EVALUATION OF THE FIFE HEALTH AND WELLBEING ALLIANCE COMMUNITY- LED PROJECTS: FINAL REPORT

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1. INTRODUCTION

Fife Health and Wellbeing Alliance (FHWA) is a partnership between Fife Council NHS Fife and the voluntary sector which is tackling health inequalities in Fife. The partnership works to a set of principles which include:

- Addressing the underlying causes of health inequalities;
- Early intervention; and
- Tailoring action across communities to suit people's life circumstances.

The Alliance supports 10 outcomes identified in the *Fife Health and Wellbeing Plan 2011-14*. Outcome 7 is specifically about working with communities: *Communities develop and lead local health and wellbeing initiatives which create supportive social networks and increase participation in community activity.* Since March 2013, FHWA has funded 6 *community-led* health projects to address this outcome.

The Scottish Centre for Community Development defines a community-led approach as being *'concerned with supporting communities experiencing disadvantage and poor health outcomes to identify and define what is important to them about their health and wellbeing; the factors that impact on their wellbeing and to take the lead in identifying and implementing solutions'.*[1]

The community-led projects fit well with this definition as they aim to support communities to:

- *Define their own health issues and priorities and identify solutions;*
- *Become organised and active in the interest of collective wellbeing;* and
- *Participate in and influence wider decision making processes that affect health and wellbeing.*

The agencies involved in these projects aim to *work in partnership with each other and communities to respond to the issues identified by communities.*

The kinds of activities expected to be developed by the community-led projects are:
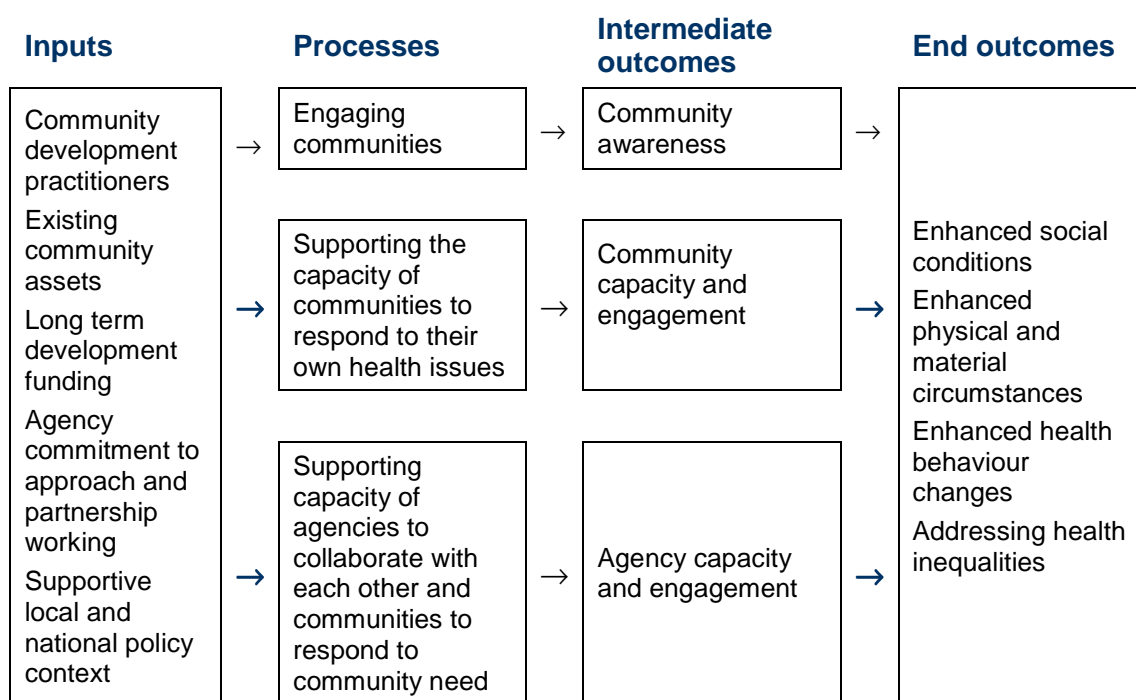
- Raising community awareness of the factors that affect health;
- Engaging communities in defining their own health issues and priorities;
- Supporting communities to identify solutions;
- Ensuring agencies and communities work in partnership with each other to respond to the issues identified; and
- Ensuring communities participate and influence wider decision making processes that affect their health and wellbeing.

A logic model for community-led health developed has been developed by the Scottish Community Development Centre and Community Health Exchange (CHEX). Figure 1 depicts the logic model[2].

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[1] Dailly, J., and Barr, A. (2008) *Meeting the Shared Challenge Understanding a Community-Led approach to Health Improvement.*
[2] We have drawn on the very clear and useful explanation of the Logic Model set out in Jane Dailly's and Alan Barr's paper, *Meeting the Shared Challenge Understanding a Community-Led approach to Health Improvement.*

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Figure 1: Logic Model for Community-Led Health

Inputs	Processes	Intermediate outcomes	End outcomes

Community development practitioners	Engaging communities	Community awareness	
Existing community assets	Supporting the capacity of communities to respond to their own health issues	Community capacity and engagement	Enhanced social conditions
Long term development funding			Enhanced physical and material circumstances
Agency commitment to approach and partnership working	Supporting capacity of agencies to collaborate with each other and communities to respond to community need	Agency capacity and engagement	Enhanced health behaviour changes
Supportive local and national policy context			Addressing health inequalities

Adapted from Dailly and Barr (2008)

The figure shows how community-led health has 5 *inputs*:
- Community development practitioners who are available to support communities;
- Existing community assets such as community activists or volunteers;
- Long term development funding;
- Agency commitment to the community-led approach and to partnership working with other agencies and the community; and
- A supportive local and national policy context which values the community-led approach.

Community-led health relies on 3 *processes*:
- Engaging communities so that they can define their own health issues and take action to work on them;
- Supporting the capacity of communities to respond to their own health issues; and
- Supporting the capacity of agencies to collaborate with each other and communities to respond to community need.

These inputs and processes will lead to change and the *intermediate outcomes* of:
- Increased community awareness of health and what can be done to tackle health issues;
- Increased community capacity to work on these issues;
- Greater capacity within agencies to work with communities in a collaborative way.

In the longer term this leads to better health in the community through achieving *end outcomes* of:
- Enhanced social conditions;
- Enhanced physical and material circumstances;
- Enhanced health behaviour changes;
- Addressing health inequalities.

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The Projects

The 6 projects looked at in the evaluation are the following.

- *A Healthy Voice* is based in the village of Oakley in south-west Fife. The village has high levels of unemployment with the SIMD identifying 16.7% of residents as 'employment deprived'. A community action plan is currently being developed for Oakley. The FHWA funding aims to support community-led health activity to complement this plan as health had been identified as an issue. The project aims to take a two strand approach to developing community-led health work in Oakley:
    - First, use *Local Investigations* and *Health Issues in the Community* (HiC) courses as a way of recruiting people and developing their interest in health issues as well as a way of identifying which health issues are seen as priorities by local people;
    - Second, building on this interest, support them to set up a community-led health group to tackle the issues.
- *Broomhead Drive Community-Led Health Initiative* focuses on the Broomhead flats which are three tower blocks near the town centre of Dunfermline. These house a mix of families, younger single people and pensioners. There are amenities close by including a sports centre, good schools, green areas and shops. However, the flats are in need of refurbishment and have a poor reputation locally for anti–social behaviour, crime and drug taking. Despite the poor reputation, a recent consultation saw residents voting to refurbish rather than demolish the flats. The consultation process identified that the creation of a community facility could provide a focus for work around health and wellbeing which was needed in the area. Following this there was a need to identify the specific activities residents felt should take place in the community facility. The project's aims are to '*identify the issues most important to the residents of the flats and assist with the development of solutions they would like to put in place'*.
- *Collydean Community Connections* (CCC) is based in Collydean in Glenrothes. Like many other neighbourhoods it is affected by increasing unemployment and is seen as '*at risk of becoming more deprived'*. It is some distance from Glenrothes town centre and has few local amenities other than a community centre, a church hall and the building where CCC is based. Local agencies feel health and wellbeing is an issue in the area with higher levels of disability and poor health, including poor mental health linked to unemployment. The FHWA funding has allowed a part-time community coordinator to be appointed to support the community to identify health and wellbeing issues and help them to take the lead on improving them.
- *HEAL 2* is based in Glenrothes. The project is targeting 3 areas of which are in the worst 20% of the SIMD, Auchmuty, Macedonia and Tanshall. The project has worked in Auchmuty since 2012 and is due to begin working in the other areas in 2014. Auchmuty is an area of predominantly council and social rented housing. HEAL 2 builds on previous work carried out by the employability service based in Auchmuty Community Learning Centre. The service runs a job club in the centre which is one of the busiest in Fife. Staff had noticed the impacts unemployment was having on clients' health and had introduced a number of activities including visits from Keep Well nurses, smoking cessation groups, and work looking at mental health and healthy eating. These had been successful and they wanted to look at health issues more broadly. The FHWA funding has provided an opportunity to do this.
- *Real Connections* is run by LinkLiving which provides a range of services for people across Fife who have experienced mental health difficulties. Real Connections focuses on people who live in Kirkcaldy. People with mental

health issues can be affected by health inequalities in a number of ways including inequalities linked to poverty, poor housing and unemployment. They can also find it difficult to decide what they would like to do by themselves and often need support to consider what options they have, to be more proactive in making decisions about their health and to get involved in local activities which can enhance wellbeing. The project aims to work with people using LinkLiving's services (who are called members) to identify what they feel would enhance their health and wellbeing and help them to identify ways of doing this.

- ***Women's Health Improvement Research*** (WHIR) - Prior to the launch of the FHWA funding for community-led health projects, Scottish Women's Aid (SWA) had considered undertaking a project in Fife to look at the issues affecting women experiencing domestic and sexual abuse and the links with homelessness. The project's aim is to use a participatory action research approach to better understand, prioritise and deal with the factors that compromise the health and wellbeing of women who have experienced domestic and sexual abuse. The FHWA funding has allowed a team of committed volunteer community researchers who are all women with experience of domestic abuse to be trained and supported to design and develop a research project drawing on the their expertise and knowledge of the issues.

From the above, the projects incorporate several aspects of the logic model including practitioner input, the aim of drawing on existing assets and promoting engagement and capacity building to increase awareness of health issues.

The Evaluation

The overall purpose is to understand how the projects are operating and their particular contribution to tackling health inequalities in Fife. The evaluation objectives as set out in the Brief were as follows.

- *Look for evidence of how the projects are employing community-led principles in their activity.*
- *Examine the community-led projects' ways of working so far. This could include levels of community consultation and participation, initiatives developed, departures from traditional or mainstream ways of working, project plans and information gathering for evaluation.*

The evaluation was formative with the emphasis on the *process* of community-led health and what can be done to strengthen the projects' activities going forward.

The evaluation methods involved:

- Visits to the 6 projects to develop case studies describing how the projects were employing community-led principles and their ways of working;
- Focus groups with key stakeholders, including people involved in their steering groups and in other ways with the projects to explore the ways of working in more detail.

More information about the method used for the case studies and focus groups is given in the Appendix.

This Final Report draws together the key findings from the Interim Report (which presented case studies of the 6 projects) and the focus groups. The focus group discussions were designed to find out more about some of the issues which had emerged from the Interim Report to:

- Understand more about this way of working – including some of the challenges that the projects had encountered and the ways they had tried to overcome these;
- Identify the outcomes of the community-led way of working from the projects' participants' points of view. This helps to show how the processes are working.

The report is organised as follows:
- Chapter 2 looks at the ways of working.
- Chapter 3 looks at the outcomes;
- Chapter 4 presents the conclusions and recommendations.

2. WAYS OF WORKING

In this chapter we look in more detail at the projects' ways of working. The logic model provides a useful framework for describing and assessing the projects' ways of working for the evaluation, as we can look at their inputs, processes and outcomes.

Inputs

The logic model shows that community-led approaches need the inputs of long term development funding, agency commitment to the community-led approach and to partnership working with other agencies and the community and a supportive local and national policy context which values the community-led approach. These are all important but the scope of the evaluation was on the aspects that are in the control of the projects: inputs related to community development practitioners and community assets.

Community Development Practitioners

It is recognised that most communities facing additional barriers or challenges will need some kind of input from practitioners to help them to achieve health outcomes and so practitioners have a role supporting communities. They also have a role working with agencies to foster partnership working between agencies and communities. The ways that practitioners have an input into the projects are highlighted in the box below.

A Healthy Voice is run by Fife Council's Community Learning and Development department (a community education worker, a team leader and the local adult learning planning group) and a community capacity building worker whose role is supporting the community action planning process. These workers support participation in the project. However, 2 staff moving jobs within the funding period has had an impact on the resources available.

Broomhead Drive Community-Led Health Initiative was initially supported by Fife Council's departments of Housing and Community Learning and Development. In the first year there were changes in personnel and the steering group was expanded so that it is supported currently by Fife Council (Housing, Community Learning and Development, Family Support and Education) NHS Fife (Health Inequalities Team), the Police, Fife Sport and Leisure Trust, the Salvation Army and Homestart. All agency steering group members have a lot of experience of working with groups in communities.

CCC's steering group involves Fife Employment Access Trust (FEAT), Fife Shopping and Support Services, Glen Housing Association and Collydean Primary School. These organisations have strong roots in Collydean and good links to the community. A part–time coordinator who is an experienced community worker and a local resident supports the project and is seen as providing a critical input to CCC.

HEAL 2 is supported by experienced community development practitioners. The project is run by a steering group, involving community members, volunteers, Auchmuty Learners' Forum, the Community Job Club, Adult Basic Education, Opportunities Fife and Adam Smith College.

Real Connections is facilitated by LinkLiving's Volunteer Manager and a '*community connector*' worker whose role is to support people involved in the project. The project also draws on the support of partner organisations (Fife Employment Access Trust and Active Fife) to deliver some activities.

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> The **WHIR Project** is led by a group of women who have experienced homelessness – or been at risk of homelessness as a result of domestic or sexual abuse. As a voluntary community research team they have designed and developed the research methods and will analyse and disseminate the findings. This team is supported by 2 staff from Scottish Women's Aid who provide training, facilitation/support and advice to the research team – on a part-time basis. The steering group which is responsible for the governance of the project is made up of staff from Fife Domestic and Sexual Abuse Partnership (FDASAP), Fife Women's Aid, Fife Council housing and community safety services, Fife NHS, FHWA and Scottish Women's Aid.

The above shows how all of the projects have some practitioner input but the nature and extent of the input varies across the projects in terms of:

- Number of staff;
- The amount of time they are able to commit to the projects;
- Consistency of involvement in the projects over their funding period; and
- Backgrounds and experience of the community-led way of working.

Drawing on the focus group discussions we look at practitioner input more detail below.

Practitioner Roles
Despite variations in the extent of practitioner involvement, the focus group discussions suggested there are some commonalities in terms of the nature of practitioner input into the projects emerged from the focus groups. For example, the role commonly involves a number of aspects including:

- Supporting people to engage in the project;
- Consulting with people about needs;
- Facilitating groups; and
- Supporting the delivery of project activity.

There are also some commonalities in the approaches and principles the practitioners use in their work. Several of the practitioners have backgrounds in community development but newer approaches including '*building social capital'* and '*asset based approaches'* were also mentioned in the focus groups and are clearly having an influence on the practitioners' practice. In one focus group an interesting discussion raised the point that community development practice has always incorporated the ideas of prevention and drawing on local assets; the principles remain the same although the language may change. There was general agreement across the focus groups that community development approaches facilitate community–led work. This involves:

- *'listening to communities;*
- *not doing it **to** them;*
- *looking for long lasting change;*
- *"making" a community – bringing people together to form a community because they live there and want to make a better place'.*

It was interesting that several people in the focus groups felt the community-led projects are providing opportunities to implement community development and asset based approaches perhaps more meaningfully than many of the practitioners felt they had been able to until now because this is an explicit focus. For example, in one focus group with a project's steering group there was recognition some lip service had been paid until now to the notions of asset based approaches and participation among the organisations involved. However, the community-led project is actually putting the principles into practice. The steering group members felt it is critical that the learning from the project is captured and fed '*higher up*' into the steering group

members' organisations so there is increased understanding about what this means in practice and how this can be incorporated more widely into the day to day work of staff in these organisations.

Some practitioners were less familiar with community development approaches and felt this way of working can present challenges to practitioners:

- In one focus group workers said they can feel *'challenged'* by the process of community-led working and it has been a learning process. Workers felt they were used to delivering things to people, whereas the community-led approach is different and less structured.
- Similarly, in another focus group workers spoke about how work is usually more about setting up projects and activities. The community-led project was more about the process and was challenging because they did not always have a clear idea what would come out of the work they were doing.
- In another the workers spoke about how it can be difficult to step back and to let the community come up with their own ideas.

The community researchers who took part in the focus group at WHIR offered a perspective on practitioners' inputs and how this can change over the project's lifetime. An ability to be flexible and work with the group to take it in the direction the members' think is important is also needed.

The community researchers were supported by a worker from Fife Women's Aid at the start of the project. This was helpful in the initial stages as it allowed them to speak to someone outside of the group about the issues raised in the group. As the group discussions moved from researching their own experiences to the wider factors affecting homelessness and became more focused on the factors in the system that needed to change the community researchers felt they needed a different kind of support. The community researchers also increased their capacity to support each other. An illustration of this change is that the community researchers now perceive each other as colleagues and see the activity of going to WHIR as work.

The workers who have supported the research were seen as very approachable and with skills and knowledge of women's issues and research which the community researchers could draw on. However, they had been very good at drawing out the community researchers' different strengths so everyone felt valued equally. The structure of the group feels very equal – with the community researchers feeling they all have valid expertise to contribute. Everyone has been encouraged to participate.

In HEAL 2, in addition to support from community workers they have a part-time worker called a 'community catalyst' whose role is highlighted in the box below. It is useful to highlight this role as it is different to other practitioner input across the projects, but it also illustrates some of the challenges involved in these roles and how roles need to change as the projects develop.

The 'community catalyst' role has been to provide support to make change happen. The community catalyst did not engage people or help deliver the activity he has been purely focused on the change process. Although this has been a critical role in helping the steering group to work together effectively they do feel that in retrospect something that has been missing has been a role to 'animate' the community get them to be more active. It has been harder to engage people than they first envisaged and they feel that they need a more full time presence who can be out and about in the community talking to people and encouraging their involvement. However the catalyst role has been invaluable to ensure community members have a meaningful role in the steering group.

Effective Practitioner Input

Despite the challenges there was a clear sense of learning across the projects around what is critical to supporting a community-led approach.

- Across the focus groups participants identified getting buy in from the group is critical. The group have to believe in what they are doing and it needs to be important to them. The practitioner can help get this buy in by being supportive, enthusiastic and committed. The practitioner can encourage buy-in by letting people know they can make a difference.
- Practitioners need to support activities that people see as relevant to the community.
- They also need to go at the pace which suits the community.
- However, practitioners need to be given long timescales as the process can take longer than expected.

The importance of the practitioner's input to the community-led projects emerges clearly from the evaluation. The projects which have practitioners with strong experience of the processes of engaging communities and building community capacity and who are very focused on this have made more progress in involving people in meaningful way in their activity.

Existing Community Assets

Community-led projects use an asset-based approach which identifies and encourages the use of existing assets in the community. These can include buildings, organisations and local people's skills.

Some of the ways projects are drawing on buildings and organisations in different ways are shown in the box below.

> **Broomhead Drive** is using the community flat in the area as the base for its activity. They hope that in the future when the flat is refurbished it will be used by the local community to develop health and wellbeing initiatives needed in the area.
>
> **CCC** is based in a Collydean Cottage which is the administration base for Fife Shopping and Support Services. The cottage is the venue for many of the project's activities and group meetings, with others taking place in the neighbourhood centre and church in Collydean. It has been useful to have a base in the community and a worker there as people like to drop into the cottage and have a talk to the worker and raise ideas.
>
> **HEAL 2** is drawing on existing community assets in Auchmuty. The area has an active tenants and residents association and the community learning centre is well used by local people because it provides services local people value and they perceive they will be treated well by staff. It is clear the community members wanted to get involved in HEAL 2 because they had had previous good experiences of involvement in the learning centre. One community member said '*it is a positive place and if wasn't here there would be a lot of people feeling worse'.* This helped them to feel positive and optimistic that HEAL 2 could make a change.

It became clear during the evaluation that local people's perceptions of organisations and buildings can have an influence in the way they perceive and engage in activity. In areas where there are positive perceptions of these local assets this can encourage people to become involved.

Community-led projects need to think carefully about where they base themselves and how they can work with local organisations to reach people. If they do this, it forms a good basis for the development of action.

Engaging Communities

Engaging communities is a key aspect of the community-led approach as it is only by doing so that appropriate action that can lead to change can be identified. There has been variation in the nature and extent of community involvement in the projects:

- some have been successful getting people involved in their projects in ways that there is potential to develop action on health issues;
- However in others there is more engagement in activities.

The box below illustrates how the projects have managed to engage people from their communities so far.

A Healthy Voice's approach has had 2 main elements. An initial consultation event took place in May 2013, to launch A Healthy Voice, to begin discussions about local health priorities and to recruit people to the Local Investigations course. At the end of the Local Investigations course the group decided to proceed with HiC. This course is recognised as a good way of raising awareness of health issues and engaging people in discussions about health to identify shared issues, priorities and solutions. The group identified mental health as a key issue and found out more about the problems to come up with solutions. This was presented at meeting with representatives of local services. The main difficulties have been keeping people engaged. Although 13 learners began the course in the autumn of 2013, only 3 completed the first part of the course and 3 proceeded to part two. There has been no progress in establishing a community-led group to tackle local health issues. Although the community education worker feels this can be achieved, there is recognition this will be challenging.

Broomhead Drive has faced several difficulties in getting community involvement in the project. Some of this is due to the nature of the community. A proportion of Broomhead's residents have lived in the flats for a long time, but others live there for only a short time before they move. The impact of a proportion of the population being in transition is that despite its compact area Broomhead is *'not a natural community'*. Lack of progress on refurbishing the community flat on the ground floor of one of the blocks has also acted as a barrier as it is difficult to engage residents in determining what could take place in the community flat when it is not ready. Door-to-door visits to talk to residents has proved to be a fairly successful way of reaching residents and raising issues but the steering group feel there is still more to do to fully understand the issues in the area.

CCC's initial approach to engaging local people was a community survey carried out by the community coordinator. The process involved a lot of face to face work with local residents to collect information about the issues they felt were important in Collydean. The needs assessment included work with the children in the primary school to identify what things in their area they felt affected their wellbeing. The survey generated local interest and most of the volunteers were recruited through it. It also raised a number of issues CCC felt they could begin working on. The volunteers were keen to take action on some of the issues quickly to generate more local interest. The first action was setting up an internet café to improve people's access to IT. Other activities followed and have been an important way of engaging more people both as participants and also leading the groups. Volunteers also help with the production and distribution of the project's newsletter which is delivered to every household in the area.

HEAL 2 carried out needs assessment using a social capital evaluation tool to provide a baseline, define the issues and establish a '*mandate*' to begin working on increasing social capital. The needs assessment identified 10 issues. Residents were invited to meetings to discuss each of these areas. There was not always a good turnout at the meetings. The steering group realised residents were not sure about the value of meetings as their views had not been asked for in the past and it was difficult to convince them they **were** going to be listened to. Nevertheless, the discussions helped prioritise the issues people wanted to work on and what activities they would like to see. HEAL 2 recognise they will need to make ongoing effort to engage residents.

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Their early activities have had a practical focus (such as organising community clean ups, a gardening project and the creation of a website). These can help people see tangible improvements and are also a good way of engaging people. HEAL 2 has made good progress in terms of engaging community members in the steering group. Most of the community members have previously been involved in the community learning centre either as volunteers or taking part in learning activities and some have also been recruited from the job club. All wanted to make a difference in their community. Some also had an interest in particular health issues, such as mental health and felt HEAL 2 could have an influence on these. Some were also interested in leading on specific activities such as the gardening project.

People get involved in *Real Connections* in a variety of ways including referral from other agencies and word of mouth. When they first come they meet with the community connections worker and talk about what they would like to do. They are then told about the kinds of activities Real Connections is providing at the moment to find out whether they would like to get involved in any of them. If the person thinks none of the activities meet their needs the community connections worker tries to identify another activity which might. The project also has 6 weekly meetings with members where there is an opportunity for members to discuss ideas for activities as a group. This is an important meeting as all of the activities provided by Real Connections to date have come from ideas raised by the members.

WHIR has recruited 7 core volunteers as community researchers. These are all women who have experience of domestic abuse. More volunteers will be involved at a later stage as research subjects/participants. The community researchers were recruited through support agencies and organisations they were in touch with. These agencies encouraged women to come along to an information day. Nineteen people attended the information day, out of which 15 attended the first meeting where their experiences and skills for undertaking research was discussed. Many of the women had no prior experience of undertaking community research. Some women were unable to continue because of other commitments, leaving the 7 who continued as the core community researchers.

The above shows that getting people involved and keeping them involved is not easy. The focus groups therefore explored the issues involved in engaging people in projects in more depth.

Challenges around Engaging Communities

As the projects are working with communities facing barriers there are inherent challenges in engaging them in projects. The focus groups identified a number of these challenges, including the following.

- Lack of time, motivation or knowledge about what opportunities there are or what could be done.
- Lack of confidence which can make people reluctant to take on the responsibilities for activities within the projects.
- Reluctance to get involved in formal aspects like meetings and training - people like tangible and practical work.
- Welfare reform is making people feel stressed. In one focus group participants said threats of sanctions and movements on to the Work Programme are threatening volunteering.
- Changes in people's personal circumstances such as illness, moving away, getting a job or going on the work programme.
- There are also bureaucratic issues which can affect people's ability to engage. For example discussion in one focus group highlighted how setting up groups nowadays can involve background credit checks on office bearers. Focus group participants in one project said some of the residents in their area would not be able to pass these checks making it difficult to set up constituted groups.

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- If only small numbers of people turn up this makes it difficult to share the burden of organisation out so that the load on the participants becomes unrealistic.

The box below illustrates these issues from the perspective of one of the projects.

> One of the projects has very good engagement of local people in their steering group. However, but have found it difficult to engage people in the wider community in their 4 key activities. This is a source of frustration to the community members on the steering group. Although they came up with a range of suggestions to try to reach people but these have not worked to encourage people to get involved as volunteers. They are persisting though and see it as an important element of the project. They have had a debate recently about whether they should continue to try to recruit more people to be involved in the project or carry on with just the people they have involved at the moment and are likely to favour the second option.

The difficulties surrounding engagement are ongoing problems for community-led projects but there is some learning from the projects around the factors that can make it more likely that people will engage. For example, the focus group with the community researchers at WHIR was very useful to understand more about people's reasons for engaging in projects.

> The community researchers all have a personal interest in the topic they are researching as they all had direct experience of the issues. All expressed a strong desire to want to change things and to improve the situation for others and build something positive from what had been a very negative experience. Seeing that their work is going to make a difference and change the system was helping to keep them involved. Some felt issues around domestic abuse were gaining more recognition and they felt that it was important to feel part of that positive change. The process has also been very important – they feel that they have been recognised as playing an important role in the project and also as part of a broader change process. As in the example above, the support of the group has been important. The community researchers feel part of a '*team effort'* and have a shared experience. At the start of the project they did not feel that there could be an impact on themselves but as they have continued to participate they feel they have '*grown*'; '*moved on*' and it has had a strong impact on their own health and well-being and helping to '*make sense*' of their own situation. This has also helped to keep them involved. In the early days of their involvement having a support worker from Fife Women's Aid who could provide emotional support if needed was helpful. The workers have worked with the community researchers been able to '*tap into* (the group members') *different learning styles'* and identify the skills they needed to help them to participate in the research. The community researchers feel the mutual support of the team and the realisation that they have something to contribute has also supported their on-going engagement. The strength of the team has made a difference to how the individual community researchers perceive their own strength, as one commented *'some weeks I have to think ''why am I even here?'' but then I realise my own strength and I have gone back'*.

Another illustration of the factors that support engagement from HEAL 2 is given below.

> The factors which have worked well to sustain the involvement of community members on the steering group have included that all of the members know each other (and the staff well). Peer support is very important. People trust the staff because they have been treated well in the past. Members know this is a *'safe place'* to come. People are also engaged in tasks they are interested in. The community participants feel they have an equal say in the project and feel that they can raise issues. The tasks offer a *'hands on role'.* People like this and outcomes which are tangible and practical.

Another example comes from the Broomhead Drive Project.

> The Real Bothy project has been the most effective way of engaging people to date and they see more promise in this kind of approach rather than trying to set up a committee. People can be involved in an informal way, they can share, learn some cooking skills and share ideas about what they would like to be involved in. Participation in the Bothy has been sustained through offering food as part of the activity (it takes place on a Friday lunchtime) and the informality of the gathering.

Taking these examples together shows the kinds of factors which support engagement include:

- Participants having a personal interest in a topic;
- A desire to work on the issue to make change happen;
- Making people feel valued;
- Feeling part of a group and peer support;
- Positive changes in individuals.

Other more practical aspects which support engagement include provision of childcare, transport and perhaps offering things like lunch. These can make the difference between sustaining participation or not. Positive word of mouth about project in a community can encourage people to get involved.

The WHIR experience also shows that having a very specifically defined target community and a defined topic which came out of work that Scottish Women's Aid had been doing already helped because the community researchers have a common interest and experience of domestic abuse and a good understanding of the issues they are investigating.

Supporting Capacity of Communities

All communities facing barriers and challenges will need support to develop capacity to identify and take action on health issues. This is a key element of the community-led way of working as it aims to support people so they are able to use their knowledge in a way that can bring about change in their community. Some of the ways the projects have worked on raising capacity are illustrated in the box below.

> *CCC* recognise it is important to build capacity in their groups so they will carry on beyond the FHWA funding period. Capacity building focuses on finding out what groups need to be self-sustaining. Support can involve helping groups to access training and funding if needed. Not all of the volunteers have needed this because some have expertise, but others have taken courses such as basic IT which has increased their capacity to work effectively in the groups.
>
> Within *HEAL 2* the community catalyst role has been important as this has allowed the development of the processes needed to support community-led work including facilitating the steering group so that it is functioning well. The community catalyst is able to work in very flexible way with no set hours so support can be offered when it is needed. They are planning training for the steering group which will aim to increase members' understanding of HEAL 2 and their role in the project and also develop their skills for working as a team. This will develop their capacity to function as a successful steering group. Mentoring is used to help community members develop their capacity to run the activity groups.
>
> *Real Connections'* members have three inputs to the project – setting the project's direction, acting as voluntary group leaders and acting as 'buddies' or mentors to help new members participate and get established in the groups. Some of the members have volunteer experience with some of LinkLiving's other projects already.

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> The community connector supports members sustain their involvement in the project, and helps people come together to identify what they would like to do and how to take this forward.
>
> By being directly involved in research to better understand issues affecting them, **WHIRs** community researchers are being empowered to be able to make better choices for themselves and to influence change in the policies and services designed to support them. They are also gaining skills and confidence. This is a community where many members would have remained silent or had not been listened to in the past and so would not share their experiences with people, let alone agencies, so the project has been vital in giving them a voice and ensuring that their issues and experiences are understood by those making policies or designing services to support them.

The above shows how supporting capacity involves actions to:
- Empower individuals – people need to feel empowered to generate effective change.
- Help communities organise effectively as this can be difficult for communities experiencing disadvantage. Support needs to be put in place to help groups to organise.
- Increase ability to participate in participatory structures more effectively.
- Promote positive action which is focused on groups facing most challenges and aims to address disadvantage and exclusion.

Capacity building is more prominent in some projects than others and there is a need for some projects to think about how they can raise capacity while those that are doing well on this should continue to refine their approach. The focus groups looked in more depth at the issues related to raising capacity, including some of the barriers to raising capacity and what kinds of approaches have worked well.

Community Capacity Building Barriers
Some of the issues identified above which affect people's ability to engage (such as lack of time, motivation, confidence and personal factors) clearly influence people's capacity to take identify and take action on health issues as well. Other factors include:
- In one community many residents are not in a position to be able to organise as they are living lives that are often in crisis. This makes it very difficult to see how they would be able to take on board organising activities linked to community-led projects. A proportion of the longer term residents who would be in scope for the project are also old and frail or young and living chaotic lives. People who are at work and likely to have most capacity are reluctant to get involved as they may feel they have little in common with other residents.
- Another faced a high rate of drop out from their capacity building activity because of participants' personal and health issues.
- Another found that people were worried about participating in capacity raising activity in case they faced benefits sanctions.
- Another project has faced a difficulty finding people who could lead the project because people they have engaged several of whom have learning difficulties as well as mental health problems. This has meant that they perceive that it has been difficult to get activity that is truly community-led – for example people can lead their own individual activity groups but can't take on responsibility for the project and they still need a lot of hands on support from the worker.

Effective Community Capacity Building

Projects need to work on overcoming these barriers. The focus groups identified the kinds of actions that can help raise capacity. One factor mentioned in a number of focus groups was the role of the practitioner where the practitioners' interactions with the community participants were seen as critical to raising capacity. Staff who are supportive and positive and encourage groups can help as this can '*sow seeds'*. If staff encourage people to raise skills and confidence and recognise their potential this can increase involvement. Thereafter achievements can increase motivation.

This works best if the capacity building activities give people opportunities to develop in a way that is relevant to their situation. For example HEAL 2 has offered training in assertiveness, leadership and communication. A volunteer (not resident) leads on this. They have also accessed some of the training run by FHWA (e.g. to become leaders on 'Bums off Seats' courses) and have found this worked well. The capacity building activities need to be appropriate for the group's interests and abilities.

WHIR provided an interesting example of how the project's structure can support capacity building, illustrated below.

WHIR's separation of the steering and community researchers' group has allowed the steering group to take on administrative tasks to leave the community researchers time to develop their research skills. As the project develops the steering group feels that the focus may change. In the longer term they hope the community researchers will have more involvement in taking forward the findings of the research. WHIR feel the role of the paid worker within the community research group is very important to enhancing capacity. Workers need to be able to empower the members so that they feel it is their group. Thought and preparation goes into each group meeting to enable that to happen. At the same time the paid worker needs to be flexible to work on the issues that the group feels is important. The worker has a clear idea of role and boundaries.

The community researchers have had ongoing training since they began the training, but interestingly commented that the '*training has not always felt like training*' because it was a mix of presentations and exercises and very participatory. It has helped them to understand research practice and also given them tools that have wider applicability than the project such as how to speak with confidence, how to work effectively in a group, interview skills. The community researchers are finding they can use these skills in their everyday life.

Discussions in the focus groups highlighted the need to invest time in capacity building. This needs to be a strong aspect of any project's work so that people develop the right skills needed to progress the project. If projects are to be sustained in the longer term this is critical. Projects need to look at what skills people need to do the things that they want to do and provide an appropriate input to this.

Raised community capacity must be seen as an outcome of community-led work. It is challenging and takes time. One focus group raised the issue that there can be pressure from *'higher up'* (in organisations) to get things done and there is not a clear understanding of the time that it takes to build capacity among funding organisations. The timescales allowed by the funders for the community-led projects have been appreciated by the projects, but regarded as unusual!

Supporting Capacity of Agencies

Partnership and collaboration between agencies and communities is also a characteristic of the community-led approach. Communities and agencies should work together to develop new and more effective ways of addressing needs. Agencies must be committed to the community-led approach and an important part of the role is raising awareness and advocating for a community-led approach in their

work with other agencies. It is critical that empowered people are able to use their voices and the community-led projects need to think about where they can influence.

There is involvement of a wide range of agencies in each of the projects which shows that there is interest in the potential of the community-led approach and the benefits of working more closely with communities to identify their needs. For example:

- In one project the service providers involved had been interested in finding out what kinds of services women wanted but felt that usual methods of consultation about services had been ineffective. The service providers felt previous approaches were not really enabling real participation in decision making and did not always reach people whose voices really needed to be heard. The community-led approach showed more potential for involving people more meaningfully in decision making about services.
- Another project identified how there has been a shift in community planning towards a greater focus on prevention and supporting community assets. This project's steering group partners felt this meant they should support the development of '*grass roots activism*'. They felt there was a lot of '*untapped potential'* in their community of interest which could be developed. The project would enable them to take this forward and test out what is involved in developing community assets and whether this is a feasible approach for services.
- Similarly, the workers involved in Broomhead Drive want the community flat to be a setting where *co-production* takes place. In such a setting people feel they have the ability to make change. They believe this can overcome inequalities in access to services.

Agency Capacity Building Challenges
The interviews for the case studies and the focus groups showed that there is good collaboration among the agencies involved in each of the projects and they are working well with each other. In some cases they would not have had this collaboration without the funding for the community-led project.

Across the projects it is the experience has not yet translated into greater capacity to respond to community needs in any substantive ways but it is early days for the projects. Several project staff are working fairly well together with the communities on developing activities that the community want but there is a need to move beyond collaborating with the community on activities to taking action on health inequalities.

Above we highlighted the challenges or barriers involved in building the capacity of communities to engage in community-led action, but there are also challenges around the capacity of agencies to support this work. As we pointed out above there have been variations in practitioners' experience of the community-led way of working. In some practitioners' roles and community development methods of working have been very clearly defined. In the focus groups several of the workers commented that the community-led approach can be '*challenging'* and '*a learning process*' and different from approaches they may have typically used in the past. Some support for the development of the community-led way of working has been provided by FHWA through seminars and networking meetings allowing all of the community-led projects to get together to share their experiences.

Responses to these challenges could involve:
- Providing further opportunities for training and networking to develop practitioners' understanding of community-led methods;

- Funding projects where the approaches to developing community-led action are specified clearly. This would allow funders to understand the principles to be used in the projects;
- Ensuring community-led projects have adequate timescales.

There also needs to be commitment to the idea that community-led approaches can help agencies work on health inequalities more effectively (which is important to the attainment of the longer-term community-led health outcomes outlined below). This can come from continued commitment to the approach for example from the FHWA, but projects can also have a role advocating for community-led approaches. Some projects are working on this. For example in the focus group at Broomhead Drive participants explained that they are sharing their learning in the council to provide members of examples of work using a community development approach with the aim of increasing understanding of the practice of community development.

One issue that emerged from one focus group is that there is value in applying the community-led approach in a targeted way. Funders should think about the areas/issues where there is potential and where there would be most benefit from involving people in this way. The example below shows how WHIR had an explicit focus on finding out more about community needs.

> The idea of carrying out participative action research had already been thought about by some service providers involved in the steering group prior to the FHWA funding becoming available. There were two strands to this. In the first place service providers had been interested in finding out what kinds of services women wanted but felt that usual methods of consultation about services had been ineffective. Previous approaches were not really enabling real participation in decision making and not always involving those people whose voices really needed to be heard. In the second place there has been a shift in community planning to a greater focus on prevention and supporting community assets. To the steering group partners this should involve supporting the development of 'grass roots activism'. They felt there was a lot of 'untapped potential' in their community of interest which could be developed. The funding would enable them to take this forward and test out what is involved in developing community assets and whether this is a feasible approach for services. They wanted to develop an approach that is really empowering and this is part of the aim of the project – the aspiration is that the issues related to housing will be better understood and taken forward.

3. OUTCOMES

There are 3 intermediate outcomes for community-led health:
- Increased community awareness of health and what can be done to tackle health issues;
- Increased community capacity to work on these issues;
- Greater capacity within agencies to work with communities in a collaborative way.

These lead to the end outcomes of:
- Enhanced social conditions;
- Enhanced physical and material circumstances;
- Enhanced health behaviour changes;
- Addressing health inequalities.

The evaluation has focused on the intermediate outcomes as the projects have been funded for a relatively short time and the end outcomes are longer term. In this section we look at the issues which have affected the achievement of the intermediate outcomes and consider the progress towards the end outcomes.

Increased Community Awareness

Community awareness means communities are able to define their own health issues and priorities, understand the factors that affect their health and identify appropriate solutions. The box below provides an illustration of this for one of the projects. The example shows some of the challenges in achieving the outcomes.

A Healthy Voice: Outcomes related to community awareness.
- *Local people understand their own health needs, share their health improvement knowledge and skills* – the HiC course is recognised as a way of developing participants' knowledge of health needs and the feedback from the course participants shows they have increased their skills. Opportunities to use these skills have been limited so far to an informal course they put on as volunteers. However they were able to discuss health issues with the participants in an informal way through this.
- *Participants will understand what is meant by a community led health approach* – similarly, the HiC course is a tried and tested way of increasing understanding of the community led approach. Participants have a greater understanding of this and feel they recognise the '*legitimacy of the community led approach'*.
- *Participants will have skills and knowledge to discuss health related issues within their families, in a community setting and within groups* - the 3 learners who completed part 1 of the course shared their learning at a presentation to local agencies people involved in the Community Plan. However, only one learner carried on to the second part of the course which has a focus on translating 'ideas into action'. According to the course tutor it is sometimes difficult to measure the impact of a HiC course as they are not always immediate. In her experience *'seeds are planted'* but it can take time for participants to get involved in activity.
- *Participants will be more aware of local community networks they can access to develop and progress the aims and outcomes of their community-led health initiative* – the participants are more aware of networks but the community led health group has not been established yet so there has been only limited progress on this outcome.

An aspect of this which emerged from the focus groups is the need for people involved in the projects to realise they *can* have an influence. As one project worker described this can be difficult for many of the people the projects are working with as they may have been '*knocked back so many times'*. It is important, as in the example below that ways of building people's awareness are built into the outcomes.

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> ***WHIR***: Outcomes related to awareness
> - *Increased awareness of WHIR project, and issues around gender based violence.* Awareness around the ongoing research has already been raised amongst these agencies and the dissemination of the findings will follow later.
> - *Women who have experienced gender based violence feel able to share experiences which will ultimately inform change in future services.* The findings of the research will be disseminated amongst the support agencies that can bring about change.
> - *Women feel empowered to participate in collective action to improve women's experiences dealing with homelessness.* The community researchers are working together to research what actions would improve support for women who are homeless.
> - *Women develop skills (including research skills) to influence change for themselves and their communities, if they wish.* The research being undertaken will not only raise awareness, but will also empower women to make better choices and to influence the policies and services designed to support them.

Capacity building should produce outcomes so that individuals are more empowered, communities are more organised and active and action is inclusive and fair. An example of this is given below.

> - Taking part in the HiC course has had a positive impact on the people from ***A Healthy Voice*** who completed it. They felt it was a good way to get back into a learning environment and the fact that it provides a qualification has a positive influence on self-confidence. One of the participants felt she has a clearer idea that '*my ideas matter'*. The participants felt they had developed skills, for example, presentation skills which helped them put their views about Oakley's needs across to local agencies and groups. They also felt they had greater understanding of the community and the availability of community services. They felt the contacts made through this course will help them get the community-led health group off the ground.

People are also more aware of the way inequalities can impact on health and wellbeing. For example, in one project the project participants now have greater knowledge and a much deeper understanding of the issues they face and the impact on their health and wellbeing. They have greater understanding of the inequalities that create additional health issues for women that are beyond their control.

It was clear from the focus groups that involvement in the projects is having a positive impact on people's health and wellbeing. One community member put this clearly: (Since being involved) *'I feel brand new and I don't think about my worries. I had just shut myself away. It is about getting people out. I want more people to ken about it - it all makes sense'.*

Real Connections workers also feel members are well for longer and have fewer relapses although they realise this might be not wholly due to involvement in Real Connections. Another positive indication of improvements in wellbeing is that more members are thinking about employment.

Increased Community Capacity and Engagement
The WHIR focus group was very useful for shedding more light on why the process of communities determining their own activities is critical to the community-led approach.

> The community researchers have determined all aspects of the research process as they are the people who are experiencing the situation and in this sense they know best about the situation. This is the only way to '*get through to the real issues'* – not the things that service providers think they want to improve, but the services that people actually want. The community researchers feel they know what the real questions are. Support workers can

have an idea but not a real understanding of the issues because they do not have the experience of being homeless due to domestic violence. The community researchers add this perspective; they also have a better idea about what change they would like to see happening. The time spent on this has been worthwhile because there is a greater likelihood that the results are more meaningful. For the community researchers a very important aspect of their involvement in WHIR has been '*finding your own voice*'. It has given the women the confidence to speak about the issues they had faced and what needed to be changed. During this process the women felt they were '*challenging their brain to work again*' after a very difficult time in their lives. This can be part of a process of '*finding themselves*' again because they have had to work to find solutions to the issues they faced as community researchers. Having to work things out for themselves was very empowering for the community researchers. Critical to this is the way the group operates – it is non-judgemental. The community researchers feel there needs to be much more effort to involve communities in issues that need to be changed. If people have had experience of the issues they are much more likely to be committed to and want to push for change because they have an emotional attachment to the cause. These values inform their actions. The women saw this as a 'big strength of the project.'

Most of the projects appreciated that the community-led approach is not about participation in predetermined activities and that communities needed to lead the way on the project's activities. However in some of the projects there is a sense that this means consulting with the community to find out what they want and then the workers putting on the activities. A stronger community-led focus would work more closely with the community to develop shared priorities and move beyond consultation. This can take time to develop. Across the focus group discussions there was a sense that some projects were struggling with how long they should allow to determine the needs and to step back from delivering activities.

In contrast, in projects which are still focused on determining the issues, not delivering activities, consensus about the issues is beginning to emerge. For example, in HEAL 2 the first three months were about determining the needs and there was a lot of opportunity for discussion within the group and with the wider community and this determined the 4 activities they wanted to work on and the more general green/environmental focus for the project (and impact on wellbeing). There is consensus around the idea of improving the environment in the community. A learning point is that this can take a very long time and services using this approach need to be aware of this.

Several projects, have found it difficult to encourage people to do things for themselves were beginning to realise the value of group discussions. Some have made progress in developing this:
- In Broomhead Drive an activity has been developed to facilitate informal discussions ('*blethers*') which have been very useful for raising issues;
- CCC has established an activity with regular attendees and is considering trying to develop discussions with this group around some of the issues that emerged from a questionnaire they distributed at the local school fair.

The projects are recognising the benefits of people identifying the activities:
- People have more enthusiasm about the things that they want to do;
- People have more ownership of the project;
- They develop skills and abilities to do things rather than being passive and waiting on things to be done for them by the workers.
- Involvement in the project in other ways can be beneficial. For example in one project there is recognition that this has given some of the community members a positive focus, helped them to move on in their lives

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Eventually the activities can lead to the development of approaches to influence action on health inequalities. However this can take time.

One focus group with a project helped to clarify why a community-led approach takes time but how this is not wasted time. It needs time to do things properly (bring people along on the process, change their understanding of their situation and themselves and what needs to happen so this will lead to sustainable change). As one participant pointed out: '*we would rather it took longer and we get it right than be rushed.*' Rushing can be damaging to people who have been through difficult experiences so it is about respecting people's experiences and how they can be empowered to take things forward.

Agencies need to understand what this involves and that it does take time but it is very important that people who have lived experience are involved in the community-led work.

Communities need to set the agenda for change in a community-led approach. Not all of the projects have achieved this yet. This is not to say that the community participants do not feel involved in all of the projects. In one focus group participants described how they discuss the particular activities they want to develop which build on what they felt people needed, what they felt they could take on and manage and what skills people already had that they could use in the groups. They feel that they have enough say in running the project. It is a very relaxed environment at the groups and they like that the worker comes along to help facilitate. They like the way that everyone works together and that their opinion matters – this is different way of being involved compared to other services. It is clear that there are good relationships across the workers and the communities in all of the projects.

Some projects have been unable to identify people to come onto their steering group. It is essential that the community has a role in the decision-making for the projects more explicitly. The difficulties engaging people in the projects and challenges about building capacity need to be overcome before this can be achieved.

Projects should still be working towards this. An example of how involvement in the running of the project can be developed in a gradual way is provided by WHIR. Initially the community researchers met separately from the steering group. The steering group '*ran*' the project and provided advice on the research issues which was taken back to the community researchers by the support workers. This meant that the community researchers could get on with planning the research component with no interference from the steering group. Both groups have met since and the steering group feel that there could be more meetings in the future, particularly when they come to taking action on the issues identified from the research. The separation has worked to empower the community researchers and develop their skills. In the future the role of the steering group may change with the workers and community researchers coming together.

Increased Agency Capacity and Engagement
The agencies also saw potential benefits around developing a better understanding of communities needs and enhancing services so they are more appropriate to what people need.

The case studies identified this is an area where there is progress to be made in all of the projects although there are examples of progress as illustrated below.

A Healthy Voice had a good meeting with agencies where the group presented the results of their health needs assessment to the agencies. This was received positively by the agencies and they expressed that they would like to be involved more with the group (included housing, transport and a local GP.) They have now built better links with these organisations which could be used in the future.

HEAL 2 are working on the environment in Auchmuty as they feel that people's perceptions of this has a big impact on people's health and well being. 2 Aspects of this are encouraging people to improve the environment through clearing up and gardening and also encouraging local people to use the environment more through being more active in their community (Bums off Seats).

WHIR's community researchers feel they are beginning to make progress on the issues that they feel need to be tackled. They have met with the steering group and asked the group how they could help them to carry out the research. A number of agencies are involved in the project's steering group and the research findings will be used to inform the agencies so that they are able to respond in a more appropriate way to women's needs.

CCC is hoping to use the results of their street audit to influence the council to make some improvements to the roads and paths in the area. They have identified potential solutions as well and they hope the council will be able to take some of this on board.

Real Connections is working in partnership with local agencies and organisations to develop the activities ideas raised by the members.

There could be more work to develop this but this may be a reflection of the fact that the projects are still fairly new and they are still focused more on engaging communities and capacity building rather than taking this forward to influence other agencies around the benefits of the community-led approach. All projects should be thinking about how they can move ahead on this.

Contribution to End Outcomes

As the logic model showed, in the longer term community-led health approaches should lead to better health in the community through achieving **end outcomes** of:

- Enhanced social conditions;
- Enhanced physical and material circumstances;
- Enhanced health behaviour changes;
- Addressing health inequalities.

At the moment, the projects are focused on the development of processes leading to the intermediate outcomes on the model; however there is some progress towards longer term outcomes. For example, in relation to enhanced social conditions:

- At Broomhead one of the outcomes is *'residents experience a reduction in social isolation and feel able to participate in their community (if they wish)'* – opportunities to participate have been created such as the family group and the Salvation Army drop in and these have been built upon by the Real Bothy project which is giving people a chance to meet new people*.
- At Collydean an outcome is '*residents are supported in developing relationships and social networks in the community'* - there has been progress in this as a number of groups have been established providing opportunities for local people to get involved and work together. The project feels it has demonstrated that *'things can be done in an area where people thought they couldn't'.* People are more active in their community than they were before CCC began. The school's head teacher feels this has had a very positive impact on parents and pupils '*people have an increased understanding of their community and their place within it'.*

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- In HEAL 2 has an outcome '*participants are supported in developing relationships and social networks in the community* - there is a strong focus on this in HEAL 2 as there is recognition that social relationships which provide support and social integration is has a critical influence on health. The processes used give people the opportunity to develop supportive relationships with other residents and local workers and to work together on the activities. In particular this is helping workless people who are at risk of becoming isolated.

In relation to enhanced physical and material circumstances, there has been less progress but the projects have increased people's confidence that circumstances can be improved. For example:

- In CCC '*residents are supported to identify existing community assets.* Several volunteers with valuable skills have been recruited and more local people are volunteering in Collydean rather than in other areas, increasing community assets. The community coordinator role is also useful in linking people to existing assets such as support that can be delivered by the Housing Association, or FEAT, or services such as Adult Learning. The newsletter, distributed quarterly is also very important to increasing awareness of what is happening in Collydean.
- In HEAL 2 '*increase in confidence of the members of the community*' – feedback from the community members of the steering group indicates that people feel confident that HEAL 2 can have an impact in Auchmuty and make changes. Participating in HEAL 2 has had a positive influence on people's wellbeing. They felt confident they would be able to take forward the activities with support from the mentors.

In relation enhanced health behaviour changes the projects contributions are offering people opportunities to participate. For example, Real Connections aims to '*increase members' participation and voice'.* The focus group with the members indicated how since they have been involved in the project people feel more confident, have more self esteem, a wider circle of friends and are doing more positive activity.

In relation to addressing health inequalities the projects fit well with the 3 themes approach developed by FHWA. For example:

- For the theme of *changing the ways organisations work* – WHIR and Real Connections are good examples of influencing approaches but the other projects are also making contributions to this by attempting to collect views on how to tackle health inequalities.
- For the theme of *creating and sustaining healthier places and communities* HEAL 2's work around the community clear–up and gardening project as well as Collydean's groups are good examples here but all of the projects are aiming to build connections between individuals in communities and developing existing assets; and
- For the theme of *supporting healthier lifestyles for individuals and families* they are beginning to make a contribution in terms of breaking down barriers by addressing some of the barriers people face to achieving healthy lifestyles.

4. CONCLUSIONS AND RECOMMENDATIONS

The community-led health projects were established to help FHWA meet the outcome of: '*Communities develop and lead local health and wellbeing initiatives which create supportive social networks and increase participation in community activity.*' It is important to remember that most of the projects were starting almost from scratch in terms of developing a community-led approach and are still learning about the approach.

Community-led projects aim to support communities to:
- *Define their own health issues and priorities and identify solutions;*
- *Become organised and active in the interest of collective wellbeing;*
- *Participate in and influence wider decision making processes that affect health and wellbeing.*

It is in these ways that such projects can make a unique contribution to reducing health inequalities. They cannot be the only approach but need to be supported alongside wider efforts. The evaluation has helped increase understanding of the community-led approach and what needs to happen to achieve the three aims outlined above. The key lessons are as follows.

Practitioner input to projects is critical. They support communities and also foster partnership working between agencies and communities. It is a skilled and multi-faceted role and usually practitioners use community development approaches. Practitioners involved in the projects identified that the community-led projects are providing opportunities to implement community development and asset based approaches perhaps more meaningfully than many of the practitioners felt they had been able to until now because this is an explicit focus. Factors which are important to working effectively as a practitioner include the following.
- Being supportive, enthusiastic and committed.
- Supporting action people see as relevant to the community.
- Going at the pace which suits the community (and practitioners need to have time as to do this).
- An ability to be flexible and work with the group to take it in the direction the members' think is important.

The projects with practitioners with strong experience of the processes of engaging communities and building community capacity and who are very focused on this have made most progress in involving people in meaningful way in their activity.

Using local assets is important. Local people's perceptions of organisations and buildings can have an influence in the way they perceive and engage in activity. In areas where there are positive perceptions of these local assets this can encourage people to become involved.

Community engagement is not easy. The evaluation has identified a range of barriers to engagement including:
- Lack of time, motivation or knowledge about what opportunities there are or what could be done.
- Lack of confidence which can make people reluctant to take on the responsibilities for action within the projects.
- Reluctance to get involved in formal aspects like meetings and training - people like tangible and practical work.

- Welfare reform which is making people feel stressed. Threats of sanctions and movements on to the Work Programme are threatening volunteering.
- Changes in people's personal circumstances such as illness, moving away, getting a job or going on the work programme or personal issues.

The factors which support engagement include:
- Participants having a personal interest in a topic;
- A desire to work on the issue to make change happen;
- Making people feel valued;
- Feeling part of a group and peer support;
- Positive changes in individuals.

The evaluation has also shown that focusing on a particular issue or working with people who have a specific interest can support engagement. This may be because several of the factors which support engagement arise naturally in such an approach. Projects should think about where there is more potential for more such a focused approach.

Capacity building is important and all communities facing barriers and challenges will need support to develop capacity to identify and take action on health issues. As with engagement, there are barriers to capacity building including lack of time, motivation, confidence and personal factors). Projects need to invest time in capacity building to overcome these barriers and so people develop the right skills needed to progress the project. Projects need to look at what skills people need to do the things that they want to do and provide an appropriate input to this. Funders need to realise that it takes time to build capacity.

If people are going to be involved in community-led activity they need to be supported to realise they *can* have an influence. A focus on increasing people's awareness of the way that they can influence needs to be built into project outcomes.

The projects can *impact on participants' health and wellbeing*. Projects already indicate progress on health and wellbeing in their annual monitoring returns but there could be more focus on ways that these kinds of impacts can be measured.

Achieving *community involvement in running the projects* is difficult and a long-term process but an essential part of the approach. Services and funders need to be aware of this. However in the longer term this will deliver benefits of:
- People have more enthusiasm about the things that they want to do;
- More ownership of the project;
- The development of skills in communities.

Agencies need to understand what this involves and that it does take time but it is very important that people who have lived experience are involved in the community-led work.

Communities and agencies should work together to develop new and more effective ways of addressing needs and taking action on health inequalities. There is involvement of a wide range of agencies in each of the projects which shows their interest in the potential of the community-led approach and the benefits of working more closely with communities to identify their needs. This needs to move beyond identifying needs to allowing communities more opportunities to influence change.

Where organisations are thinking about change there is value in applying the community-led approach in a targeted way. Funders should think about the

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areas/issues where there is potential for greater working with communities to develop joint solutions and most benefit to be gained from involving people in this way. More benefits are likely to be gained if there is a greater focus on the groups who face most barriers and who are less likely to have opportunities to have their voices heard.

Capacity building in agencies needs to be supported. The evaluation found practitioners found the community-led approach can be '*challenging'* and '*a learning process*' and different from approaches they may have typically used in the past. Some support for the development of the community-led way of working has been provided by FHWA and this could be continued. There could also be more focus in funding future projects where approaches to developing community-led action are specified clearly. This would allow funders to better understand the principles to be used in the projects and the extent they fit with community-led models.

Community-led projects cannot have large scale impact on reducing health inequalities, but they can make a valuable contribution alongside other approaches and the learning from them can influence the provision of services so that they can refine their approaches to tackling health inequalities.

APPENDIX: A NOTE ON THE RESEARCH METHODS

Case Studies

The processes used to produce the case studies were as follows.

1. A semi-structured interview schedule was developed following discussions with representatives of FHWA, and a review of the literature around a community-led approach to health. The focus of the work at this stage was gathering evidence of the extent to which the projects were following a community-led way of working.
2. Each project was visited by a member of the research team. On this first visit we attempted to speak to as many of the people involved in the projects as possible, including members of the steering group, community members and partners.
3. A framework for the presentation of the case studies was designed which focused on the methods of working the projects were using, the way they fitted with the logic model for community health and outcomes.
4. Once the case studies were in draft form, these were circulated to the projects. We then spoke to the projects again to discuss the case studies and determine whether they felt they were a fair reflection of the projects.
5. The case studies were then used to analyse the extent to which the projects are working in a community-led way.
6. Other findings from the case studies, including lessons from the experience so far were also identified.

The numbers interviewed for each project were as follows.

Project	Community members	Agency members
A Healthy Voice	2	3
Broomhead Flats Community Health Initiative	3 *	4
Collydean Community Connections	1	4
HEAL 2	4	4
Real Connections	8	2
WHIR	0	2

* 3 members of a family group run in the community flat

Focus Groups

The processes used in the focus groups were as follows.

1. A semi- structured interview schedule was developed building on the findings from the interim report. WHIR community researchers also had an input into the design of the questions for their focus group.
2. Focus groups were set up for each project involving practitioners and community members. At Broomhead Flats and A Healthy Voice only practitioners were involved in the focus groups.
3. The key themes across the focus groups were identified and integrated with the findings from the interim report. The themes included practitioner input, engagement and capacity building and benefits.
4. The draft final report was circulated to the projects for comments.

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The numbers involved in the focus groups were as follows.

Project	Community members	Agency members
A Healthy Voice	-	1
Broomhead Flats Community Health Initiative	-	4
Collydean Community Connections	3	3
HEAL 2	5	3
Real Connections	5	2
WHIR	4	3

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