much of the learning that was held within these projects may disappear. There is also an issue about how, and whether, the lessons from programme evaluations are learned and by whom. The problem of how the knowledge and learning derived from such interventions could be utilised was discussed at length with very different views being expressed. On the one hand there were those who were idealistic about the prospects of learning from the experience of the programme (even if it was learning about the lack of learning from the HLC programme so that it would not be repeated in future programmes), and on the other there were those who were not optimistic that lessons would be learnt:

> *We can talk about how we learn lessons, the lessons are blindingly obvious and they have been for generations we just … We don't want to learn the lessons. The lessons*

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[39] Cropper et al (2007) *Community Health and Wellbeing,* Bristol: Policy Press

are simple. The people will always move on, this will probably always recur and there is no point in pretending that it won't, nor will all our fine words stop it from recurring. The best thing is to say at the outset that this problem will come, in 3 years or 5 years or whenever, you have this problem, you will not be able to sustain this work because the people who signed up to this in the first place will have gone or changed their minds, or will have moved into different positions when it is embarrassing for them to say that they still want to support this. So let's be clear about that lesson… Now I don't have any answers to any of that but, you know, I think we need to get a bit more honest about these realities if we are going to make any progress on these things. Because, we've all, I suspect, everyone in this room, has been here before and we will be here again.

<div align="right">Policy Seminar participant</div>

However, as one person argued 'cynicism and idealism are two sentimental extremes'. On the one hand it was felt that HLC managers have had to be pragmatic and realistic about the situation they find themselves in, but on other hand there needs to be some sense of idealism to drive people forward and try to make a difference. Furthermore, another participant argued, there is perhaps 'something about having a mandate to learn' and that requirement to learn needs to be embedded in community based programmes. It needs to be held in the organisational memory in some way and HLC staff should not be left with the responsibility of selling the value of their product.

The SHARP initiative was mentioned as an example which explicitly considered issues around embedding learning processes from the outset. For instance, projects had an academic partner and there was, it was argued, a strong commitment not to simply undertake research and publish papers, but to make sense of what was going on and to disseminate this. In addition, a network of learning support was established to ensure that projects could learn from each other throughout the process. Learning was therefore disseminated through mechanisms other than publications and books which may have had some impact on learning in policy and practices settings. It also ensured that although individual projects did have a responsibility to disseminate, they were given the support and the resources to do that.

Another participant recalled the NHS document *'An Organisational Memory'* but observed that in a world where there are multiple organisations with multiple memories, some kind of memory bank for partnership, or perhaps an impact social policy unit, is needed. It could possibly be run by a voluntary sector organisation particularly interested in the health of deprived populations, who could champion the cause in tracking the evidence on behalf of the many health, social care and well being and regeneration partnerships in the UK. In 5 or 10 years time, when new cycles of community initiatives are commissioned, there needs to be some kind of data base or memory bank to which organisations and their partnerships can refer. The Community Development Projects of the 1970s, then the biggest social action programme ever funded, was mentioned as an example of a programme that has been lost in terms of the lessons that were learned and ignored in terms of the development of the ideas for more recent community based programmes. In response to the point that systematic reviews tend to focus on experimental design evaluations and therefore miss out on much that is valuable in these kinds of intervention, it was pointed out that there is now a recognition by organisations such as the National Institute of Health and Clinical Effectiveness (NICE), that different forms of systematic review are needed to address this limitation. [40]

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[40] Kelly MP, Speller V and Meyrick J (2004) *Getting Evidence into Practice in Public Health.* London: Health Development Agency http://www.nice.org.uk/niceMedia/pdf/evidence_into_practice.pdf

Who needs to learn and where learning should be routed was also discussed. Learning, if it has any use at all, needs to be translatable into practice and therefore change the way in which things are traditionally done. One suggestion was that middle managers in health and regeneration organisations ought to be involved in seminars or workshops such as these so by the time they move to more senior positions they are already thinking differently. Politicians also need to be engaged in forums for learning about the potential impact of such projects, particularly advancing about how things could be done better in the future. Another point that was made was that across the public policy community there needs to be recognition that there are policies and practices beyond health services that can make an important contribution to health improvement and therefore the learning has to find ways that of reaching other sectors. In addition the contribution to health by other sectors needs to be understood by the medical profession itself and find its way into the training of doctors.

Asked how the learning from one LA/LHB area had been utilised and reflected in wider Health, Social Care and Well-being Strategy objectives, it was clear that the HLCs had had some influence on the sustainability of some aspects of individual projects. However, the learning was reported to be fairly tacit, facilitated by commitment within the LHB and support from their strategic partners who were, in some cases, able to take on parts of HLC activity after the project funding had come to an end. It was suggested that a distinction perhaps needs to be made between learning what works and the existence of 'champions' who are able to find ways of 'making the case' for the future of activities in a context where there is no new money to support them.

Finally, there is an opportunity for using learning from this programme, including the issues about how we continue to learn from such interventions, to inform current major developments. The development of a Public Health Strategic Framework for Wales (*A Healthy Future*) was seen as an opportunity to pick up on the work that has been done in Wales and the lessons of the HLCs programme could feed into this as well as the next phase of the Communities First Programme.

5.4   The Role of the Big Lottery Fund (BIG)

Shortly after funding the HLC projects, the Big Lottery Fund decided to set up four support and development programmes to help projects think about the sustainability of their work. In Wales this work was led by Momenta in partnership with the Wales Centre for Health. Although set up from March 2004, provision was not up and running until 2005. Following a scoping exercise, a Support and Development group provided a series of training sessions for managers and co-ordinators to support their efforts to sustain their work. They also supported existing networks in south Wales and organised a conference to showcase the achievements of the HLCs. While training sessions were felt to be of a high quality, many respondents felt that the support was 'too little, too late' and often too generic to be of value to individual HLCs. Furthermore, a conference to flagship the work of HLCs in Wales scheduled for January 2007 was cancelled due to a lack of interest from wider stakeholders. To respond to the need for bespoke support, grants of up to £5k for consultancy were offered from 2006 and in some cases were used for small scale evaluation reports.

On the whole, the experience of HLCs in Wales, as found elsewhere in the UK, was that they were let down in some crucial areas. Although recognised that BIG would not provide funds to extend projects and that some HLCs were intended to be short term pilots or capacity building programmes, a number of comments suggested ways in which the commissioners could have built in measures at an early stage that could have helped sustain their work.

In two HLCs, as their funding was running out grants were awarded to new initiatives in the area, the respondents suggesting that these would duplicate much of the work that they had

worked hard to set up in the first place. It was felt that rather than funding new projects which would have to start from scratch and make the same mistakes it would have been preferable to build on existing work.

Suggestions for additional support include practical assistance such as resources and guidance for undertaking evaluation, better feedback in terms of the monitoring reports that were submitted, local and national advocacy in terms of highlighting the value of the programme and making it visible, tighter requirements with regard to the commitments of partners in relation to sustainability plans and more sensitive commissioning of future projects. Some of these points were raised in the policy seminar and it was suggested that some of these issues have been addressed in subsequent programmes. For instance, larger strategic programmes are now required to outline evaluation plans in their bids and more funding is provided within the grant to support this process.

5.5   Conclusion

To conclude, although at a local level there were some opportunities for HLCs to secure their position in future strategic development, in practice a number of factors were levelled against them. These included structural changes which impacted on HLC partnerships, a lack of certainty about the role of HLCs and whose financial responsibility they were and a lack of capacity and structures for local policy makers and commissioners to learn from the experience of HLCs. Voluntary sector led projects were particularly disadvantaged in terms of 'reading' the local policy environment and making sense of local structures. Future programmes may like to consider ways in which project staff could be supported to become policy savvy as well as identifying ways in which local policy makers and commissioners could learn from the achievements of such initiatives.

Chapter Six: The legacy of the Healthy Living Centre Programme

Key points

- Although it is unlikely that many HLCs will exist as entities in the future and that the core activities will cease, it is clear that the programme has left an important legacy in many areas in terms of improved health, well being and skills for many individuals, new physical and social assets available to communities and some improvements in the quality of, and access to, services.

- It is important that this legacy is highlighted early enough to acknowledge the contribution of the HLC programme to these changes.

- However, the possibility of a negative legacy should also be recognised as local people and HLC users become resentful of the loss of a valuable resource. It is possible that this could have a negative effect in future efforts by public agencies to mobilise communities.

6.1   Introduction

The extent to which the HLC programme has been sustained as it was originally intended is, on the face of it, disappointing. Early documents clearly expected some of the initiatives to survive programme funding, drawing on funds from a range of partners. [41] Even where a HLC's work is sustained, it is likely to be with a much reduced resource and at some cost to core activities such as engaging with communities, facilitating partnerships, and developing new approaches to emerging issues, concerns and local aspirations. However, the respondents felt that projects had left, or would leave, some legacy for individuals and communities, in terms of services, facilities and activities, even if those were not always receiving sustained statutory support. Towards the end of project funding HLC managers reported that they, their staff and, in some cases their partners, had worked hard to find a way of resourcing and sustaining activities. Even where HLCs no longer exist there was a commitment to disseminating and 'celebrating' the achievements that they felt they had left as a legacy to the people and communities that they had worked with through glossy reports or celebratory events. Perhaps most interesting are areas of work that are currently entirely sustained through the efforts of local people. If sustainability is seen as the transfer or adoption of programmes into communities then there is some evidence that this has happened.

As well as benefits to individuals, some HLCs felt that their work had led to improvements to the social and physical fabric of their communities, such as helping to create cleaner or more attractive places to live, providing new walking paths or play facilities, improving relationships between different parts of the community and new places for people to socialise, learn or organise their own activities. Some HLCs also felt that they had left their mark on

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[41] Department of Health (1999) HSC 2009/008

other organisations to work more sensitively with particular population groups or with a better understanding of their health needs.

However, it was also suggested that there was likely to be a negative legacy as a consequence of the withdrawal of programme funding and this chapter discusses these as well as the more positive achievements of HLCs.

6.2 For individuals

The Health Monitoring Survey, the results of which were appended to the final report of the UK evaluation, was a longitudinal study of characteristics, health, lifestyles and attitudes of a sample of 1, 402 (at baseline) from 155 HLCs. After baseline there were two follow-up surveys at 6 and 18 months.   It is not the intention to repeat the results of the study here and there were certainly limitations with certain aspects of the methodology and interpretation of results. However, what was clear was that regular use of HLCs appears to have been protective of health and associated with significantly higher assessments of self-reported health and well being (see below).

> **HMS – Key results**
>
> - Deterioration in physical and mental health not found in regular users
>
> - Regular use associated with healthier lifestyles (smoking, physical activity and fruit and vegetable consumption). Alcohol an exception – no association
>
> - Regular HLC attendance associated with significantly more positive assessments of health and well being (physical health, mental well being, self-esteem, contact with people, feeling part of the community and hope for the future)
>
> Hills et al 2007[42]

Respondents were asked to report what kinds of benefits the HLC will have left individuals. Though not to be taken as 'robust' evidence in terms of prevalence, reach and significance, the findings do provide some indication of the kind of legacy the HLCs may have left as a result of programme funding. Though some doubts or misgivings were expressed as to how sustainable some of these changes would be respondents described ways in which they thought that changes may persist to some extent.

6.2.1 Improved health and well being

One way in which sustainability can be understood is in terms of the benefits to health which may have come about as a direct result of involvement in programme activities or through changes in their lives through new skills, knowledge and attitudes or being involved in new kinds of supportive networks, groups or friendships. Asking what legacy the HLCs may have left in terms of health and well being, respondents described a number of ways in which their projects had impacted on health. Although difficult to provide evidence, some local evaluations did try to put some numbers around health impact, particularly if they had been directly involved in activities. Most of these measured self reported health whilst others asked questions relating to visits to GPs or use of medication. For instance, one evaluation

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[42] Hills et al (2007) op cit

looking at a range of activities reported that 48% of people said that involvement in HLC activities had improved their health (CS25).

Health effects were described in different ways and varied according to different population groups. For example, HLCs that were aimed at older people's health described the benefits in terms of better mobility, more stability, and independence on the one hand and feeling safe, having something meaningful to do and the well being experienced through having someone to talk to on the other. One co-ordinator reported that through interviews and discussion with older clients, many of the beneficiaries have reported that they now look forward to going in to the day centre, enjoy being there and they now feel that they are important to people (CS11). More than any other group, managers feared that the benefits to older people well be threatened by any loss of resource to sustain the activities but felt that the small changes to some people's lives could persist for some time as a result of renewed confidence and physical improvements. Often these were felt to be small changes that had a major impact on people's lives.

> *One lady had broken her wrist and had gone for physiotherapy but it wasn't doing any good and she was in a lot of pain, so she went to the EXTEND class, she got back mobility in her hand, which meant she could then cut her food, which she hadn't been able to do and because she couldn't cut her food she wasn't going out for meals with the family because she was too embarrassed to go out and have her meal cut for her, and also, her granddaughters play in the national youth orchestra, and she hadn't been able to play the piano at home to accompany them, but she got back the use of her hand and it was such an important thing to her. Its things like that that make you think 'oh this has done good'.*
>
> CS13

Health as independence
The project has helped to reduce obstacles to health and wellbeing. Previously people had perceived day centres as a step towards residential care, but now people see it as a way of keeping independent from heavier care packages. By offering activities in centres that people are already attending, obstacles to access have been removed. In addition, there have been many more activities provided and given people the opportunity to do a variety of things that they did not have before. Information and advice workers have been involved with the project through Age Concern and have helped people with financial problems to claim the appropriate benefits. Subsequently, people are now more aware of what is available to them and have been able to increase their income. CS11

Others talked about impact on health in different ways but also about well being in terms of self-confidence, improved self esteem and improved levels of fitness. One respondent struggled to pin-point what it was about the walking activities that they supported that had made the difference to individuals but felt that some of the most surprising effects had been in terms of well being rather than just improved fitness. For volunteers involved in delivering the scheme the coordinator talked about a 'sense of being worth something again, the opportunity to learn something new and then make a contribution' (CS24). The advantage of the scheme was felt to be that it was about enjoyment and people discovering their connections to other people and their physical environment rather than a negative programme that focused on what people should not do.

> *One of the things I think is good about the environment, going out walking getting out into it is there's an immediacy in the sort of dose response in terms of I mean 'I feel*

better', it's also not about getting better through an abstinence program so 'don't eat the curry, don't drink the beer and don't smoke'. It's 'why don't you go and do something that you can do with your family, you know etc, so I think it's a positive to that extent, albeit....well I worry that it's a bit sort of apple pie.

<div align="right">CS24</div>

Since Walking the Way to Health schemes have continued to be supported at a national level, through the Sports Council for Wales and at a local level, the health and well being benefits of walking may well persist beyond the programme. Similar improvements to individual health and well being were reported for food co-ops, another programme supported at a national level.

6.2.2 Improved knowledge, skills and lifestyles

Another legacy of the programme was described in terms of the changes that individuals had experienced as a result of newly acquired knowledge and skills. For some the changes stemmed from a better awareness of health issues which HLC staff
provided, benefiting the respondents, their families and/or the wider community. For instance, better knowledge of nutrition and how to cook on a budget may benefit their own children. However, those respondents that spoke in didactic terms about the way in which these skills and knowledge were developed, were less hopeful than those who felt that they had worked participatively that these changes would be sustainable.

Didactic v Participative approaches to health knowledge and action

Didactic
The HLC has made progress in educating people about health issues such as physical activity and healthy eating, and made people aware how important these things are to health and wellbeing. Staff feel that they have worked hard to get messages such as 'five a day' or 'five times thirty'[43] across to the community, but are now concerned that these messages may be seen as somewhat less important when the HLC finishes. Staff have built up good relationships with local people and feel that without their presence in the local community, people may not take as much notice of health issues.

CS07

Participative
The main impact that the HLC has had for individuals has been through improving people's confidence and enabling people to gain new skills and knowledge. An aim of the project was to make policy and campaigns more realistic to people, for example, they promoted the 5-a-day campaign alongside the food co-op to provide them with the opportunity for healthy eating and to improve people's health skills.

'That's been the most important role for us really, you provide the information and you provide the opportunity for people and support them to undertake that change really

CS05

For most participants, awareness was a starting point to more complex processes of skills development. Some HLCs felt that they were able to build on that initiative by providing new resources and opportunities to sustain those changes.

Awareness and sustainable resources to support change
It has made a big difference to people's health skills and awareness; people were given pedometers through an inequalities in health project and are now walking more, there is a competitive element in who can get the most steps. People are now walking and meeting up together so this has helped people to socialise. For all the healthy food that is cooked, menus are prepared so people are able to prepare these foods at home and healthy buffets are provided for activities in the HLC. People have been saying that they are changing their eating habits and eating healthy food. There is also a gardening club which encourages composting and growing vegetables that are then used for cooking the healthy food e.g. stew, which is much cheaper and healthier than ready meals that people used to rely on.

CS14

The language of choice and responsibility, probably reflecting current political discourses on health, was sometimes used as a way of expressing individualised conceptions of lifestyle changes that could be sustained after the provision of programme funding.

Choice and responsibility - lifestyle
Staff feel that the project has had a significant impact on people's health choices, particularly with the involvement of dieticians, who have made people more aware of healthy eating

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[43] This refers to recent health advice to eat five pieces of fruit and/or vegetables a day and to exercise for 30 minutes at least 5 times a week.

issues without preaching to them. The dietician sessions have been particularly welcomed by beneficiaries as many people had queries about appropriate food to eat for medical conditions such as diabetes. Physical activity sessions have also been successful in enabling people to improve their mobility in a way that is enjoyable and easily accessible to them. The project aimed to give people information and choice to enable them to take control and responsibility for their own health.

<div align="right">CS03</div>

6.2.3 Soft and hard skills

Another reported legacy of the project was the development of skills which could be used in other settings such as in taking up new leadership roles or in the labour market. When talking about skills, respondents usually talked about the development of qualities and capacities such as confidence and self-esteem as a stepping stone to developing health skills which could impact directly on their wider social and economic prospects. In HLCs which encouraged volunteer activity, respondents told stories of people who had never been employed or involved in community activity but through the HLC had developed the confidence to seek further training and, in some cases, employment.

Skills legacy – three stories

All six local people who undertook training to become Community Mothers decided to go into formal education for social work and related professions. None had been involved in training previously.

<div align="right">CS16</div>

The HLC ran a first aid course which was attended by eight young mums; now six of them have set up a babysitting circle which enables them to go out and leave their children with people they can trust. Local people have begun to realise that they can make a difference in their own lives. For example, one girl experiencing depression was referred to the HLC for exercise class, which then led to her attending healthy eating sessions and has progressed to her becoming a crèche worker and undertaking a NVQ. It has given people a sense of worth, pride and community spirit by bringing people together and knowing other people are going through the same things.

<div align="right">CS14</div>

'People have been sign posted on to X College and other computing courses from that, so yeah there is that link and, or a good example I would say, is our admin assistant here, is a local girl. Story?… she started here on 8 hours a week and as her confidence grew we increased her hours, she gained qualifications, it enabled her to go through the business admin course through the council, and various customer care, and all the rest of it, now she's got a full time post in the health alliance, and she was on incapacity benefits before that and she's gone through job centre plus is it…and she's now not on any…that's just an example of someone who used to work here but its you know… a similar thing.'

<div align="right">CS17</div>

Other respondents reported individual changes that had led to wider community capacity changes. For instance, the growing confidence and development of skills for some people were ploughed back into the community by developing leadership skills such as leading activities, developing groups, bidding for future funding, lobbying on behalf of their community and public speaking.

Development of leadership skills

For some people it has made a big difference and they are now taking a lead role in development in the community. The number of people in this position is small but their involvement in lobbying for or flag-shipping the community has been impressive. The people in this position are not frightened to take on new things or to speak their mind. One resident

6.2.4 Friendships and connections

The social impact of HLC activities was often seen as the most surprising and striking. Well being through social interaction, even in activities that were aimed primarily at improving physical fitness, were often seen as the most important health benefit though it was considered difficult to provide robust evidence of these impacts. One legacy that some HLCs felt that they would leave was new friendship groups and social networks. The development of more formal groups is discussed in the next section but in terms of a legacy for individuals, the provision of new opportunities to make friends and to reduce a profound sense of isolation was felt to be important.

> *There seems to have been a big impact socially in terms of getting people out of the house, getting people to interact with other people, getting them to feel better; that's been probably not foreseen in terms of how much that would take off, and also confidence building and health in that sense.*

CS02

These benefits may be sustained in a number of ways. They may be self sustaining through the creation of new friendships which will survive the original opportunity to meet; it may be through using existing facilities or new facilities established in the community; or it may be through new community activities which will continue to exist locally once the programme funding ends.

6.3 Legacy and community change

In this section we identify the extent to which the HLC programme could be said to have left a legacy in particular communities by providing new physical and social resources that may support health and well being or by strengthening and supporting the capacities of communities themselves to drive change forward.

6.3.1 Physical resources

As highlighted earlier, physical centres and some hub and spoke models had a valuable resource to leave their communities. Although the future of these buildings is uncertain there was hope that these would remain in community use. In two cases there was a legal obligation for the new buildings to be in community use for at least twenty-five years. In some other cases it was felt that LAs would be reluctant to lose access to buildings that had had relatively good use and provided community benefits and/or a valuable base to co-locate services. These buildings were seen, in themselves, as providing a means of sustaining some of the activities developed by the HLCs as well as providing a base for social interaction and organisation. They also provide a place from which local people can access information on traditional health messages, about other health related activities or other community information.   New community cafés were reported in four HLCs providing a new social hub and an informality which was said to make people feel more comfortable. These buildings had also had an impact on the way in which organisations had worked together and it was felt that this could continue so long as there was not too much change in terms of the use of the building.

New Buildings: a focus for community and service activity

The HLC has been able to impact upon the way organisations work together. People now collaborate instead of working in isolation. There have been many local groups e.g. kitchen clubs, dancing that would not have been set up before the HLC existed, some have been set up directly by the HLC, and others just use the HLC as a building to meet. Without funding for the building it would be very difficult for the social groups to continue because there is a lack of other suitable venues in the areas, and people do not want to go anywhere else. The centre has become a base and is central as part of people's talk in the community.

CS14

The community now has a modern building with a café, computer suite, library and training rooms, which they did not have before.

CS19

Most other HLCs had, to some extent, left a legacy in terms of improving existing community venues through minor upgrades and/or the provision of new equipment such as

improved kitchen facilities, computers, or improved disabled access. In some places HLCs had help to improve play facilities for children such as the provision of a youth shelter and a skate park. Finally HLCs reported connecting people to the facilities and making better links to existing provision such as leisure centres, support services and social groups

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Improved access to local facilities

As the parent groups have been held in the local leisure centre, awareness of the range of activities that go on there has increased, making people more aware of the variety of physical activities they and their children can participate in. The work of the HLC has also benefited the community through helping to link young people with the council in the design of a new skate park. In addition, the HLC established drop-ins, which previously did not exist, enabling wider access to health-related information.

<div align="right">CS12</div>

They have made good use of existing facilities throughout the estate – particularly the youth club and the leisure centre. The HLC helped to make people aware that there are buildings and facilities that they can use in the area. X House now provides a new building for older people that would not have been there otherwise.

<div align="right">CS20</div>

6.3.2 Development of new community groups

The strengthening of the local community infrastructure is seen by many HLCs as a key contribution that HLCs are making to their local community or neighbourhood. A focus on 'community capacity building' was made explicit by many HLCs throughout the evaluation. The Home Office Civil Renewal Unit has defined community capacity as:

> *'activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and leading roles in the development of their communities'* [44]

One important legacy of the HLC programme could be seen in terms of the development of community led activity. As highlighted earlier, there was disappointment in some areas at the lack of activity that was really led and continued by local people but there have been some impressive examples of community leadership in terms of people developing, leading, running and bidding for new activities. For example, in one HLC that finished in 2006, the respondent reported that some of the social groups had been determined to continue and still do with one group in successful receipt of funding from the BIG People and Places programme. Another HLC helped to set up a group before it closed, which had strong resident involvement and a remit to deliver and seek funding for projects which impact on health and well being. Where HLCs still operate as physical centres, local people are represented on the management groups looking to secure their future. In some projects HLCs have helped to create a volunteer workforce and identified 'champions' willing to take on and lead new activities.

Building a sustainable volunteer workforce

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[44] NCVO (2005) Briefing on Firm Foundations - the Government's framework for community capacity building http://www.cvsrd.org/eng/docs/Connections%20and%20Communities/firmfoundationsjan05.pdf

Groups that are self-sustaining will be continued by the people who have been attending the groups, and staff have found that there is often one person in a group who is willing to take on the running of it. HLC staff have approached people that they think would make good leaders and have provided them with training and support, gradually reducing their involvement with them so they can work independently.

CS10

HLCs feel that they have also been responsible for less formal social groups which meet for a range of social and educational reasons. These are self organising and sometimes apply for funding or contribute a small amount for occasional outings or treats. Particularly noticeable were the creation and anticipated continuation of luncheon clubs for older people, some of whom in the past did not have an opportunity to meet with others.

New informal social groups and networks
The HLC has helped people to develop groups and activities for themselves, such as the 'You and Me' *(not real name)* coffee morning where they have set up a community group and have gone on to undertake a women's history course. Through activities, people have also benefited socially by meeting people they wouldn't have known before and this has helped to build social networks and reduce isolation. This is particularly apparent in the led walks which are predominantly attended by older women and by young mums who had previously felt isolated and did not want to go out and exercise alone.

CS05

Areas where lunch clubs have been set up have seen significant community benefits, by bringing together people who are often forgotten about, who are now in similar situations and facing the same sort of issues. These groups are well attended, with one weekly lunch club seeing around eighty people. This provides a good opportunity to give older people a voice and for other agencies to access their views and opinions. Activities have helped to pull communities together, as in some lunch clubs people from the youth club work to serve the older people, and this has helped to reduce stigma and improve integration between groups.

CS07

The HLC has helped to establish local groups and networks, for example they recently started a walking group from a disparate group of people who had been accessing projects at the HLC and this has become a constituted group so members now run it themselves. The HLC has also helped people to make new social contacts and reduce social isolation by bringing people together for activities.

CS16

6.3.3 Improved relationships within or between communities

Some HLCs aimed to build social capital within communities, focussing on the social fabric and relationships within communities rather than individual health or community resources.

As a legacy, individual HLCs may not have had time to make any real or sustained impact, although the legacy of other aspects of the project may be a factor in helping to improve the quality of relationships within and between communities. Smoothing community tensions was a particular focus of many of the HLCs based in Northern Ireland where sectarian violence had destroyed relationships between people in Protestant and Catholic communities. [45] Though not dealing with the same level of conflict, HLCs in Wales that were focused on estates or neighbourhoods often highlighted the territorial nature of the places in which they operated. At the very least, the projects helped to bring different groups of people together who may not have had the opportunity to meet and interact. In addition, in some areas, including some of the projects focusing on older people, activities were directed at improving intergenerational relationships with at least one HLC winning national recognition for this work.

Improved relationships between groups

The two wards that the HLC operates in are quite different and people do not tend to travel to the other area for activities. Whilst staff feel that they have not had enough opportunity in a relatively short space of time to improve relations between the two areas, the project has helped individuals within those communities to mix with one another and break down barriers between different groups. Activities provided by the HLC were previously unavailable in the area, and activities such as 'Walk for Health' have helped people to go out and enjoy their local area and visit local sights.

CS06

Staff have worked hard to break down barriers between the three areas of the community and encouraged people to mix, which has led to the formation of inter-generational social networks.

CS10

There are three schools close by who can all access the HLC and bringing the children together in this way has got rid of rivalry and encouraged them to get along together.

CS14

6.3.4 Cleaner, safer and more attractive environments

Most locally focused HLCs developed some kind of environmental project with two setting up self sustaining environment groups with responsibility for improving the local environment and setting up small planting and garden improvement projects. Other HLCs, particularly in partnership with environmental groups such as Groundwork, helped to develop walking paths which, in turn, were reported to have had some impact on the way in which people use their local physical spaces. Green Gyms were also set up in some areas and one HLC reported that this was now self sustaining with two local people being trained as Green Gym leaders. Other HLCs reported that they had made efforts to improve the appearance of the area with litter collection reported to have made a contribution.

Some HLCs felt that local evaluations and comments from local workers and people suggested that they felt a new pride in the area and that it was a better place to live. Other evidence to support this was reduced vandalism to community facilities and, in one case, the fact that there were no longer any void properties on the estate but, instead, a waiting list to get onto the local housing list.

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[45] Institute of Public Health in Ireland (2007) Evaluation of Healthy Living Centres in Northern Ireland: A Summary. http://www.inispho.org/phis/catalogue/resdetails.php?resID=1333

People will now come onto the estate, people will now walk the streets without fearing for their lives because of the stigma that was attached to the place, but now there's no problem with that at all.

<div align="right">CS14</div>

6.4   Improved quality and access to services

A key element of the HLC programme was that it should provide the basis or focus for new ways of promoting health and addressing inequalities by improving quality and access to services or by bringing together partnerships so that services are provided in a different way from that which they have traditionally been provided. Although the extent to which the programme has transformed the way in which services address these issues has been disappointing, there have been a few examples where services have reshaped their provision or have agreed to take over aspects of work that may have been piloted by the HLC. In addition there are indications that new forms of service connections have been made allowing them to be provided in a more 'joined-up' way. However, the most frequently cited way in which HLC managers reported that they had impacted on services was through developing the capacities of individuals or organisations to deliver them in a more appropriate way.

In terms of mainstreaming new approaches to service provision the most dramatic example was that of the take up of a new form of play work that had been piloted throughout the life of the HLC.

Mainstreaming of play work

The respondent felt that the biggest impact has been on children between 4 and 11 because there was nothing for this age group previously. Now there are a number of structured activities. The play work based in shipping containers in the local park took advantage of, and revitalised, existing play spaces rather than in more traditional play centres or after-school clubs. They run a wide range of outdoor and covered activities after school and in holidays. This work is now funded by the local authority and has been extended to another area in the county.

<div align="right">CS25</div>

Local food related activities were particularly successful in being taken up or supported by mainstream services. Whilst food co-ops tended to be run by local people these were seen as an opportunity for other services to deliver more effectively. For instance, dieticians and Surestart services in some areas saw food co-ops as opportunities to create bridges with other work they were doing in relation to supporting families to gain skills in healthier eating. In other areas cooking classes were piloted and have continued to be run by local providers. One respondent highlighted their Get Cooking project as an activity that would not have been taken up by other services if the HLC had not piloted it first.

Three HLCs reported that their work had highlighted gaps in current provision in mental health services or older people's services. In one HLC, which has since closed, it was reported that the LHB has employed a new physiotherapist because of the demand that was uncovered.

The actual work we've done with the physios coming in and doing falls prevention talks has actually established now within the local health board that there is a huge need, and it's actually now acquired for the physiotherapy department extra money to

employ an extra physio, purely on those grounds because it's been so successful.

CS03

The greatest legacy that the HLCs felt that they had left in terms of improving services was in building the capacities and awareness of the health issue or population with which they were concerned. Some HLCs had encouraged placements on their programme from students on health and social care courses, New Deal schemes as well as young people from secondary schools on work experience placements. In some cases HLCs reported that those students reported an interest in being involved in community development work as a consequence of their involvement.

Capacity building was undertaken through training but also through joint working. For instance, one HLC had engaged with GP practices and developed protocols to enable them to identify carers and to then refer them to the carers' organisation. One GP was reported to have been good at referring and in helping to raise awareness of carers' issues in their practice. On the whole, however, involvement with primary care and GPs in particular was thought to have been very disappointing throughout the programme in Wales and so a legacy of partnership working between community health development and primary care is likely to be very limited.

Capacity building through joint working
Staff feel that community development workers have developed new ways of working with the community through face to face engagement, and have helped to make health a priority. The work has also helped to link organisations with the communities they would like to target and helped to link agencies with one another to promote partnership working. The development workers have helped to bring previously segregated groups together in order to form health and wellbeing groups and look at how they can collectively address health issues. These groups are now taking over a lot of the projects set up by the HLC.

I think they (organisations) work differently as a result (of the HLC) because they suddenly realise that all these other organisations are out there who they can tap into, which they didn't know before.

CS09

Other HLCs spoke more generally about the legacy that partnership working may have left in terms of a better notion of tackling issues of common concern together. At this stage, it is not possible to assess the extent to which the partnerships that were established through the HLC are likely to be sustained if the core functions of these schemes no longer exist.

Building Capacity through training
The HLC has helped to build the capacity of other organisations through providing training e.g. Surestart and a local mental health organisation, who have then trained their workers in healthy eating so they can carry out sessions and provide information to their own group of

clients. In addition, HLC staff have provided cultural diversity training for local workers to help create a better service for minority ethnic groups.

CS06

Regarding the breakfast, snack and lunch clubs currently run with Surestart, HLC staff have provided training for Surestart staff e.g. food nutrition qualification to enable them to continue, with a small charge to parents.

CS07

The work of the HLC has also had an impact on other agencies; by increased awareness of available facilities and services and by providing training for staff from other agencies (e.g. YMCA), whose own agencies would not have provided training.

CS12

Finally, some HLC managers, particularly in projects that were led by voluntary organisations, felt that the programme funding had developed their own capacity to understand and address health related issues. Some of these had not focused on health as a priority previously and it enabled them to look in different ways at their core activities. Two HLCs described how the programme has impacted on everything that they now did as an organisation. In one, health impact was mainstreamed through everything that the community organisation leading the HLC did, which included evaluating all their activities in terms of possible health outcomes.

Programme funding as a catalyst for organisational change
Initially HLC staff pushed people who were already working in the area to make the HLC a part of their work and they have now taken a lot of the work on themselves, which has been successful in terms of sustainability. To begin with there was some resistance from other groups because the HLC had a totally different way of working in terms of monitoring and evaluation, but now people have seen the value of this and have adopted it into the way they work.

CS16

6.5 Negative legacy

Although the HLCs were keen to highlight the achievements of the programme they were also fearful that the withdrawal of the human and financial resources that the programme provided could have some negative impacts. Managers have been aware from the outset that the Big Lottery Fund would not provide continuation funding but it was felt by some that they had been misled by messages that mainstream organisations and their partners would be willing to take over the running or funding of the schemes. Even where HLCs were set up as time limited projects, respondents felt that the expectation that new ideas or activities would be inherited by communities, services or though partnerships of these, was over optimistic.

In terms of a potential negative legacy respondents highlighted a number of issues, including: the loss of the trust that had been built with communities and the possible loss of motivation to re-engage; the waste of resources in terms of skills and knowledge that have been built up through the programme; the inability to benefit from the programme fully if staff leave early; and the impact on lead organisations to function effectively if demand has increased.

In terms of the impact on the community, some managers felt that many of the advances they had made in terms of health could not be sustained. In particular it was felt that older people

may suffer a greater sense of loss as they were more likely to feel dependent on the range of support that they had been offered. In some cases managers also felt that particularly hard-to-reach groups may again fall through the net as the HLC was seen as a trusted organisation that had built up the skills and trust that statutory organisations were unlikely to have.

> *I think probably the worst thing (resulting from loss of funding) is the fact that we know from the coordinators and from what they were telling us at steering group meetings, we know that they did reach people who either weren't on the books of the* [health service] *team, or who would come into a place like this, and if you're not on anyone's books you're not really getting any service at all are you? We know that those people exist because we've had other projects that have identified the same thing, and those are the people I think are going to suffer the most from the project having ended because they had the contact of their coordinator and they had the contact of the volunteers.*
>
> CS02

One respondent reported that she wished that she had never taken the project on. She felt that they had built people's expectations and developed relationships and now they will not be there anymore. She believed that for some people the project had become a big part of their lives and that it was going to be taken away from them. 'It's become like a family hasn't it? The project is theirs.' CS20

For this same reason it was felt that this relationship would also be missed by service providers as they will not have the same access to possible beneficiaries that they currently enjoy and will have to form contacts themselves. Statutory organisations, it was felt, do not have the same relationships with members of the community

> *We're very active in getting hold of all the agencies and telling them where we are and what we're doing, and they like that because that saves them going out looking for groups, so it ticks all their boxes because they have a commitment to go into groups of older people, so they're going to miss us for that.*
>
> CS03

In addition, where HLCs that were visible and had been established in the community were to close or to change their purpose, this would risk damaging future relationships between public agencies and local communities.

Negative impact on community relationships

The coordinator feels that if this project was to end, there would be a huge impact on local people, as they will no longer have the opportunity to try new things. She feels that there has already been damage caused by the removal of a previous community-based project in the area, and this would compound the negative feelings towards the local authority by taking away established relationships, making it increasingly difficult to establish any similar projects in the future. Staff have found that a lot of work has to be undertaken to build up relationships, but there are no funding opportunities for these essential core posts. They contend that the value of community development and health prevention work needs to be recognised by the statutory sector and in funding opportunities.

People with the purse strings need to recognise that these things take a while and if they want to reach people with what seems to be the correct approach of community development, it needs time.

The manager is concerned that people in the area are used to projects being set up and taken away, which meant they encountered some initial resistance, and with the closure of this project it is likely to make it increasingly difficult for any future projects to do similar sort of work

CS06

The trusting relationship that HLC staff had worked hard to build up with young people will be lost, and staff are concerned that young people who regularly visited the HLC office for help and advice will now not know who to turn to. Whilst some activities may continue, the lack of a coordinator role will make it difficult for other groups to survive. It will also mean that there is nobody to get people together and start new groups, as it can be difficult for new people to join established groups, yet the need for this kind of support remains. In addition, the loss of a central coordinator means there is nobody to push issues forward or to try and reach out to other marginalised groups.

CS12

Some voluntary organisations suggested that the loss of funding may have an unanticipated impact on their own organisations because the programme has increased demand or raised an issue for the organisation that they felt they now had to address. For instance one HLC has had so many referrals to their organisation that without extra resources they feel they cannot provide an adequate service.

Loss of knowledge

The coordinator feels that it has been a rewarding and enlightening project, showing that the simplest of activities can have an impact on people's health. The project has helped to strengthen working relationships between the HLC and other organisations and staff have learned more about older peoples needs. However, she is concerned that the knowledge will be wasted if they cannot find funding to continue the project.

It's going to be a great shame if all those lessons learned are going to be lost, purely for the fact that somebody won't put their hand in their pocket.

CS11

Finally, it was felt that the knowledge that had been built up though the programme would be lost as staff move to other jobs and the memory of the projects within organisations diminished over time. Furthermore as projects came towards the end of funding staff started to leave as they needed to secure their own position in the labour market. This meant projects risked 'fizzling out' rather than having a planned approach to knowledge and skills transfer.

However, one HLC remains optimistic about the future and felt that with good planning there was no reason for communities or services to become dependent on the resources that programme funding offered. Staff believed that they have not created any expectations that they will not fulfil, as their health promotion team will be able to provide some training and support when the HLC finishes.

I don't think people are relying on us, I think they're glad to have us around short term to maybe guide them onwards with the ways they can continue to work then.

<div align="right">CS09</div>

However, although this HLC is different to the extent that it is almost entirely based on capacity building, the responses reflect some of the optimism of other HLCs when they still had at least 18 months funding to run. This HLC will be the last one to finish under the programme.

6.6   Conclusion

Although it is unlikely that many HLCs will exist as entities in the future and that the core activities will cease, it is clear that the programme has left a legacy in many areas in terms of improved health, well being and skills for many individuals, new physical and social assets available to communities and some improvements in the quality of, and access to, services. It is important that this legacy is highlighted at a stage early enough to acknowledge the contribution of the HLC programme to these changes. However, the possibility of a negative legacy should also be recognised. Whilst it is right to hold a cautious interpretation of these fears, since HLC managers may have a vested interest in being critical of the loss of continued financial support, the points made above have some support in the broader literature on community based initiatives. [46] In particular, earlier HLC evaluation reports documented the focus on building relationships and developing trust with marginalised groups and neighbourhoods. Unless mainstream services themselves are able to rekindle or support these relationships in the wake of HLC closures then respondents are right to highlight the potential difficulties in community/public service relationships in the future.

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[46] Shediec-Rizkallah, M. C. & Bone, R. L. (1998) op cit

Chapter Seven: Conclusions and recommendations

7.1   Introduction

This chapter sums up the main factors that facilitated or hindered the sustainability of the programme from the perspective of HLC managers. It concludes with a number of recommendations for three groups of potential stakeholders: national and local policy makers in Wales; future commissioners of community based interventions for health; and applicants and/or managers for future projects in similar programmes of work. It is recognised that it is too late to support most HLCs now but the learning should be reflected in future programmes.

The big question with regard to the sustainability of the programme is whether the approach embodied by HLCs as a way of improving health and addressing inequalities has survived. Initial statements of what the programme could do in terms of creating new ways of addressing local need through partnership and through mobilising 'community' resources seem to be limited. There have been individual examples of where particular activities are being led by communities and supported by diverse partners and even where community representatives have taken a lead in delivering activities, raising funds or in managing the future of what may be left of the HLCs.

However, the HLCs programme has made little long term difference to how 'things are done' in public health.   HLCs were meant to be accessible to the 20% of the most deprived in the UK population but it is difficult to assess whether substantial changes will be made to the long term health prospects of that same population. If the experience in Wales is similar to other countries in the UK it is also unlikely that many HLCs, as a sustained holistic entity, will be available in the long term. There are a variety of possible reasons for this, including: a change in focus and priorities in public health away from community-level approaches to address health inequalities; lack of flexibility in existing health structures to accommodate HLCs as an idea; lack of financial resources in the health system to redirect existing funding; a lack of a strategic home for cross-cutting programmes of this kind; and a flawed theory of community capacity.

Other commentators have warned that localised solutions in the context of economic instability and increasing inequality could contain problems associated with deprivation rather than address them[47]and that a system so entrenched in a disease model of 'health' may be unable to accommodate the conceptual paradigm shift from pathogenesis (disease or ill-health) to salutogenesis (positive health) underlying community well being projects.[48] More recent research highlights the reluctance of primary care organisations to see local people as experts on their local health problems.[49] Respondents reinforced the view that the cultural changes that HLCs aimed to shift in communities and services may take generations to

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[47] Ilife S (1999) 'Pioneering or engineering/', *Health Matters,* 38, pp14-15
[48] Scott-Samuel (1997) 'Health through co-operation.' *Lancet,* 349 p746
[49] Peckham S (2004) 'How the NHS risks ignoring the health experts'. *Health Matters,* 56 p8

achieve.[50] In the face of such structural and conceptual barriers the programme could well be seen as surprisingly resilient in the face of such adversity.

This study demonstrates that there may well have been factors that enabled some elements of HLCs to survive. Indeed, it is still possible that some HLCs will survive as entities although it remains to be seen whether they will embody the same principles and maintain similar objectives. There is no definitive set of ingredients for sustainability. Much depends on the receptivity of wider health and political systems to support such programmes and there will be different sets of factors depending on who the lead organisation is and particularly whether they are a statutory or voluntary organisation. However, sustainability also depends on a well thought out sustainability plan from the outset as well as the skills and capabilities of HLC managers, staff and partners in the implementation phase.

7.2   Factors relevant to sustainability

There were factors at the design and implementation phases as well as the wider local and national health economy that facilitated the sustainability of HLCs, their activities and ways of thinking.

The application stage was crucial in terms of both developing a theory of change, as to how programme resources may result in some desired change, as well as considering how projects, their activities, their ways of working and/or their underlying ideas may survive into the future. It also helped if all partners had a clear role and a responsibility for the long term prospects of the project. Having strategic support with partners able to influence future commissioning was more important than having operational partners, who were important for the delivery of new activities. There were different risks attached to whether a HLC was a physical centre or virtual but what was important in terms of sustainability was a core resource or set of ideas to which the partnership was committed and over which they had some ownership. In some cases it was the history of partnership working before the application that maintained that commitment beyond project funding. Management structures could make a difference. There was some evidence, for instance, that secondments from health organisations, particularly public health, could help to develop the learning from the projects to other geographical locations or population groups after funding had finished. However, in many cases core staff were made redundant with the loss of valuable learning and skills to the organisation and local population. However it may also be the case that the skills of some staff, and indeed local volunteers, have been reinvested as they moved into other community based projects.

It was clear that HLCs led by a statutory organisation had better prospects of sustaining elements of the projects as they could be aligned with their own local health objectives, although a more arms-length approach to the operation of the HLCs meant that managers and staff could be more flexible and take risks in ways that were felt to be more acceptable to local communities. The readiness for statutory organisations to accept some level of risk in terms of deviating from the way in which things are usually done may therefore also be important.[51]

In terms of the implementation phase, the skills of staff were key to the prospects of sustainability. Though often not a key part of their job descriptions, HLCs that had a member of staff, usually the manager, who had skills in communicating with key strategic

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[50] Salisbury C (1999) 'Healthy Living Centres' *BMJ,* 319 pp1384-1385
[51] Pluye P et al (2004) op cit

stakeholders or who had good fundraising skills were crucial. The efforts of partners were also crucial with one HLC in the final stages emphasising the role of partners in securing resources or support from their own organisations to sustain elements of their programme. Where the structures were put in place for partners to consider sustainability from the outset, this was also an advantage. This was not only for instrumental reasons to find ways of securing future support but because partnership steering and advisory boards were a way of communicating, disseminating and motivating stakeholders who may have been crucial for securing longer term support.

A multi-agency steering group responsible for overseeing and agreeing the terms of reference for evaluation was also important. There was a lack of local evaluation in the programme but this may actually be less important than having a partnership group to agree what kind of evaluation, or evidence of effect, is required. As one manager said their multi-agency advisory group were the translators of the evaluation and they were able to act on evidence as it emerged rather than being passive recipients of a final report. Finally, training and capacity building coupled with securing resources to sustain ongoing work throughout the projects made it more likely that local people, users or local services would themselves sustain some changes in their own lived or working environments.

 No matter how well a HLC is planned and implemented, factors in the local health economy or system also impact on the prospects of individual projects. Those LHBs and LAs that declared support for community health development approaches in their Health, Social Care and Well-being Strategies were in a better position to secure support than areas which did not. However, this support must be seen in the context of other pressures and the financial position of LHBs and LAs to provide support. The voluntary sector led HLCs were at a clear disadvantage in the context of changes in the policy environment. Strong relationships with statutory partners at a strategic level were important in reading the opportunities inherent in the local policy environment. HLCs which spanned a number of LHB/LA areas had the added difficulty of negotiating several local strategic relationships whilst the challenge for very local HLCs focusing on one neighbourhood or estate was to demonstrate the value to overall health and/or regeneration objectives.

7.3   Recommendations

Programme evaluation provides an opportunity for learning as well as demonstrating 'what works' in interventions. Although there are general lessons from this evaluation it has also raised a number of issues which are relevant to specific audiences. Below is a set of key recommendations to inform the development of sustainable programmes in the future.

7.3.1 National and local policy makers

- The evidence of national and local policy learning from the HLC programme has been limited despite programme level evaluation, and some at project level. A review of the effectiveness of policy learning approaches which considers both evaluation approaches to community based public health programmes and other methods of knowledge transfer should be considered. Future programme evaluations need to reconsider what needs to be done to maximise learning at project and programme levels.

- The role of community development/civic renewal approaches to public health should also be reviewed in the context of this and the experience of similar programmes in Wales. In particular an assessment of the readiness and capacity of national and local structures to support these approaches as part of a health improvement and

inequalities strategy would be suitable given current activity in developing a public health strategic framework. Other aspects of the review could include the human, organisational, and financial resources required to sustain these approaches, the roles and responsibilities of different policy areas and the place of evaluation in distinguishing between successful and unsuccessful approaches.

- Project staff found it difficult to demonstrate the value and impact of their projects and there appeared to be a lack of discussion and agreement about the criteria for success and how that could be captured. In such a diverse programme where the emphasis was on responsiveness to local health need and aspiration the development of a common data set is unrealistic. However, the development of a potential basket of indicators from which project staff, their partners and local stakeholders could draw on would be of value in assessing the success of projects in similar programmes. Particularly useful would be the development of well being indicators as this was an area that the respondents felt was particularly successful but was ill defined and difficult to demonstrate.

- While there have been a proliferation of community based projects and activities funded locally and nationally in recent years, it is not clear how these work together and indeed if they are working synergistically or antagonistically. In particular, the experience of working with Communities First partnerships has varied. Research which maps the distribution, relationships and synergistic effects of community-based programmes and projects relevant to health improvement is overdue.

7.3.2 Commissioners of similar public health programmes

- Programme evaluation is key to learning how programmes work and what they deliver. Commissioners must consider how evaluation can be used iteratively from the outset and support efforts to sustain successful elements of the programme. In particular commissioners are urged to consider the following:

  o to build evaluation into funding arrangements on an adequate scale
  o to provide ongoing support from the outset
  o consider clustering evaluation efforts to maximise learning rather than spreading scarce resources too thinly
  o to ensure teams have skills mix as pre-requisite for funding
  o to clarify nature and level of partnership commitment to evaluation/knowledge transfer arrangements

- Commissioners should consider other methods of learning throughout the programme. This may include the support for a network to encourage peer learning and local dissemination events through the programme. Although there was some networking in south Wales this was given formal support fairly late into the programme and only benefited some projects.

- Commissioners should consider ways in which requirements for considering sustainability could be made stronger, guided by a better understanding of sustainability, its different meanings and informed by the factors that are likely to be important in the initial design and orientation of projects. In particular the roles and responsibilities of partners in ensuring the sustainability of successful projects should be made clear from the outset and regularly reviewed.

7.3.3 Applicants and managers of similar community level projects

- Clear agreement on definitions of sustainability and the opportunities and risks of different sustainability strategies should be considered from the outset with partners.

- The roles and responsibilities of different partners should be agreed at the application stage. Having partners on board who have some strategic influence will be important particularly for voluntary sector led projects who will need to understand and realise opportunities in a changing policy environment.

- Applications need to ensure that core staff are appointed with skills relevant to sustainability such as good communication skills, an understanding of local policy structures, fund raising skills, research and evaluation and so on.

- Good sustainability management from the beginning is likely to benefit the long-term prospects of individual projects. Project managers should ensure that there is a group to consider and operationalise a sustainability strategy from the beginning. Members of this should include stakeholders who have a strategic interest in the outcomes of the project and have some influence regarding its future beyond core funding.

Appendix

HLC Programme Policy Workshop held on 13th September 2008:
Observations from the chair

Four points remain with me from my observation of this day. The first was the willingness of a number of senior managers and policy makers to attend this meeting, and discuss the implications of healthy living centres for future policy in Wales. The second was the difficulty, or challenge, of finding an appropriate the right balance, between idealism and realism (or even scepticism) when talking about the kind of activity that HLCs represent. The third key issue was the importance – and difficulty - of finding an appropriate approach to evaluation of this kind of initiative if they are to find a permanent place in public policy. And finally, there remains a real difficulty in ensuring that learning from relatively short term initiatives of this kind being taken on board and informing future policy decisions.

The level of engagement in this seminar to discuss findings from the evaluation of the HLC programme by those tasked with making key decisions in the area of public health was in marked contrast to difficulties in getting this level of engagement elsewhere in the UK. There appears to be a genuine interest in understanding the lessons arising out of the experience of centres in Wales, and a genuine concern that most have been able to maintain their core functions given the present constraints of funding across the health service. The strong commitment in Wales to community engagement and cross sector working is probably an important factor in the level of interest in healthy living centres, as well as current concerns about public health issues such as rising levels of obesity. However, the lack of strong policy in Wales commitment to, or targets for, tackling health inequalities may be one reason for some at a policy level having difficulties in understanding the rational for HLC interventions, particularly their focus on engaging those who are not engaged by other initiatives and addressing wider determinants of health.

It was apparent that one obstacle to further funding for HLCs remains their difficulties in demonstrating clear health outcomes. This is a major difficulty in terms of finding continuing funding for the centres from mainstream health sources. However, as one participant noted, there is a danger of a double standard operating in relation to community level interventions – which are asked to produce evidence of health related outcomes while mainstream health services (as opposed to specific treatments) are not.

The role of HLCs in mobilising the community was acknowledged. However, although there may be a strong policy commitment to this kind of work, sources of funding, and which organisations are responsible for supporting this kind of work, remains unclear. This was also one area in which scepticism was expressed – that in spite of policy statement, whether there was any 'real' is the commitment to finding new ways of working, really 'engaging' communities or promoting strong local leaderships.

Finding the right balance - between idealism and scepticism – was a theme running through the workshop. Many acknowledged that HLCs *do* represent an innovative way of working, even if many have struggled to achieve their full potential, or the outcomes that anticipated when they were first set up. A real sadness – and perhaps despair – was expressed at the loss of experience and emergent community level organisations that the closure of most of the HLCs in Wales represents – and at the betrayal that this might appear in to communities.

Many will leave some legacy – in terms of new activities, new interest in health, or better communication between local services and the community, in their areas. However, it was clear that in some areas there was a danger of there also being a legacy cynicism, from communities that have seen many such interventions come and go. The real risk is that new initiatives of a similar kind will have to work even harder to overcome such cynicisms in order to get people involved in such activities in the future.

Realism was expressed in the fact that, in a situation where funding sources are limited, hard choices do have to be made, with activities of this kind do have to compete, in the real world, alongside other priorities for funding. There was also a question of realism about how far initiatives of this kind can be sustainable only through the support of local people, or social enterprise type activities. This is likely to be particularly difficult in activities like healthy living centres, which were deliberately targeted at the most vulnerable communities, and those least able to find resources within themselves to support such ventures.

The importance of evaluation, and what is the right kind of evaluation, for making the case for continuing support for HLC was a recurring theme during the day. Too often, it was argued, this is considered too late in an initiative – and in the HLC programme there had been no specific requirement for them to evaluate in the original terms of funding, nor much advice and support to local projects to support this. A closer partnership, between HLCs and local universities, was one useful idea put forward to enable effective evaluations to take place. What constitutes 'valid' evidence of effectiveness was one theme discussed, and it was suggested that it might have been useful to gather more consistent evidence of the impact of centres in terms of their effectiveness in developing social capacity and social capacities in their areas. However, it was also acknowledged that there were few tools available for the systematic measurement of this at the time the programme was set up. It was also recognised that in interventions of this kind it is important to look at both their direct and indirect benefits – that even if no hard health outcomes could be demonstrated, often their social, and sometimes economic, benefits might be demonstrated in terms of number of people involved in new activities or unemployed people finding employment. Evaluation was also hampered by the amount of variety in the programme, which made it difficult to compare centres with one another, and distinguish the more effective ones – and what made them effective – from the rest.

Another key point emerging from the day was about where responsibility lay for ensuring that learning from interventions of this kind lay – and how this might be achieved. Part of the scepticism lay in the fact that similar initiatives have come and gone in the past, and the lessons do not appear to be taken on board – with the same lessons - about the time and effort that it takes to set up activities of this kind, the importance of evaluation, or of addressing sustainability issues – being learned again and again. It is hoped that a report on the present seminar, together with the final evaluation report on HLCs in Wales will receive sufficient dissemination, and lodged somewhere sufficiently visible, to ensure that some of the learning is taken on board in policy circles.

Dione Hills
15th October 2007