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The opinions expressed in this publication are those of the author/s and do not necessarily reflect those of Health Scotland or the members of the Community-led Supporting and Developing Healthy Communities Task Group unless explicitly stated.

The photography in this report is intended to represent a diverse range of real communities throughout Scotland. The pictures aim to depict everyday settings typical of both rural and urban communities: they do not seek to say 'healthy' or 'unhealthy', they simply highlight a snapshot of community life.

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This study was conducted by researchers in the Department of Urban Studies at the University of Glasgow. The research was commissioned by Health Scotland on behalf of the Evidence/Measuring Success sub-group of the Community-led – Supporting and Developing Healthy Communities task group.

We would like to thank members of the Evidence/Measuring Success sub-group who provided information and comments at various stages of the research.

In addition, thanks go to all those who participated in the qualitative research via scoping interviews and case studies.

The views expressed in this report do not necessarily reflect those of the commissioning organisation and partners.
The aim of the study was to explore and review evidence and current activity around community-based health improvement in Scotland.

The objectives were:

- to examine the evidence underpinning community-based approaches to health improvement
- to gain an insight into the characteristics of effective and less effective partnership working between the different stakeholders involved in community-based health improvement.

The research presented in this report brings together a range of evidence underpinning current approaches to community-based health improvement. This has been achieved via two strands of work:

- a review of existing literature on factors that promote community health and well-being, and the role and effectiveness of community participation in health improvement initiatives
- qualitative research involving key player interviews and two exploratory case studies concentrating on the process of partnership working from the perspectives of community and statutory partners.

SUMMARY OF FINDINGS OF THE LITERATURE REVIEW

The review looks first of all at factors associated with community health and well-being, before moving on to concentrate on research findings on the role and effectiveness of community participation in health improvement initiatives.

Understanding community health and well-being

- People’s health, and that of whole communities living in and sharing the same space, is affected by factors relating to the individual, the community and society, and wider structural factors such as economic and environmental conditions.

- It is appropriate to define health broadly to include: physical and mental health and functioning; illness and disease; well-being; sense of life satisfaction; and quality of life. In this way individuals are seen as biological, psychological and social entities.

- A holistic perspective on health seeks to examine a range of interconnections between different domains at the level of the individual, the community and the wider region. At the individual level this includes the way in which psychosocial stressors derived from home, community or work can impact upon physical health through biological processes. At higher levels, the holistic perspective would consider, for example, how a community’s relative position within the region can have direct effects upon the level of provision of health and other services, as well as investigating the psychological impacts of area stigma upon resident populations.

- Inequalities in health between communities are important to improving population health as a whole, in social justice terms, and because some communities may become unsustainable if poor health is not improved.
Inequalities in poverty and health may have further health impacts via the isolation, anxiety and insecurity they produce among members of a poor community. The extent to which these effects are present at different spatial scales, including within local communities, is largely unknown and worthy of investigation.

Neighbourhoods and communities can be viewed as physical, social, service and cultural environments. Least attention has been paid to assessing whether local communities have local cultures that protect or damage health.

The accessibility, connectivity and reputation of an area are also important determinants of what people and communities can achieve in terms of advancement and integration into wider society.

Social capital, health and well-being

There has been growing interest in the theoretically plausible connection between social capital and health. Social capital also provides a focus for community-based programmes seeking to improve people's circumstances beyond the physical environment in which they reside.

The evidence on links between social capital and health is very mixed and the effects of social capital are weaker than those of structural factors.

There is some concern that the emphasis on social capital diverts attention away from the effects of poverty and disempowerment. It is difficult to separate the effects of material deprivation and social capital at community level.

The operation and impacts of social capital are context-dependent. There is some evidence that aspects of social capital (for example, strong, close family ties) have different effects on different groups in different residential circumstances.

Although not based on research evidence, it has been suggested that, in socially excluded and fragmented communities, social capital can have negative effects upon health, through the production of conflict and risk, as well as by the perpetuation of unhealthy norms. The nature of existing social capital needs to be taken into account in designing community interventions.

More sophisticated, local studies of social capital and health are required, combining measures of individual and community social capital. Some aspects of social capital are poorly measured (such as bridging capital). Particular dimensions of health, rather than simply general health, should be assessed.

Plausible mechanisms of interaction between social capital and health should be investigated. Whether social capital can be preventative and/or curative can only be established through longitudinal study.

The view of social capital as a ‘resource’ for communities has led to more attention being paid to the practical (social networks) side of social capital rather than to the cognitive aspects (norms and trust). The relative impacts of these two dimensions, and their connections, should be a focus of study.

Social capital operates at different spatial scales. Community interventions should not be relied upon alone to enhance social capital. Wider influences and connections are also important for social networks, norms and trust.
Successful partnership processes

- Partnerships vary in type, and guidance on the configuration of partnerships is lacking. Within the health sector ‘partnership’ has tended to focus on statutory organisations, with a more recent acknowledgement of the role of the private and voluntary sectors. The community's role is unclear in many references.

- Partnership theory argues that partnership working contributes collaborative synergy. By combining the knowledge, skills and resources of different partners, new ways of thinking and acting are produced. This leads to more effective (community) problem solving, and, in turn, improvements in community health.

- It is argued that communities benefit from partnership working through empowerment of individuals (who are actively involved in addressing the problems they face) and creation of bridging social ties across different groups.

- Key considerations for successful partnership working mentioned in the literature include:
  > Distinguishing between strategic and operational levels in partnership arrangements may avoid confusion over the role of community partners.
  > Uncertainty about the financial future of a partnership can lead to community disappointment that its efforts are to some extent in vain, or to an over-reliance on, or dominance by, the larger, often statutory, partners.
  > Community partners will feel valued if regular monitoring and effective communication makes them aware of progress.
  > Partnership leaders need a strong vision as well as good interpersonal skills.

- Getting staff with the right skills is particularly important for partnerships involving the community. Key staff need to be skilled in community development, facilitation and listening on the one hand, and in negotiation, advocacy and strategic influencing on the other. This is a difficult mix to find.

- Achieving agreement and commitment to partnership aims, and the place of health goals within these, is key to sustaining partnerships.

- Successful partnerships depend upon trust between partners. This is developed through joint working over time, and through partners demonstrating competence, reliability and honesty. The community’s past experiences of partnership working may need to be taken on board.

Community engagement in health improvement partnerships

- Knowing why the community are involved, or have been engaged, in partnership activity is relevant to being able to explain the level and nature of that involvement. It is worth remembering that community involvement can serve the interests of various parties including the policy-maker, the practitioner, the individual and the community.

- Communities have varying traditions, skills, structures and internal relations. An assessment of community conditions is essential as preparation for community engagement. Lead-in time for partnerships is crucial.

- Capacity-building and skills development applies to professional staff within partnerships as well as to communities. Partnerships should consider working with a community empowerment plan that develops over time, and employ at least one member of staff dedicated
to community development and engagement work. This person needs to have influencing skills to achieve most for the community.

- Partnerships need to work with existing community structures and experienced activists, but also develop strategies to engage hard-to-reach groups and minority cultures.

- The community’s contribution to a partnership has to be valued and their influence demonstrated. Openness and honesty about things that cannot be achieved is essential to maintaining trust with the community. The community should not feel less powerful than other partners making financial contributions.

- Communities appear to have had little influence over the strategic decisions and directions of partnerships. It has been suggested that communities are more comfortable working at the operational level, but the evidence is anecdotal.

- Partnerships that engage with the community and involve them in the work of the partnership need to be flexible. This relates both to accepting that key aims and objectives may have to change over time as the community’s interests and assessment of its own needs develop; and to the fact that partnership structures need to be flexible, allowing for varying levels of community involvement over time.

- Many of the factors affecting community engagement in partnerships are interrelated. Thus, the length of lead-in time may affect the ability to develop skills and capacity among the community and voluntary sectors, which in turn may affect their status within the partnership and therefore their ability to have strategic influence.

The effectiveness of community-based initiatives for health improvement

- It is extremely difficult to establish a connection between collaboration involving communities and health outcomes for communities at aggregate level.

- A major difficulty lies in the measurement of community health. Aside from broader methodological issues such as the design and implementation of survey research, there are complications in matching area-level health data to community-based health interventions.

- It is also difficult to attribute any change in community health to a particular intervention because of the influence of broader economic, social and cultural trends. There are particular problems linked to area-based initiatives which seek to improve health alongside addressing other concerns.

- There is more evidence on intermediate health-related outcomes as health improvement initiatives can address short- to medium-term concerns more easily. In addition, intermediate outcomes related to healthy neighbourhoods are more readily measured.

- Partnership working involving communities in a meaningful way has benefits for the delivery of health improvement efforts.

- Health-related benefits, such as increased confidence and control, can be identified among individuals taking part in community-based health improvement efforts. These benefits can be significant for those individuals. However, research has been less able to demonstrate population health gains at the level of community.
Evaluating health and well-being outcomes

- Despite an increase in the number of community-based health programmes, there remain difficulties with their evaluation.
- Echoing some of the points made in relation to the impacts of health improvement collaboration which involves communities, there are difficulties associated with measurement. In particular, there are various approaches to measuring community involvement, and successful outcomes.
- Alternatives to traditional evaluation methods are being developed, and the use of a number of evaluation tools designed to capture a variety of types of data is increasing. These may offer increased validity of results as evidence from different sources is brought together.
- Different sectors tend toward particular cultures of evaluation: for instance the inspection culture of local authorities and the project monitoring approach of the voluntary sector. The purpose of evaluations is reflected in the sort of information that is gathered and the way it is used.
- Organisational capacity to undertake evaluation is frequently lacking.
- Reports of much small-scale evaluation are inaccessible, or difficult to obtain. This means that lessons are lost from a good deal of relevant information. Structured approaches to information-gathering are required to remedy this position.

SUMMARY OF QUALITATIVE FINDINGS

The following summarises the findings of qualitative interviews with key players and two qualitative case studies of partnerships to improve health.

- The current institutional environment can be characterised as one of increasing complexity in terms of partnership arrangements. This comes with potential to create added burden on partners.
- There is, nonetheless, an optimism about the opportunities which are opening up due to the changing policy environment and the ways in which practitioners are embracing the idea of community engagement in health improvement activity. There is a sense that policy notions based on the value of community participation are gradually filtering down to practice level.
- This is accompanied by a recognition of the difficulties of encouraging effective community participation, but, despite this, the aims of community development are perceived as being worthwhile.
- Some vital ingredients for effective community participation in partnerships for health improvement are time, trust, respect, skilled facilitation, and a willingness on the part of statutory partners to forge balanced relationships and to address their own skills shortages.
- Meaningful partnership working occurs where there are mutual benefits for all partners.
The importance of ownership of partnership processes is recognised across the board, and there are examples of attempts to empower community partners within each of the qualitative case studies. Much of the emphasis within partnerships is around community development to enable effective engagement by communities. This is, to an extent, at the expense of less achievable aims connected with seeing community-based plans and ideas through to completion.

Experience indicates that voluntary sector and community partners are much more heavily involved at the operational level as opposed to playing a part in strategic level decision-making.

The management of expectations is key for successful partnership working between statutory and voluntary sectors and community partners. This works in different directions: representatives of the community must make clear what level of participation is desired, and statutory partners should specify the role that they expect community partners to play.

By bringing together partners from different sectors, and with particular interests, it is possible to broaden awareness of the array of influences on community health and well-being, and to draw on resources that can be used to address these various influences.

The difficulties of evaluating partnerships that involve communities are well-established. However, there can be perceived health-related benefits for the members of communities who participate, in terms of personal self-esteem.

RECOMMENDATIONS FOR FUTURE RESEARCH

In considering these findings from both the literature review and the qualitative research we conclude by focusing here on the gaps in existing knowledge, and themes which should be taken into account in further research.

Understanding community health and well-being

- The measurement of health within communities focuses predominantly on physical health (mortality and disease) and on the level of provision of health services. It would be helpful if community measures of mental health and of subjective well-being could also be developed. This could highlight places where community level interventions might impact upon health, as well as identifying any places where there is a mismatch between physical and mental health and well-being.

- The associational patterns and causal mechanisms between social cohesion, poverty and health inequalities, and mental health and well-being need to be examined at the city regional scale. This will help us to establish whether arguments founded upon national and international research are applicable at a more local level. There are good grounds for thinking that, in a meritocratic society, social comparisons and pressures to succeed and conform will operate at a local level so that feelings of exclusion and inadequacy could impact upon the health of poor communities.
Some aspects of local neighbourhoods and communities which impinge upon community health and well-being are poorly measured. These include empowerment, accessibility, local cultures, and area reputation. Without measuring these aspects of a community, we rely upon static measures of those things that can be easily ‘delivered’ locally, such as improvements in services and environments. It may well be that more resources should go into community development, but research cannot indicate this need very well until some of the social and cultural aspects of communities are better measured.

Social capital, health and well-being

There is a common assumption that social capital is a good thing and will have beneficial impacts upon a community’s health. However, the mechanisms which operate between social capital and health have only been set out theoretically rather than explored through research. If these links can be explored we might find out whether people in different communities use social capital for different ends or with different effects. In the absence of this research, somewhat unrealistic expectations may be expressed about what social capital can provide for poor communities.

In some cultures and communities, social capital may have negative impacts on some people. For example in some communities the use of strong social networks to enforce norms of behaviour may constrain social integration or social advancement; in other communities strongly bonded gangs may engage in damaging activities or inflict a drug dealing and crime culture on those around them. Again, this calls for a contextually sensitive study of the effects of social capital, drawing on in-depth interviews and observation rather than large-scale social surveys.

The process of community-based partnership working

It is assumed that partnerships are empowering for individuals and organisations because they develop creative synergy to find new ways to solve problems through combining skills, competencies and resources. However, more research which explores whether and how such synergistic outcomes occur in partnerships with different members would be useful. It may also overcome scepticism about whether or not statutory bodies in partnerships can operate outwith and beyond their usual practices and procedures.
Trust is a key component to successful partnership working. Yet we did not find many studies of trust in such circumstances. Research which could show how trust between the community and other organisations in partnerships is developed and maintained would be useful in demonstrating whether and how local needs can be met alongside organisational goals.

**Community engagement in health improvement partnerships**

- Partnership working has impacts upon community and voluntary sector organisations which often lack spare resources to put into partnerships. An assessment of these impacts and costs may indicate whether this is a sustainable approach if expanded to other areas of activity and service delivery in the future.

- There is conflicting argument and evidence about whether community-sector partners want to be involved in strategic or operational decision-making within partnerships. Some clarification of the meaning of each of these aspects of partnership working would help future partnership arrangements, as well as evidence about community preferences and abilities in relation to each.

- A question that might be considered in more depth is: To what extent do communities want to be included in health improvement initiatives, and what role do they wish to play? This consideration could take the form of more intensive qualitative research to examine the expectations of community and statutory partners in terms of what level of involvement (strategic or operational) by communities is appropriate, the ways in which community inputs fit in with the role of the partnership as a whole, as well as the consequences of conflicting roles and expectations.

- Communities are not homogenous entities, and partnerships face the challenge of trying to engage both the more vocal and the more hidden members of communities. The degree to which partnerships, or their community sector members, manage to make connections with all elements of the community is worth exploring. The barrier to this may be the fact that some groups are hard to reach; it may be that some groups are more powerful within communities and thus ‘drown out’ others; resources to engage more widely may be a constraint; or the organisational infrastructure may be lacking locally to enable this to happen. Research could tell us which of these factors was the most important in constraining engagement with all elements of a community, if it is indeed constrained.

**Impacts and outcomes of community initiatives for health improvement**

- Several issues are highlighted here which have implications for further research: clarity about the type of outcomes that are defined in health terms (i.e. improved well-being or changes in factors that are linked to ill health); how to measure these outcomes (i.e. relying on self reporting or the perception of those involved in community health improvement initiatives or members of the community, versus more objective indicators).

- Research should combine studies of particular communities with contextual or ecological measurements of health within the wider urban or regional area, and the communities therein. This will enable researchers to assess whether local initiatives contribute to health gains beyond what is improving as a result of wider policy actions and social changes, as well as to gauge the extent to which local actions help reduce health inequalities across communities.
Studies of community understandings of what constitutes a healthy or unhealthy community, and of communities' views on what is affecting health locally should be undertaken in a range of Scottish communities. Not only will this help identify local influences upon health, but it will also begin to address the question of whether there are local community cultures in which health issues are considered in different ways from mainstream or conventional understandings.

Individual gains from participation in community-based health improvement partnerships should be explored, covering both immediate impacts upon the individuals concerned and secondary effects through these individuals upon the members of their own social networks and the wider community. Active individuals with an interest in health improvement may act as catalysts for wider impacts which have yet to be considered.

Quasi-experimental research, which would add to our repertoire of investigative tools for studying health impacts, should be expanded. Such studies, comparing intervention and comparison areas (no areas are static enough to be controls), would enable researchers to identify the added value of community-based initiatives, over and above the effects of other activities, particularly targeted at deprived communities.

Longitudinal community-based research programmes should be established so that we can assess the relationships between intermediate health outcomes (those that help create healthy neighbourhoods) and longer-term community health improvements.

**Evaluation**

A range of evaluation tools are available, and thought should be given to the most appropriate forms of evaluation for a particular initiative. Important lessons can be taken from evaluation of community-based health improvement, but the variability of approaches to evaluation, in terms of research methods and the purpose of the evaluation, mean that it can be difficult to draw conclusive results. Research could attempt to investigate to what extent different models and tools of evaluation can provide useful assessments and learning for communities, practitioners and policy-makers.

**Policy context for engagement in partnership working**

Of course, any further research will be conducted as current developments in the policy environment are played out. Both the review of literature and the experiences of the case studies in the current research have highlighted the difficulty faced by partnerships on the ground when major policy changes are implemented. As highlighted by the scoping interviews reported here, evaluation of the new community health partnership structures will indicate whether the optimism highlighted in the key player interviews is justified, or whether the changes in fact have less positive implications than is hoped.
PART I: BACKGROUND
This part of the report begins with an overview of the policy context relating to health improvement and community participation. This is followed by a description of the aims and objectives of the study, and the methods that have been employed as part of the research carried out by the University of Glasgow for the Evidence/Measuring Success sub-group of the Community-led – Supporting and Developing Healthy Communities task group.

**Policy developments in Scotland**

The Scottish Executive’s focus on health inequalities, with attention to deprived communities, is combined with an emphasis on involving individuals and communities in the design and delivery of health services.

The benefits of partnership working and collaboration are widely recognised, and this has resulted in a variety of initiatives including Joint Health Improvement Plans which are produced for each local authority area through community planning partnership mechanisms. Emerging community health partnerships will play a central role in future planning and delivery, working with other community planning partners.

**Research aims and methods**

The research presented in this report aims to bring together a range of evidence underpinning current approaches to community-based health improvement. This has been achieved via two strands of work:

- a review of existing literature on factors that promote community health and well-being, and the role and effectiveness of community participation in health improvement initiatives
- qualitative research involving interviews with key players, and two exploratory case studies concentrating on the process of partnership working from the perspectives of community and statutory partners.
1. INTRODUCTION AND POLICY CONTEXT

On behalf of the Evidence/Measuring Success sub-group of the Community-led — Supporting and Developing Healthy Communities task group, Health Scotland commissioned this research to explore and review evidence and current activity around community-based health improvement in Scotland.

The primary aim of this report is to review the lessons to be learnt from activity aimed at improving the health of communities, concentrating predominantly on the UK, with a focus on current activity in Scotland. The objectives were to examine the evidence underpinning community-based approaches to health improvement, and to gain an insight into the characteristics of effective and less effective partnership working between the different stakeholders involved in community-based health improvement.

A broad range of health improvement activity is ongoing in Scotland and there is great potential to draw on experiences to date. While all of this work goes on it is useful to learn from existing efforts, share the lessons of what has or has not worked, and feed this into future planning and development. The report considers:

- What do we know about the impact of collaborating for community health improvement?
- What can we learn from this in order to build on current knowledge and to progress health improvement efforts in Scotland?

The report is intended for practitioners and policy makers with an interest in health improvement. This will include individuals from a range of sectors: community, voluntary, statutory and academic. We believe the added value of this piece of work, other than its Scottish focus, is that it explores definitions and views throughout the whole ‘community-based’ health improvement spectrum, ranging from practitioners and delivery agents to policy makers. It specifically attempts to uncover what, indeed if, we know about how community-based health improvement efforts have impacted on communities, as opposed to individuals.

This report can, therefore, inform the future development of health improvement work in Scotland. Findings have been arrived at through a comprehensive review of literature, and qualitative research comprising interviews with key players and case study work. The report includes boxes with summaries of the key points emerging from the research. Before moving on to the research, we provide an overview of the context within which community participation is being promoted, and the key policy developments that underpin health improvement activity for Scottish communities.
The current interest in participation is offering unprecedented opportunities for citizens to engage in the decision-making process.

(Taylor 2003: 111)
COMMUNITY ENGAGEMENT

‘The current interest in participation is offering unprecedented opportunities for citizens to engage in the decision-making process’ (Taylor 2003: 111). We see policy documents filled with reference to ‘citizen engagement’, ‘collaboration’, ‘community participation’, ‘capacity building’, ‘partnership’ and so on (e.g. Audit Commission 1998; Department of Environment, Transport and the Regions 2000; Department of Health 1998).

McLaverty (2002) argued that this interest in citizen participation occurs for a number of reasons. Participation is thought to be desirable because of its educational value for individuals, because it facilitates deliberation over different viewpoints, or for its potential to enhance social capital with the result being increased trust and reduction of social exclusion. There are also instrumental reasons for promoting citizen engagement, for instance local authorities’ involvement of the public in consultations in response to the agenda of central government. A further rationale focuses on the value of the tacit knowledge and skills which are present in communities (Taylor 2003).

These rationales have emerged from perspectives external to the communities that they address. A community development perspective, on the other hand, would emphasise that empowerment is central to the participation agenda. Several authors have produced models of citizen participation that indicate the various gradients of empowerment. The most often cited model is that of Arnstein (1969). This model moves through degrees of participation from non-participation and tokenism to citizen power, the highest degree being citizen control. Burns et al (1994) took this model forward with the assertion that citizens can experience different levels of participation within different spheres. Similarly, a model produced by Labyrinth Training and Consultancy addressed degrees of participation in specific situations (cited in Smithies and Webster 1998).

Thus, community participation in public policy initiatives is promoted for a number of reasons, mostly not directly health-related. These reasons range from those which serve the interests of the policy-maker (e.g. to support the legitimacy of the policy process or to share risk and responsibility with other actors); to those related to the success and sustainability of the initiative itself (e.g. achieving shared ownership of the activity or intervention or making better-informed decisions); to those reasons pertaining to individual benefits (e.g. the educational and experiential value of participation) and to community gains (e.g. in terms of enhanced social capital). In any attempt to assess the impacts of community engagement it is important to establish the rationale(s) which prompted such engagement in the first place.
SCOTLAND’S POLICY CONTEXT FOR
HEALTH IMPROVEMENT

The Scottish Executive attaches the highest priority to tackling inequalities and improving health. This move towards a focus on inequalities was a feature of the white paper *Designed to Care – Renewing the NHS in Scotland* (Scottish Office 1997). This also aimed to refocus health care provision in order to create a shift towards patient centred care. Following this, the consultation document *Working Together for a Healthier Scotland* (Scottish Office 1998) placed an emphasis on community development and established that social and economic inequalities and individual and community involvement should be acknowledged within health policy. The paper stated a commitment to ‘strengthen communities in need, promoting a sense of belonging, hope, self-esteem and confidence...’, recognising that this was a role for a broad policy and practice approach and not just for the health sector.

The green paper and the white paper which followed – *Towards a Healthier Scotland* (Scottish Office 1999) – took on board recognition of the impact of life circumstances on health inequalities and highlighted the need for public health policies to tackle the wider determinants of health that affect quality of life.

In 2000 the Scottish Executive set out their commitments to rebuild the Scottish NHS in the Scottish Health Plan, *Our National Health: A Plan for Action, a Plan for Change* (Scottish Executive, 2000). In addition to service planning and modernisation, the document made a commitment to building a national effort to improve health and to reduce inequalities in health. This was reinforced by the announcement in 2000 of the Health Improvement Fund (Scottish Executive 2001), which placed expectations on health boards and local authorities to work together to direct money towards local communities, with a particular focus on Social Inclusion Partnership areas (Taylor 2002).

In addition to increasing the emphasis on health improvement, *Our National Health* also outlined core aims to give patients a stronger voice and to involve people and communities in the design and delivery of health services. Further policy moves in this direction included the release of the Scottish Executive Health Care Division document *Patient Focus and Public Involvement* (Scottish Executive 2001a). This stated that a ‘patient-focused’ NHS is a service which exists for the patient and which is designed to meet the needs and wishes of the individual receiving care and treatment. These efforts to increase involvement in planning are intended to ensure that services meet what users consider their needs to be, and that value for public money is obtained (Foley and Martin 2000). Participation at service level has been developed in numerous ways, typically through consultation with users or patients (that is, service users in health related settings), focus groups, user groups and representation on committees. Once passive recipients of health care, users and patients are increasingly acknowledged as active consumers with the right to certain standards of service, including the right to full information, to be treated with respect and to be actively involved in decision-making about treatment.
HEALTH POLICY AND COMMUNITY ENGAGEMENT

The shift in thinking and policy regarding the health of the population during recent years has acknowledged the need not only to improve and modernise services and to tackle the wider determinants of health (Scottish Office, 1997, 1999; Scottish Executive 2000), but also to engage with local populations so that real improvements in the health of individuals and communities can be delivered.

The communities we live in can have a significant influence on our health, as evidenced by the wide gap between the most deprived and most affluent communities (Scottish Executive 2000). In recognition of this, the Scottish Executive has focused on measures to secure social justice. The Scottish Executive strategy to improve the health and well-being within communities embraces all communities in Scotland but is particularly targeted at deprived communities (Scottish Executive 2003). The approach has acknowledged the ways in which disadvantages in early life carry over into later life. It has involved anti-poverty work particularly focused on children and young people, and community regeneration programmes which have targeted areas of concentrated deprivation as well as vulnerable groups, alongside a range of other policy initiatives. The vision for social inclusion in Scotland was based on the five key principles of integration, prevention, understanding, inclusiveness and, importantly in the context of this study, empowerment. This is key because ‘the benefits of action to promote inclusion will only be sustainable if they enable individuals and communities to take up new opportunities, and to take control of their own situations’ (Scottish Office 1999a).

In addition, a number of key national policy developments have emphasised the need to work in partnership for health improvement planning and delivery at a national and local level. Partnership working is seen as vital to the success of health improvement activities. The white paper, Partnership for Care (Scottish Executive 2003a), highlighted the value of partnership working in the delivery of services to the population, and outlined the Government’s commitment to improving partnership working.

The emphasis on the benefits of engaging with communities for improving community health gained momentum with the release of Improving Health in Scotland: The Challenge (Scottish Executive 2003). This emerged in response to Scotland’s continuing poor health in relation to our UK and European neighbours, and commits to an approach which will ‘encourage, support and enable individuals and communities to take shared responsibility for their own health and to work together to bring about improvements’, as well as supporting action to ‘address poverty, lack of physical activity and leisure facilities, poor housing and other factors that contribute to inequality’ (Scottish Executive 2003). One of the four key strands of the challenge is ‘community’, along with early years, teenage transition and the workplace. Consequently, the Community-led – Supporting and Developing Healthy Communities Task Group was established in November 2004 to progress the community-based pillar of the ‘Health Improvement Challenge’ and to address health inequalities in the context of ‘Closing the Opportunity Gap’.
An approach which will:

Encourage, support and enable individuals and communities to take shared responsibility for their own health and to work together to bring about improvements.

(Scottish Executive 2003)
A priority for the task group was the establishment of a dialogue with key local and national networks to advance a shared vision and ownership for community-based health improvement amongst community planning partnerships, community health partnerships and the social economy. The task group also set out to review the evidence on community-based health improvement action and to make recommendations to improve the evidence base. The promotion of effective community-based approaches, together with highlighting models of good practice which demonstrate health improvement have been central to the group’s remit. The task group undertook to engage with individuals and groups within communities who are currently working in this field in order to highlight and promote best practice, and to fully develop ownership of this health agenda across sectors (Community Health Exchange 2005). Four sub-groups were established: planning and partnership working, community-based activities, community engagement, and evidence/measuring success. It was decided to commission research to explore and review evidence and current activity around community-led health improvement in a Scottish context, from which this study has emerged.

A concurrent development was the launch of the National Standards for Community Engagement (Communities Scotland 2005). This included 10 standards for community engagement, each with a series of indicators to assess performance, that can be used to improve working relationships between communities and agencies that deliver public services.

CURRENT POLICY DEVELOPMENTS

The Local Government in Scotland Act [Scottish Parliament 2003] set out a duty for local authorities to lead the community planning process, and it also sets out further duties on other local statutory agencies to participate in the community planning process. Moreover, Part 3 of the Local Government in Scotland Act 2003 gave local authorities discretion to ‘do anything they consider is likely to promote or improve the well-being of their area and/or persons in it’ (Scottish Executive 2004).

Community planning partnerships provide the overarching framework through which public services in an area are planned and provided in consultation with public bodies and with the community (Scottish Executive 2003b, 2004a). The local authority, NHS and other agencies within the partnerships were expected to agree processes to ensure that the health improving potential of community plans, social inclusion partnerships, healthy living centres and other community-based initiatives are optimised in future (Scottish Executive 2003b).

A national move to bring local partners together was evident in the development of Joint Health Improvement Plans. These are produced for each local authority area by local authorities, NHS Boards and other partners within the community planning partnerships. The Scottish Executive (2002) issued guidance requiring the development of Joint Health Improvement Plans that emphasised health as a key element of community planning.
The National Health Service Reform (Scotland) Act 2004 provided for the establishment of community health partnerships by placing all health boards under a duty to establish either a community health partnership for the area of the health board or two or more community health partnerships for districts which will include the whole area of the Health Board (Scottish Executive 2004b). The background to the development of community health partnerships is contained in Partnership for Care (Scottish Executive 2003a), and reaffirmed in the Partnership Agreement (Scottish Executive 2003b). This stated that local health care co-operatives will evolve into community health partnerships, which will have a new, more consistent and enhanced role in service planning and delivery, working as part of decentralised but integrated health and social care systems. The statutory guidance states:

‘It is intended that Community Health Partnerships will create better results for the communities they serve by being aligned with local authority counterparts and by playing an effective role in planning and delivering local services’ (Scottish Executive 2004a).

The Community Health Partnerships Development Group Sub-group on Health Improvement (2005) have also asserted that community health partnerships are well placed to play a key role in developing an approach that seeks to address the life circumstances, lifestyle and health priorities identified nationally, and will be important partners in shaping future development and delivery of these plans within the community planning framework.

STRUCTURE OF THE REPORT

The report is divided into three parts: Part I compromises this introductory chapter and Chapter 2 which outlines research aims and methods. The remainder of this report brings together research addressing the nature and impact of community-based initiatives for health improvement. The research is presented in two parts: Part II covering the literature review, and Part III presenting the findings from qualitative research. Contents summaries are provided at the start of Part I and Part II. In addition, summaries are included in boxes at the beginning of individual chapters within Part II to highlight the key findings of the literature review. Tables containing details of key pieces of research are included at the end of Chapters 5–8 as a quick reference guide to key publications included in the review. The current state of play with regard to the evidence base on community participation in health improvement partnerships is examined at the end of Part II and Part III, indicating areas of research that have yet to be taken forward.
RESEARCH AIMS AND METHODS

AIMS AND OBJECTIVES

The overall research aims were to gain an understanding of current evidence underpinning community-led approaches to health improvement and to gain an insight into the characteristics of effective and less effective partnership working between the different stakeholders involved in community-led health improvement.

There were two objectives:

- to explore, review and synthesise published and unpublished literature regarding evidence, activity and influences on factors which promote community health and well-being
- to conduct qualitative research to explore partnerships and relationships within community-led initiatives and programmes designed to strengthen and improve community health and well-being.

These research aims and objectives were addressed through the following research questions:

1. What factors affecting health and well-being have relevance for community-led interventions?
2. How do community-led projects and initiatives seek to improve health and well-being in the local community? e.g. What aspects of community health and well-being are being tackled, and by what means?
3. What role do communities and community-led initiatives play in partnerships? What barriers and opportunities exist for engagement by community-led initiatives in partnership work?
4. How effective are collaborations for health improvement in terms of partnership working?
5. How does involving the community contribute to the outcomes of community health improvement initiatives?

METHODS

The research was carried out in three stages:

- a literature review to establish what is known about the influences on community health and well-being, and the effectiveness of partnership working in this area
- qualitative scoping interviews to provide a broad picture of partnership working at a local level
- qualitative case studies to investigate the effectiveness of partnership working involving communities.

Stage 1: Literature review

The initial stage of the research involved conducting a literature review in order to determine current knowledge of the factors which affect community health and well-being, and the characteristics of effective and less effective partnership working involving community-based initiatives. The review informed the remainder of the research strategy by identifying key issues within the policy and research context.

The criteria for inclusion/exclusion were as follows:

- Search terms – community, partnerships, health, well-being, and derivatives;
- Geographical focus – with respect to the first research question (see page 27) the geographical focus was on the developed world, while searches relating to the remaining research questions were UK focused;
Time – searches were limited to materials available from 1990, although earlier key documents identified in the course of the review were also included; 

Language – non English-language material was excluded.

The review of literature was conducted with due consideration given to the diversity of information sources available, including published and unpublished material, and encompassing academic, policy and practitioner outputs (Grayson and Gomersall, 2003). The sources that were utilised are listed below.

The published academic literature was searched via the following databases:

- MEDLINE (Bibliographic records and abstracts of biomedical literature from 1996 onwards)
- CINAHL (Cumulative Index to Nursing and Allied Health Literature)
- EMBASE (Records of biomedical literature)
- Cochrane (Database of Systematic Reviews)
- PsycINFO (Records of research in psychology and related behavioural and social sciences)
- ASSIA (Applied Social Sciences Index and Abstracts)
- Web of Science (Social Science Citation Index)
- BIDS (International Bibliography of Social Science)
- ZETOC (British Library Electronic Table of Contents)
- Regard (ESRC awards and publication outputs)
- WebSPIRS (Sociological Abstracts)
- UKOP (database of UK official publications).

Tables of contents from specific target journals considered likely to include academic research on community participation and healthy communities were searched electronically. These included journals in the fields of social policy, sociology, voluntary sector studies, and health studies.

Searches of the grey literature (i.e. material that is unpublished or not formally published) were carried out in a systemised way using relevant policy, practice and research web sites. In addition, unpublished literature produced by community-based organisations was gathered via calls for information issued by Community Health Exchange and members of the steering group for this research.

Certain limitations of the search strategy should be noted. Firstly, there are limitations in relation to the coverage and quality of databases, and the variability of search facilities (Grayson and Gomerall, 2003). Efforts were made to address terminological difficulties by considering alternatives for non-specific key words such as ‘community’. Secondly, it has not been possible to gather unpublished literature to the extent initially hoped for because of difficulties in accessing this kind of information. Limitations of the items reviewed are discussed below (see p.19).

Stage 2: Scoping interviews

Stage 2 of the research was devoted to providing a broad picture of the existing processes for the involvement of community-based initiatives in partnerships aimed at improving community health. Semi-structured interviews were carried out with key players in the public sector and the voluntary sector (eight interviews in total, including one interview wherein two interviewees were present). The following were interviewed:
Stage 3: Qualitative case studies

The third stage of the research employed qualitative methods to investigate the perceptions and experiences of different stakeholder groups involved in partnership working to improve community health and well-being.

Selection of cases

Two types of partnership were chosen as examples of contrasting approaches to the formation and/or development of partnership working. We recognise that there are key elements of partnership formation and development that we have not been able to control for, such as the nature of the issues they were designed to tackle, and the resources that have been made available. However, the focus of the research is to increase understanding of the process of community involvement in health improvement, and we make no claims for generalisation of the findings to other partnerships.

Data collection and analysis

Background information was gathered for each case study, drawing on local reports and other available documentation. Semi-structured interviews were carried out with representatives from public, voluntary and community sector groups active in each setting. Interviews were used to elicit participants’ interpretations of the challenges and achievements of community-based health improvement. These covered the organisations’ involvement in formal governance structures, including how far they aimed to represent local communities and the extent to which they offer a representative perspective, expectations in terms of how much influence can be exerted, the nature of the relationship with local public bodies, and shared understandings of community health problems and solutions.

Interviews were recorded and transcribed. Full consent for participation was obtained from all research participants on provision of an information sheet about the research. Analysis of interview transcripts was ongoing throughout the data collection period. The case study reports were forwarded to a key member of the selected projects in order to check the accuracy of the findings.
PART II:
REVIEW OF EVIDENCE AND APPROACHES
This part of the report presents the literature review findings. The review looks first of all at factors associated with community health and well-being, before moving on to concentrate on the role and effectiveness of community participation in health improvement initiatives.

Factors that promote community health and well-being

Chapter 4 considers aspects of community and neighbourhood that can affect community health and well-being. This draws on a holistic framework that brings together medical and social models of health. The broad spectrum of influences on community health and health inequalities takes in demographic characteristics, social and physical environments including service provision, cultural influences, and community empowerment. In Chapter 5 special attention is given to the role and impact of social capital with regard to community health, due to the predominance of literature addressing this topic. These chapters offer a guide to the literature on factors that influence health, rather than a full systematised review.

Community participation in health improvement

The second part of the literature review looks at the ways in which communities can participate in the planning and delivery of health programmes and initiatives. This begins with an overview of the literature on partnership working (Chapter 6) before examining more closely the role of communities in collaborations for health improvement. The process of engaging communities (Chapter 7) and the impacts of community engagement (Chapter 8) are considered in turn. This is followed by a chapter on evaluation of community-based health initiatives (Chapter 9). Finally, the gaps in knowledge indicated by the literature review are discussed in Chapter 10.
3. AIMS AND PARAMETERS OF THE REVIEW

The purpose of this review was to gain an understanding of current evidence underpinning community-based approaches to health improvement and to gain an insight into the characteristics of effective and less effective partnership working between the different stakeholders involved in community-based health improvement. The review covered literature relevant to four of the research questions (1, 3, 4 and 5) outlined on page 25.

The review was based on a search of published and unpublished literature using a variety of academic search engines and relevant policy, practice and research websites. Criteria for inclusion in the review included papers and documents which addressed both community strength and health issues, and explicitly focused on activities which aim to improve health. The geographical focus for the review varied according to the research question being addressed. In relation to the first question (what factors affecting health and well-being have relevance for community-based interventions?) the review took in material from the developed world, though retaining an emphasis on evidence from the UK. However, searches relating to health improvement activity (i.e. the focus of research questions 3, 4, and 5) were primarily UK-focused, using Scottish examples wherever possible. A full description of the methods used can be found in Chapter 2.

There are a number of limitations to the review. The material presented has been included due to the degree of relevance to the study, but the nature of the research evidence should be borne in mind. The material reviewed did not lend itself well to formal rating of evidence or production of graded recommendations for action. However, as far as possible, comments have been included throughout the report on the appropriateness and quality of the reported evidence.

A specific limitation arises from the fact that a considerable portion of the evidence for this review comes from evaluations of larger scale complex community-based initiatives such as health action zones (HAZs), and within Scotland the National Health demonstration projects and social inclusion partnerships, which tend to be government-funded evaluation. Whilst they have presented us with valuable learning they also have their limitations in that they provide a broader picture of an initiative which might miss smaller-scale impacts of health improvement work.
A systemised review of unpublished ‘grey’ literature was conducted using the British Library website, those of research institutes, and other relevant Scottish policy and practice websites. However, a particular difficulty associated with reviewing material in this area has been the extent to which ‘grey literature’ can feasibly be included. This stems primarily from the location of a wealth of relevant information and experience within the voluntary and community sector that is either unpublished, or not easily accessible using conventional approaches to literature searching. It was not within the remit of this study to systematically capture this material. This would have required a much more resource-intensive approach, for instance employing surveys of voluntary and community groups and networks to gather relevant publications. So, whilst efforts have been made to gather this sort of material, we recognise the potential for adding to this.

Where grey literature has been included it has often been in the form of small-scale evaluation. Again, the difficulties associated with evaluation and monitoring by smaller projects and initiatives resulting from a lack of support and resources for the task have been acknowledged (Hills 2004). Much of the available information about activity in Scotland was in the form of brief project summaries or short magazine and website pieces. This made it difficult to gauge the progress or ‘success’ of many community health initiatives due to the limited availability of information. A decision was taken, therefore, to include information where some level of independent judgement of progress against a project’s objectives could be made. A small number of additional examples of community-based projects were sent to the research team in response to a call for information on health improvement activity in Scotland. These have been included in boxes throughout Chapters 6 to 8 to illustrate activity.
4. UNDERSTANDING COMMUNITY HEALTH AND WELL-BEING

This chapter examines the extent of understanding of health and well-being at community level, using holistic models of health. Dimensions of these models are considered in the context of neighbourhood and community.

KEY POINTS

- People’s health, and that of whole communities living in and sharing the same space, is affected by factors relating to the individual, the community and society, and wider structural factors such as economic and environmental conditions.

- It is appropriate to define health broadly to include: physical and mental health and functioning; illness and disease; well-being; sense of life satisfaction; and quality of life. In this way individuals are seen as biological, psychological and social entities.

- A holistic perspective on health seeks to examine a range of interconnections between different domains at the level of the individual, the community and the wider region. At the individual level this includes the way in which psychosocial stressors derived from home, community or work can impact upon physical health through biological processes. At higher levels, the holistic perspective would consider, for example, how a community’s relative position within the region can have direct effects upon the level of provision of health and other services, as well as investigating the psychological impacts of area stigma upon resident populations.

- Inequalities in health between communities are important to improving population health as a whole, in social justice terms, and because some communities may become unsustainable if poor health is not improved.

- Inequalities in poverty and health may have further health impacts via the isolation, anxiety and insecurity they produce among members of a poor community. The extent to which these effects are present at different spatial scales, including within local communities, is largely unknown and worthy of investigation.

- Neighbourhoods and communities can be viewed as physical, social, service and cultural environments. Least attention has been paid to assessing whether communities have local cultures that protect or damage health.

- The accessibility, connectivity and reputation of an area are also important determinants of what people and communities can achieve in terms of advancement and integration into wider society.
A HOLISTIC MODEL OF HEALTH

As a foundation for wider interventions to promote and support health, many commentators, researchers, and practitioners have referred to a ‘social model of health’, contrasting this with a biomedical model seen in turn as ‘disease-centred’ and prescribing a clinical approach focused on identifying and treating specific conditions. Such polarisation is open to challenge. It can be argued that the key distinction is between a narrow biomedical view of health and a wider, or holistic, model that also incorporates social influences and dimensions.

There are a number of definitions and concepts relating to the idea of a wider model of health.

In 1948 the World Health Organisation acknowledged the broader dimensions of health encompassing social and emotional elements, and defined health in idealistic terms as a ‘complete state of physical, mental and social well-being and not merely the absence of disease or infirmity’ (www.who.int/home-page). The 1998 World Health Declaration stated that the enjoyment of health is one of the fundamental rights of every human being and argued that health is a precondition for well-being and quality of life, and a benchmark for measuring progress towards the reduction of poverty, promotion of social cohesion and elimination of discrimination.

Whilst these definitions are important, they have previously been regarded as ambitious or even utopian (Mackenzie et al. 2001). The World Health Organization’s (1986) Ottawa Charter on Health Promotion put forward a now widely adopted definition of health promotion as enabling people to gain control over and to improve their health.

It placed the emphasis on empowering people to have greater control over their health and shifted the spotlight away from health care services and toward other determinants of health in the environment and in living conditions and lifestyles. However, it is important to acknowledge the difficulties of this approach for some individuals. As stated by the Population Health Agency of Canada (2002), ‘self-responsibility for health must be distinguished from self-reliance. Individuals, families and communities cannot be blamed for failing to rely on resources (economic, social, psychological) they do not possess or have reasonable access to.’

There are several models or frameworks of health which have been reproduced in theoretical and policy literature about health promotion. One interpretation by Dahlgren and Whitehead (1991) is shown in Figure 1 overleaf. Their model is built around layers of influence and there is now a well-established literature exploring these layers, which form part of a ‘holistic’ model of health.
Self-responsibility for health must be distinguished from self-reliance. Individuals, families and communities cannot be blamed for failing to rely on resources (economic, social, psychological) they do not possess or have reasonable access to.

Population Health Agency of Canada (2002)
Figure 1: Dahlgren and Whitehead’s Social Model of Health (1991)
The inner layer consists of factors that are 'fixed' such as age and sex of individuals. Collectively these form the demographic composition of a community and will be strong predictors of population-level outcomes of health improvement (Roussos and Fawcett 2000).

The next two layers of the model can be seen as encapsulating what is known as 'social capital' (discussed in more detail in Chapter 5). Thus, the inner layer is surrounded by lifestyle factors that can be either health enhancing (e.g. physical activity and healthy eating), or health damaging (e.g. poor diet and smoking).

The next layer is the interaction of the individual with family, friends and others around them in their wider communities. The positive health effects of the social support that individuals and communities gain from these sources have been widely documented (Seeman 1996). Furthermore, community empowerment through increased social connectedness has been related to the community’s sense of its own identity, power and influence and its connections and integration with wider political sources and economic structures, which in turn may affect people’s health. Health outcomes are linked to what a community can achieve for itself and how community strength makes people feel about themselves. These interactions are considered to have important influences on health through the development of social capital.

Wider influences on individual health are related to living and working conditions, including access to essential services and facilities. The neighbourhood as a physical and service environment can also have a significant impact on health. For instance, differences in housing conditions between neighbourhoods may relate to physical and mental health (Parkes and Kearns 2006). Area health differences could also reflect differences in the ease of access to essential services such as food shops, pharmacies and health services, as well as the provision of leisure services that afford opportunities for health related activities (Parkes and Kearns 2006).

Environmental factors such as appearance and noise can also determine whether a place is an enjoyable or stressful place to live. These types of factors have been tackled through a range of work that aims to improve quality of life through the addition of green space (Greenspace Scotland 2004). This work exemplifies the impact that environment has on the lives of individuals and communities, including transport (e.g. providing cycleways and walkways), health (walks led by volunteers, walks on prescription), education (creating educational green spaces) and arts (community arts projects and restoration of green spaces by communities).

Overarching all these layers is the set of economic, cultural and environmental conditions, many of which have a bearing on every other layer. A combination of these factors and the inner layers of the model interact to provide or obstruct opportunities for advancement and integration. This could provide individuals with new skills and opportunities for employment, for example, enabling them to advance towards a healthier, more stable life. At the community level, the prime ability of neighbourhoods and their connectivity externally will also affect people's opportunities.
Generally, the wider models of health that have been proposed share a holistic approach and a multi-causal understanding. In this model people are more than bodies – human existence is simultaneously biological, psychological and social. A healthy life suggests not only a healthy body but also a healthy mind and a safe environment, so health becomes a concept that embraces all the dimensions of human existence (Hughes 2000).

The multi-layered determinants of health can also be viewed as having a cumulative effect. In recent years there has been an increasing recognition of the impact of the lifecourse on ill health. The lifecourse is described as combining biological and social elements which interact with each other. An individual’s biological development takes place within a social context which structures their lifecourse chances, so that advantages and disadvantages tend to cluster cross-sectionally and accumulate longitudinally (Bartley et al. 1997).

A further socio-ecological model of health determinants was proposed by Labonte (1998), which incorporates domains of physiological, behavioural and psychosocial risk factors as well as risk conditions which includes poverty, social status and discrimination.

A model proposed by Evans and Stoddart (1994) consists of several interactive or feedback loops which include factors that influence the health of a community. Distinctions are drawn between ‘health and function’ (i.e. the subjective experience of the individual), ‘disease’ (a category used by the health care system) and ‘well-being’, the individual’s sense of life satisfaction.

To an extent, therefore, well-being is psychological and subjective, related to how people feel about themselves (Callahan 1978), which for many people will involve comparisons between their current circumstances, their aspirations and expectations, and the circumstances of others. The Evans and Stoddart model is complex in that it identifies several major fields of influence on health status and their interactions. Key drivers of the model are the physical environment, which includes the built environment, and the social environment, incorporating family, work and networks. The model explicitly acknowledges a broader definition of health, with the broader outcomes of disease, well-being, health and function.

These models share a holistic perspective which incorporates health and well-being, and makes connections between the social and the medical models of health. It is clear that we are beginning to learn how social conditions can not only affect a person’s mental health but also impinge upon physical health mechanisms. For example, there is a lot of current interest in exploring how psychosocial stressors (which may have their source at home, in the community or at work) can have biological impacts (Steptoe and Marmot 2002). A holistic model of health also recognises that health services are extremely important both in preventative health work and in treatments, influencing variations in recovery and survival rates for major diseases, even within a country such as the UK with relative global prosperity.
HEALTH INEQUALITIES

Health inequalities are differences in various aspects of health which are found between different groups in society. The publication of the Black Report (Department of Health and Social Security 1980) placed the difficult issues around inequalities in health into the political arena. There is now a considerable body of evidence pointing to the direct and indirect links between unequal social and material circumstances and health inequalities (see Marmot and Wilkinson 2005; Graham 2003).

There is a general consensus in the published academic literature that inequalities in health are inextricably linked to socioeconomic factors such as education, employment and income (e.g. Blamey and Murie 2002; Davey Smith et al. 1999; Marmot and Wilkinson 2005; Shaw et al. 2001) as seen in the outermost layer of Dahlgren and Whitehead’s model.

In the Scottish context, analysis of local authority area health statistics found that poverty was strongly associated with area-level health (Patterson 2002). Recently-published research showed that poverty and social exclusion in Scotland is high with almost a million people in Scotland still living in income poverty (Palmer et al. 2005). These studies also demonstrated substantial health inequalities between different areas in Scotland and between different groups within the population. The most recent analysis, based on the Scottish Index of Multiple Deprivation 2004, shows an 11 year life expectancy gap between the most deprived and least deprived communities. Inequalities in the experience of illness are also evident: limiting long-term illnesses are two and a half times more common in the most deprived areas than in the least deprived; admissions to hospital for respiratory illnesses are three times more common in the most deprived areas (Scottish Executive 2005).

There are also inequalities in access to health care. For instance, there is lower take-up of all types of preventive care in deprived communities and among black and ethnic minority populations (Majeed et al. 1994). Some of this is likely to be due to the health care seeking behaviour among these groups, some to access problems (partly due to language barriers and a lack of information), and the capacity of GP practices to provide the care, particularly in inner city areas. Inequalities also exist in health outcomes, and these may be related to a mixture of individual, lifestyle and socioeconomic factors as represented in Figure 1, in addition to access to health and social care services.

The evidence that inequalities in health have a strong geographical or spatial dimension is well established and there is growing understanding of the role that ‘place’ plays in influencing individuals’ and families’ levels of exposure to health risks as well as their chances and opportunities for being healthy (Health Development Agency 2003). Physical as well as mental health is influenced by the stress associated with living in neighbourhoods where the environment is seen as threatening, where the quality of the housing is poor and transport facilities are lacking (Department of Health 2002; Parkes and Kearns 2006). It has also been argued that attitudes towards the community in which a person lives can influence their health (Mitchell et al. 2000). This research showed that attitude to the community is significantly related to health, independent of other individual characteristics and the degree of deindustrialisation in the area.
Building on the Black Report (Department of Health and Social Security 1980), and the subsequent growing body of research demonstrating the extent of health disparities in the UK, (Benzeval et al. 1995), an independent inquiry into inequalities in health was established in 1997 and led by Sir Donald Acheson. The review examined aspects of the life course, the socio-economic determinants of health and health-related behaviours. It explicitly recognised the link between poverty and poor health and called for more equitable and democratic services, including wider use of community-based approaches. The findings of this report emphasised the need for concerted, co-ordinated action to address the causes as well as the consequences of health inequalities, which would require action across a wide range of government departments and organisations.

Investment at a number of different levels of the holistic model of health are required. Benzeval et al. (1995) identified four such levels of intervention:

- improving the physical environment
- addressing social and economic factors
- reducing barriers to adopting a healthier lifestyle
- improving access to appropriate and effective health and social services.

Central to health improvement efforts at the community level is the alleviation of poverty. Thus employment, income maintenance and social security policies are crucial (Shaw et al. 1999). Similarly, educational interventions have a vital role to play in improving life chances and, therefore, health (Blane et al. 1996). Adequate housing and improvements to the physical environment also have a role – particularly in relation to respiratory health and accident prevention, for example (Thomson et al. 2001).

In recent years the Government has made steps towards these goals through area-based initiatives, centred on the more deprived communities with the aim of reducing inequalities in health and its determinants. The Scottish Executive has adopted the ‘closing the opportunity gap’ framework which includes an aim to ‘increase the rate of improvement of the health status of people living in the most deprived communities – in order to improve their quality of life’ (Scottish Executive 2003c).

However, there is a danger that local, area-based interventions to tackle severe inequalities might be seen as substitutes for action on the bigger influences. For instance, the Health Action Zone initiative was initially criticised as a way of tackled health inequalities because of its focus on the local level (Bauld et al. 2005). It was argued that the structural causes of health inequalities could not be addressed locally, and it was only through economic reform that health inequalities could be reduced. It is clearly true that major reductions in poverty require such reforms, and should in time reduce health inequalities (Benzeval et al. 2000).
Well intentioned health promotion policies may actually increase, rather than decrease, inequalities in health.

MacIntyre (2001: 118)
Evidence suggests that knowledge regarding effective ways to reduce health inequalities is sparse (Bauld et al. 2001). Petticrew and MacIntyre (2001) found this to be explained in part by the difficulty of defining ‘effectiveness’ in relation to inequalities: that is, interventions can only be considered successful in relation to inequalities when they are at least as effective for the lowest socio-economic group as for the highest. An alternative perspective is that differential effectiveness can be compensated for through targeting those in most need. For instance, Petticrew and MacIntyre (2001) have reported on a number of effective interventions to address inequalities in health including home injury prevention in children and heating installations in damp, cold homes. Nonetheless, it is the case that interventions that are effective in general health terms may be ineffective in reducing health inequalities; as MacIntyre (2001: 118) suggests, ‘well intentioned health promotion policies may actually increase, rather than decrease, inequalities in health’.

This reflects the fact that improving health and tackling health inequalities are related but distinct issues. Graham and Kelly (2004) have recently highlighted the importance of the distinction between ‘determinants of health’ and the ‘determinants of health inequalities’, by noting that ‘tackling the determinants of health inequalities is about tackling the unequal distribution of health determinants’ (p. 5).

In summary, cross-cutting interventions aimed at tackling some of the broader determinants of health may be among the most important mechanisms for health improvement for individuals and communities. Within such an approach, as noted above, increasing attention is being given to community-based approaches.

THE NEIGHBOURHOOD AND COMMUNITY DIMENSION

Community Understandings

Terms such as ‘community health’, ‘community well-being’, ‘healthy communities’, and ‘community strength’ are used to describe the health and well-being experiences of communities. All of these terms are broad and inclusive of social and psychological aspects of health as well as economic and environmental well-being (Hird 2003). For instance, a thriving community might be expected to have an effective system of governance, provide quality services for local people, be clean and safe, and offer opportunities for active involvement.

There has been a move toward asking communities to define health for themselves in order that they can take action to improve their own quality of life. In this context it is important to understand how communities make sense of common terminology, and how their understandings might differ from, for example, those of health professionals. Abbott et al. (2002) explored the meaning of health improvement among those working in and with primary care organisations. Responses ranged from government strategy and NHS service provision, to socioeconomic determinants of population health or the quality of life of individuals. Health inequalities were not mentioned, however. Community understandings of health and health improvement tend to focus on environmental factors (Conner and Tanjasiri 2000; East 2002).
The Impacts of Inequalities

We get a different perspective on priorities if we ask the questions: ‘why do inequalities in health matter?’ and ‘how do health inequalities matter?’ To the first question we might suggest three answers. Inequalities in health between places matter because:

- Without removing inequalities in health between communities we cannot improve the overall health status of the population (Davey Smith and Ben-Schlomo 2003).
- Differences in mortality and morbidity between communities transgress our accepted notions of human rights and social justice (Davey Smith et al. 2003).
- Unhealthy communities will become unsustainable communities because people will die, populations will fall, and there will no longer be continued demand to live in such places (Kearns and Turok 2003).

All three of these dimensions can have wider social and economic consequences for the nation which has to respond and deal with the effects of these situations.

Several answers can also be given to the second question of how inequalities in poverty and health matter. Here we can adapt arguments made about societal differences to the position of different communities within one society. Inequalities in health matter because:

- Inequality between communities reduces social cohesion and results in lower levels of trust, reciprocity, co-operation and civic engagement (see Wilkinson 1996). But in fact the cause and effect pattern may run in both directions: low levels of social cohesion within a society or community may result in few supportive or redistributive mechanisms to constrain inequalities; at the same time, larger inequalities between groups may breed fear and mistrust between them.
- Inequality influences isolation, anxiety and insecurity among those worst off in poverty and health terms, so there is a psychosocial mechanism operating through chronic stress (Jones et al. 2004; Wilkinson 1998). Recent research, in turn, is pointing to plausible pathways whereby psychosocial factors impact upon physical health (Steptoe and Marmot 2005; Steptoe et al. 2005).
- Differences in the design and implementation of public policies between areas can affect people’s social position, their exposure to health hazards and the effects of those exposures, and the social impacts of being ill such as whether disability results and how daily life is changed (Whitehead et al. 2000).

We do not know to what extent residents in any particular community are aware of the hierarchy of inequalities within which they are positioned. Nevertheless, the effects of inequality between communities within a nation or region, and internal to any one community, deserve more identification and exploration. There has been some research on the social and economic effects of area reputation (e.g. Dean and Hastings 2000), but not on the mental and physical health impacts of area stigma.
Studying Neighbourhoods and Communities

In order to consider why community engagement in health improvement might be worthwhile, and what sorts of interventions might result from that engagement, we need a framework for understanding the link between neighbourhoods and health. There have been several recent attempts to provide such a model of the place/health connections, and we shall illustrate three here that take different approaches.

Cummins et al. (2005) adapted Mazlow’s hierarchy of human needs to ask how neighbourhoods meet these needs through what they provide. The quality of neighbourhoods can then be assessed, for example in terms of housing for shelter, health services for healing, crime for security, libraries and swimming pools for play etc. This model has helped in terms of considering data needs to assess neighbourhood conditions, but is better at looking at material than social conditions.

Based on a substantial review of empirical research and theoretical models of neighbourhood effects upon health, Gould Ellen et al. (2001) proposed that four overarching causal mechanisms were involved: neighbourhood institutions and resources, which affect access to health services and the costs of healthy behaviours; physical stresses in the neighbourhood which increase health risks; social stresses such as exposures to crime, violence and noise; and local social networks which keep people informed, shape norms of behaviour, and provide protection against depression and isolation.

A broader approach to the services and features offered by different neighbourhoods which can impact upon health and well-being was provided by Macintyre and Ellaway (2003). The neighbourhood embraces not only physical and built environment features but also socio-cultural features and reputation. Kearns and Parkinson (2001) illustrated how the functions of a neighbourhood in these regards varied across spatial scales, with for example psycho-social benefits (such as status and belonging) operating at a smaller home area scale, and services at a slightly larger locality scale.

Based on research carried out within the ESRC Centre for Neighbourhood Research (www.neighbourhoodcentre.org.uk), Box 1 presents our perspective on the features of a neighbourhood and community which can serve as assets or liabilities when it comes to community health and well-being. Some of these things can be changed locally and others require actions at a larger scale, either to provide necessary resources or to change the wider circumstances within which any particular neighbourhood sits.
### Box 1: Neighbourhood characteristics influencing community health and well-being

<table>
<thead>
<tr>
<th>Demographic and social composition</th>
<th>Community empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical environment (e.g. green spaces, play areas)</td>
<td>(sense of control and involvement in decision-making)</td>
</tr>
<tr>
<td>Social environment (including social capital, civility)</td>
<td>Accessibility and connectivity (e.g. to larger-scale services, to other places)</td>
</tr>
<tr>
<td>Availability and quality of local services (e.g. policing, education, street cleaning)</td>
<td>Area reputation (e.g. postcode discrimination in labour and service markets)</td>
</tr>
<tr>
<td>Local culture and lifestyle(s) (e.g. eating and drinking habits, gang cultures, parenting, attitudes to learning)</td>
<td></td>
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5. SOCIAL CAPITAL, HEALTH AND WELL-BEING

This chapter turns to a highly topical concept in discussions around communities and health: social capital. The evidence of a relationship between social capital and health is examined, taking into account the potential for both positive and negative outcomes.

KEY POINTS

- There has been growing interest in the theoretically plausible connection between social capital and health. Social capital also provides a focus for community-based programmes seeking to improve people’s circumstances beyond the physical environment in which they reside.

- The evidence on links between social capital and health is very mixed and the effects of social capital appear to be weaker than those of structural factors.

- There is some concern that the emphasis on social capital diverts attention away from the effects of poverty and disempowerment. It is difficult to separate the effects of material deprivation and social capital at community level.

- The operation and impacts of social capital are context-dependent. There is some evidence that aspects of social capital (for example, strong, close family ties) have different effects on different groups in different residential circumstances.

- Although not based on research evidence, it has been suggested that, in socially excluded and fragmented communities, social capital can have negative effects upon health, through the production of conflict and risk, as well as by the perpetuation of unhealthy norms. The nature of existing social capital needs to be taken into account in designing community interventions.

- More sophisticated, local studies of social capital and health are required, combining measures of individual and community social capital. Some aspects of social capital are poorly measured (such as bridging capital). Particular dimensions of health, rather than simply general health, should be assessed.

- Plausible mechanisms of interaction between social capital and health should be investigated. Whether social capital can be preventative and/or curative can only be established through longitudinal study.

- The view of social capital as a ‘resource’ for communities has led to more attention being paid to the practical (social networks) side of social capital rather than to the cognitive aspects (norms and trust). The relative impacts of these two dimensions, and their connections, should be a focus of study.

- Social capital operates at different spatial scales. Community interventions should not be relied upon alone to enhance social capital. Wider influences and connections are also important for social networks, norms and trust.
There is not a complete acceptance of the value of the concept of social capital, particularly since there is no consensus over definition. Putnam’s definition is widely cited: ‘the features of social life such as networks, norms and social trust that facilitate co-ordination and co-operation for mutual benefit’ (1995: 67). This definition has been expanded by Putnam (2000) and others (Gitell and Vidal 1998; Woolcock 2001) to identify different types of social capital:

- **Bonding Capital** – strong ties between like individuals, often in the same neighbourhood. These ties enable people to ‘get by’.

- **Bridging Capital** – weaker, less-dense, cross-cutting ties to different types of individuals and groups across a wider space. These ties to more distant acquaintances who move in different circles (Field 2003, p. 65) enable people to ‘get on’.

- **Linking Capital** – vertical connections beyond the community and into networks of power. These ties to individuals with different levels of power and resources enable people to change their situation more so than the other ties, which enable people to simply cope or to improve things to some degree.

A review of the social capital literature carried out by the Office of National Statistics demonstrated clearly the range of definitions that have been employed, and consequently the variation in approaches to measurement (Office for National Statistics 2001). Measures include aspects of social relations, formal and informal social networks, group membership, trust, and civic participation.

Nonetheless, the idea of social capital has received sustained attention over the past decade, being seen as a means of taking forward the discussion on the social determinants of health (Gillies 1998). Campbell (2000) noted the value of the concept in bridging individual- and societal-level explanations of health inequalities. Proponents of strategies to increase levels of social capital, and analysts thereof, suggest that social capital can have various effects at community level (Campbell 2000; Campbell et al. 1999; Kawachi and Berkman 2000), as described below.

On the basis of plausibility, social capital may, firstly, influence health behaviours, either by spreading health information quickly through a community, increasing the adoption of healthy norms, or acting as a break on health-damaging behaviours (e.g. smoking, drug-taking, crime). Social networks, one component of social capital, may also provide access to resources of various kinds.

Secondly, communities with strong social capital may obtain better access to health services and other local amenities due to collective lobbying behaviour for services and better tactics to avoid any reductions in local services. It is also suggested that communities strong in social capital can exert greater influence over policy developments.

Thirdly, social capital, especially in the form of bonding relationships, may impact upon psycho-social processes in a number of ways which have health benefits: as a source of self-esteem and mutual respect (Wilkinson 1996); boosting feelings of safety and a trusting environment; providing social support and care, which in turn produces a sense of well-being and belonging; reducing social isolation and its effects upon ill health; improving the functioning of the human immune system through emotional support and confiding opportunities (Kennedy et al. 1990).
Propositions about the ways in which social capital might operate have been criticised. One strand of criticism suggests that by placing so much attention on strategies for enhancing social capital, policy-makers are diverted from formulating ways of tackling structural inequalities (Almedom 2005). Another relates to the focus on horizontal relationships within communities, which it is argued, ignores power differentials between communities and external agencies (Wallerstein 2002). DeFillipis (2001) uses examples from community development to show that it is the social networks of particular groups that wield power and gain access to capital to improve circumstances. Thus, he is critical of community development programmes that focus on enhancing the social networks of individuals since they ignore the question of access to power circuits.

There has also emerged a literature on the 'downsides of social capital', again based mostly on plausible argument rather than research (see for example Aldridge et al. 2002; Campbell 2000; Portes and Landolt 1996). This warns of the exclusionary effects of social capital, with the potential for highly cohesive communities to have negative health impact on those residing outside. Social capital, operating as a 'club good' rather than as a 'public good', may sustain or exacerbate inequalities between social classes. As well as exclusion, the effects of social capital within a community may be perverse: for example, strong norms conveyed through dense social networks may sustain unhealthy behaviours rather than healthy ones; strong communities may be oppressive and seek conformity in ways that have adverse impacts on psychological well-being or that inhibit routes out of poverty.

Turning to the existing evidence base, the following discussion includes examples of research at differing spatial levels, and examining a variety of measures of social capital, and their associations with different health outcomes.

**SOCIAL CAPITAL AND GENERAL HEALTH OUTCOMES**

The large body of research offers contradictory conclusions in relation to the link between measures of social capital and general health. Much of this research has involved secondary analysis of existing national survey data (see Office for National Statistics, 2001 for a comprehensive description of datasets used in this way). However, while a link has been shown between measures of social capital and health at national level (Cooper et al. 1999), local area studies tend not to support this finding (Mohan et al. 2005; Veenstra et al. 2005; Ziersch et al. 2005).

Moreover, this relationship appears to be weakened when structural factors are included in the analysis (Prevalin and Rose 2000). The relative importance of structural influences has also been demonstrated in international comparative work (Carlson 2004).
SOCIAL CAPITAL AND MEASURES OF ILL HEALTH

It is not only in relation to general health outcomes that there is a lack of positive confirmation of the value of social capital. Cross-sectional data cannot indicate whether ill health is caused by lack of social involvement since a positive relationship between these variables may reflect a co-incidence of reduced social contact with illness. However, longitudinal analysis (which can indicate the temporal ordering of events) of the British Household Panel Survey over nine waves from 1991 to 2000 indicated that social capital does not play an important role in the onset of poor health and in recovery (Prevalin and Rose 2000). The authors suggest that more investigation is required into the relationship between health and social involvement variables.

Research indicates incomplete understanding of the different types of social capital and the ways in which they might help or hinder health outcomes. There is some qualitative evidence that the different forms of social capital are present within different groups (Campbell et al. 1999). Factors such as socio-economic status have been associated with particular forms of social capital (Altschuler et al. 2004). Moreover, different elements of social capital can have various effects (Stafford et al. 2004). These findings suggest that contextual factors are vital for understanding of how social capital actually works.

In summary, this chapter has highlighted both the prominence of the social capital debate in the health field, and the extreme difficulties associated with providing evidence to support or refute the various theories that have been put forward in terms of the link between social capital and health. Varying definitions and measurements abound, and the research evidence is inconclusive. Whilst there are strong associations to be found between social capital and health, evidence is lacking of a strong link between levels of social capital and the incidence of health problems or the rate of recovery from illness. Further research is needed, employing both quantitative and qualitative approaches, to take into account the influence of structural factors such as employment, social class and education; the power relations of communities as a whole; and the consequences of social capital for the exclusion of particular groups within communities. More needs to be known about how different forms of social capital (bonding, bridging and linking) operate in different community contexts.
### Table 1: Relationship between social capital and health

<table>
<thead>
<tr>
<th>Author</th>
<th>Study</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altschuler et al (2004)</td>
<td>A total of 49 qualitative interviews and 9 focus groups were carried out among residents of diverse neighbourhoods in one large Californian city to understand perceptions of the ways in which their local communities were affecting health.</td>
<td>Higher socio-economic status was linked to higher levels of bridging social capital, while neighbourhoods characterised by varying socio-economic status had more bonding social capital which provides opportunities to improve neighbourhoods.</td>
</tr>
<tr>
<td>Campbell et al (1999)</td>
<td>Qualitative study of subjective experiences of ‘community’ within two wards in Luton, matched for socio-economic status, but one characterised by high social capital while the other had low social capital. Focus groups and 37 in-depth interviews were carried out.</td>
<td>The forms of community cohesion that underlie Putnam’s definition were not found community-wide. These were only present in groups well-known to one another such as families and friends.</td>
</tr>
<tr>
<td>Carlson (2004)</td>
<td>Comparative study using data drawn from the World Values Survey 1995–97 for 18 countries in Europe.</td>
<td>Economic factors were found to be a greater predictor of health differences between western Europe, and central and eastern Europe and the former Soviet Union, than factors associated with social relations.</td>
</tr>
<tr>
<td>Cooper et al (1999)</td>
<td>Secondary analysis of national survey data (Health and Lifestyles Survey, the Health Survey for England, and the General Household Survey).</td>
<td>Statistically significant relationships were found between social capital and self-reported health at national level.</td>
</tr>
<tr>
<td>Mohan et al (2005)</td>
<td>Coefficients produced from multi-level analyses of the national Health and Lifestyles Survey were linked with census data, to explore the effects of social capital on mortality rates at the level of electoral wards in England.</td>
<td>The authors’ overall conclusion was that there was little support at electoral ward level for the proposition that area measures of social capital exert a beneficial effect on health outcomes.</td>
</tr>
<tr>
<td>Author</td>
<td>Study</td>
<td>Findings</td>
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<td>---------------------</td>
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<tr>
<td>Prevalin and Rose (2000)</td>
<td>Investigated links between social capital, social support and health using data from the first nine annual waves of the British Household Panel Survey. Data were analysed cross-sectionally to identify correlates of social capital, social support and health, and longitudinally to identify changes in levels of social capital and social support along with periods of poor health.</td>
<td>While virtually all measures of social capital that were examined had a positive effect on health measures, social capital was not found to mediate the effect of structural factors such as age, sex, income, class, marital status, employment and education on health. Social capital does not play an important role in the onset of poor health and recovery.</td>
</tr>
<tr>
<td>Stafford et al (2004)</td>
<td>Structural and cognitive aspects of social cohesion were measured in a selection of over 250 neighbourhoods in England and Scotland using a postal questionnaire. Responses were linked to existing survey data (Health Survey for England, the Scottish Health Survey and the Whitehall II study).</td>
<td>Self-rated health was positively associated with local trust and tolerance; and with participation and neighbourhood integration into wider society, even after accounting for participants’ socio-demographic characteristics.</td>
</tr>
<tr>
<td>Veenstra et al (2005)</td>
<td>A telephone survey of a random sample of adults (1504 respondents) in a Canadian city, which examined relationships between involvement in voluntary associations and various measures of individual health.</td>
<td>There was a statistically significant, though weak, relationship between involvement in voluntary associations and well-being. This did not persist after controlling for demographic, socio-economic, health behaviour and coping variables.</td>
</tr>
<tr>
<td>Ziersch et al (2005)</td>
<td>Explored the relationship between elements of neighbourhood life and neighbourhood-based social capital, and health, based on quantitative (2400 questionnaires) and qualitative (40 in-depth interviews) research within the western suburbs of Adelaide, Australia.</td>
<td>Neighbourhood-based social capital was found to have a low impact on health measures. Social capital is unevenly distributed, and social and economic factors influence both health and possession of social capital.</td>
</tr>
</tbody>
</table>
6. SUCCESSFUL PARTNERSHIP PROCESSES

In this chapter the general literature on partnerships is reviewed and related to situations where the community is also involved as a partnership member. Details of the main studies reviewed are given in table form at the end of the chapter.

KEY POINTS

- Partnerships vary in type, and guidance on the configuration of partnerships is lacking. Within the health sector, ‘partnership’ has tended to focus on statutory organisations, with a more recent acknowledgement of the role of private and voluntary sectors. The community's role is left unclear in many references.

- Partnership theory argues that partnership working contributes collaborative synergy. By combining the knowledge, skills and resources of different partners, new ways of thinking and acting are produced. This leads to more effective (community) problem solving, and, in turn, improvements in community health.

- It is argued that communities benefit from partnership working through empowerment of individuals (who are actively involved in addressing the problems they face) and creation of bridging social ties across different groups.

- Key considerations for successful partnership working mentioned in the literature include:
  > Distinguishing between strategic and operational levels in partnership arrangements may avoid confusion over the role of community partners.
  > Uncertainty about the financial future of a partnership can lead to community disappointment that its efforts are to some extent in vain, or to an over-reliance on or dominance by larger, often statutory, partners.
  > Community partners will feel valued if regular monitoring and effective communication makes them aware of progress.
  > Partnership leaders need a strong vision as well as good interpersonal skills. Getting staff with the right skills is particularly important for partnerships involving the community. Key staff need to be skilled in community development, facilitation and listening on the one hand; and in negotiation, advocacy and strategic influencing on the other. This is a difficult mix to find.
  > Achieving agreement and commitment to partnership aims, and the place of health goals within these, is key to sustaining partnerships.
  > Successful partnerships depend upon trust between partners. This is developed through joint working over time, and through partners demonstrating competence, reliability and honesty. The community's past experiences of partnership working may need to be taken on board.
DEFINING AND ORGANISING ‘PARTNERSHIPS’
Roussos and Fawcett (2000) defined collaborative partnerships as ‘an alliance among people and organisations from multiple sectors working together to achieve a common purpose’. Designing partnerships for improving health may appear to be a straightforward aim, but in practice partnership working may take a variety of forms: for example involving groups and networks of community members, or alliances among service agencies and grassroots initiatives. There is a lack of clarity around the way in which partnership working is discussed within policy documents. Indeed, the lack of a clear model of partnership working has been highlighted by government bodies such as the Audit Commission (1998) and the Department of Environment, Transport and the Regions (1999).

A recent review of health policy highlighted that the primary emphasis within recent UK health policy development is on partnerships between statutory agencies: local health agencies and local authorities working together (Bauld et al. 2001). Policy developments in the health field also acknowledge the importance of the voluntary sector, and in some cases, the private sector, but specific suggestions regarding how statutory agencies should work effectively with these types of organisation are notably absent from most national policy documents (Bauld et al. 2001). So, whilst partnership is assumed to be the way forward, precisely how partnerships should be configured and who should be involved is in most cases something left to the discretion of local initiatives or programmes. This has resulted in local variation in the definition of partnership, and confusion in particular around the participation of communities (Voluntary Health Scotland 2002).

ARE PARTNERSHIPS EFFECTIVE?
Relatively little is known about how the collaborative process enables partnerships to accomplish more than the efforts of individuals or organisations on their own. Weiss et al. (2002) proposed that partnerships gain this advantage by creating ‘partnership synergy’ and have identified this as a key characteristic of a successful collaborative process. Based on a comprehensive study of partnership functioning, the authors argued that this synergy is created by combining the perspectives, knowledge, and skills of diverse partners in a way that enables the partnership to think in new and better ways about how it can achieve its goals, plan more comprehensive, integrated programs, and strengthen its relationship with the broader community. It is, therefore, only when a partnership maximises this synergy that it can be said to have realised its full collaborative potential.

The concept of achieving synergy also forms a key part of a ‘model of community health governance’ proposed by Lasker and Weiss (2003), which ‘lays out the pathways by which broadly participatory collaborative processes lead to more effective community problem solving and to improvements in community health’. This argued that communities need collaborative processes that achieve three intermediate outcomes:

- empowering individuals by getting people directly and actively involved in addressing problems that affect their lives
- creating bridging social ties that bring people together across society’s dividing lines, build trust and a sense of community, and enable people to provide each other with various kinds of support
creating synergy – the breakthroughs in thinking and action that are produced when a collaborative process successfully combines the knowledge, skills, and resources of a group of diverse participants.

Although the model has not been validated in practice, it provides a useful framework for considering key factors, based on practical experience, that contribute to community health improvement. It is worth noting that the model is primarily aimed at collaborations with a narrow scope, whereas many recent and current partnership arrangements and initiatives such as health action zones, social inclusion partnerships and community planning partnerships, are extremely complex. However, the elements of the model are clearly applicable to more complex initiatives and multi-disciplinary collaborations.

**WHAT CONTRIBUTES TO SUCCESSFUL PARTNERSHIP WORKING?**

If partnership working is to provide added value, it is essential to understand the factors that contribute to successful partnership working. The general elements of successful collaboration have been researched elsewhere (e.g. Hudson and Hardy 2002; Lasker and Weiss 2003; Palmer 2003), and Figure 2 provides a useful overview of the sorts of themes that have been associated with effective collaboration.

These themes are interrelated, referring to the sorts of relationships that develop (e.g. relationships built on compromise, or those built on trust) as well as the various types of resources that are available (from finances to commitment). As is evident from the discussion that follows, the evidence taken from a Scottish context incorporates each of these themes. Firstly, the evidence concerning the different sorts of partnership arrangements is presented, and this is followed by research addressing different aspects of the relationships that emerge out of these arrangements.

**Figure 2: Themes in collaboration**

![Figure 2: Themes in collaboration](image-url)

Adapted from Huxham 2003
CLEAR AND ROBUST PARTNERSHIP ARRANGEMENTS

The arrangements, or the structures and processes, that are laid down for a particular partnership have implications for the degree of success of the partnership. Three aspects of partnership arrangements can be identified. Firstly, the need for structures and processes to be as unambiguous and straightforward as possible in order to avoid excessive bureaucracy and to promote effective communication; secondly the need for sufficient resources to be available; and thirdly the value of monitoring and evaluation practices.

With respect to the first point about clarity, partnerships have been shown to work well where structures and processes clearly distinguish between and incorporate working at strategic and operational levels (Crow et al. 2004). Moreover, variations in working conditions across partner organisations within these levels have to be considered. This applies, for instance, to differing employment grades and accountability structures across partner organisations (Blamey 2003).

A separate theme that is key to the emergence of clarity within partnership arrangements is the development of an appropriate communication strategy, offering effective modes of communication, including for example, email, phone and face to face contact (Palmer 2003), and linking all levels of the partnership (Communities Scotland 2005a).

Moving on to the second aspect, which focuses on the resources required for the effective working of partnerships, most of the evidence addresses financial resources, which have been described as a requirement for ‘oiling the wheels’ of change (Barnes et al. 2003). The reality of much partnership work is that financial resources are not available in the longer term. This often means that valuable connections and relationships that have taken time to establish and develop may be lost, and as a consequence there may be heavy reliance on key individuals who are well networked locally to find ways to sustain partnership efforts (Tucker et al. 2005). Their efforts are likely to be constrained by lack of co-ordination between agencies.

Research on resource issues has also addressed the role of organisational size within partnerships. There is a tension between the need for ongoing financial support, which often means reliance on resource-rich partners, and at the same time the recognition that resource obligations need to be more widely diffused if ownership of the partnership and its activities is to be truly achieved. The resolution of such issues is likely to be shaped by lifecycle considerations that would identify the stage of development of the partnership and its funding needs (Alexander et al. 2003). In relation to organisational size, larger partner organisations can also offer non-financial resources. For example, larger partners can offer small voluntary organisations links to more established and powerful platforms, and promote dialogue between partners (Tucker et al. 2005).

Finally, financial security might depend on a partnership’s ability to demonstrate its contribution to community change and population health improvement (Roussos and Fawcett 2000). In this respect, evaluation – the third aspect of partnership arrangements considered here – will be key. Another type of resource is time and this is especially important in relation to the lead-in time for partnerships when the foundations of the process are prepared.
Palmer’s partnership toolkit (2003) includes the ‘year zero’ concept which legitimises preparation time for the partnership and its members. It recognises that the time needed to establish new partnerships should be acknowledged from the outset so that unrealistic expectations can be avoided.

However, in practice partnerships may have to work to an inadequate time frame for getting off the ground. This has been shown to be the case for the Scottish National Health demonstration projects (Blamey et al. 2004), healthy living centres (Platt et al. 2005), and health action zones (Barnes et al. 2003). A key recommendation from the first phase of the National Evaluation of New Deal for Communities included that the scale of ‘setting-up’ tasks should not be underestimated (Office for the Deputy Prime Mininster 2003). That is, partnerships have a range of issues to deal with to form new links with organisations and communities as well as getting on with programme development.

This short lead-in time is often combined with pressure from funders to begin delivering on activities and targets. This can lead to projects having to rush into the implementation phase before they are truly ready for it, with difficulties including insufficient time for staff recruitment and preparation of facilities (DTZ Pieda Consulting 2003). The case studies included in the evaluation of Healthy Living Centres indicated a mixed picture, though overall it was recommended that a longer lead-in time was essential to allow for improved planning, appointments to be made and commitment from all partners including the community to be secured (Platt et al. 2005). This has been recommended by a number of programme evaluations including the Scottish National Demonstration Projects (Blamey et al. 2004; Mackenzie et al. 2004) and Health Action Zones (Barnes et al. 2003).

The third issue in relation to partnership arrangements concerns monitoring of progress. Partnerships should incorporate mechanisms that enable partners to continually review how well the partnership is working, and to monitor the extent to which collectively agreed aims and objectives are being met (Hudson and Hardy 2002). Where necessary, reconsideration and revision of partnership aims, objectives and arrangements can act as a refining process towards a more efficient and effective partnership, and consideration of intermediate outcomes can be particularly important in this respect (Roussos and Fawcett 2000). Evaluation can also enable partnerships to highlight and celebrate accomplishments, ensuring that partnership members feel valued (Palmer 2003).

Evaluation issues are further explored in Chapter 9, but the review now moves on to consider research that addresses some aspects of the relationships that emerge out of partnership structures: leadership, commitment and ownership, and trust.

**LEADERSHIP**

A key issue that emerges from the available research literature is the significance of strong leadership for partnership work. Leaders might be fully paid members of staff of an organisation, or at a grassroots level the leader might be the person who mobilises community members around a common concern. Research has highlighted the importance of leaders in directing partnership work (Russell 2001), particularly where circumstances and roles change since strong management is needed (Platt et al. 2005). Weiss et al. (2002) demonstrated that partnership synergy was most closely associated with the effectiveness of partnership leadership.
However, what makes a good leader is not straightforward. The importance of leadership style has been highlighted (Blamey 2003), and core leadership competencies have been identified, including communication (including cultural competence), meeting facilitation, negotiation and networking skills (Mackenzie et al. 2003). With respect to partnerships involving communities, an additional key skill lies in promoting and developing communities (DTZ Pieda Consulting 2003).

Clear definition of the leadership role also appears to be important. A key point highlighted by Roussos and Fawcett (2000) is that different leadership skills may be more useful during different stages of partnership development. For instance, earlier on, facilitation and listening skills will be needed to engage diverse and representative membership. At a later stage when a partnership has developed a strong identity (and community presence), negotiation and advocacy skills may help bring about changes that are less feasible politically but important to a partnership’s mission. Sullivan and Skelcher (2002) suggest that the role of facilitation is important for ‘an individual to act as a leader while still maintaining collaborative working by facilitating others involved and guiding them through cooperating’.

The presence of a dedicated project worker has been identified as a key facilitator of partnership working. Such posts can provide leadership through maintaining momentum, increasing the active involvement of partners and keeping projects focused on core objectives (Crow et al. 2004; DTZ Pieda Consulting 2003). However, a combination of community development and strategic influencing skills are needed for effective project co-ordinators, and it can be difficult to recruit qualified individuals where levels of remuneration are low (DTZ Pieda Consulting 2003).

In reality, the leadership role may be shared by several individuals. It is perhaps more useful to conceive of leadership teams wherein individual members contribute the range of skills that are required for successful joint working.

**COMMITMENT AND OWNERSHIP**

It is clear that commitment has to be present for partnerships to be established and maintained. There are two main lessons that can be drawn out from the available evidence.

Firstly, commitment is associated with the aims of a partnership initiative. Lack of agreement around the aims can lead to difficulties due to a lack of ownership (Mackenzie et al. 2004). These might affect the availability of resources. The more the outcome matters to community members, grant makers, and influential leaders within and beyond the community, the more likely there will be human and financial support for progress towards those outcomes (Roussos and Fawcett 2000). Similarly, a broad base of recognition and support for a particular health domain increases the likelihood of sustaining a partnership (Scott and Thurston 1997).

Secondly, the organisational level at which commitment is expressed appears to have significance. Hudson and Hardy (2002) found that organisational commitment to partnership working is more likely to be sustained where there is individual commitment to the venture from the most senior organisational levels, and that without this it is possible that the efforts of enthusiasts in middle and lower-level positions will become marginalised.
DEVELOPING AND MAINTAINING TRUST

The development of trust and relationships has been highlighted as a critical success factor in many partnerships, and common themes associated with building and maintaining trust include reputation, competence, reliability, altruism and shared codes of conduct (Hudson and Hardy 2002). Trust can be promoted through demonstrating honesty and by ensuring a high level of contact (Palmer 2003).

Cambuslang and Rutherglen Healthy Living Initiative provides an example of how a successful partnership can be maintained by developing trust. The partnership was initiated by voluntary sector organisations with funding from the New Opportunities fund. Dominance of statutory sector partners was avoided. A key to success was early and honest discussions about the history of partnership in the area. This was particularly important as the organisations had previously experienced the prioritisation of organisational agendas over local needs, and mixed experiences around joint funding bids. As all partners were willing to discuss these difficulties, despite some awkwardness and discomfort, issues were resolved and all partners remained part of the process. This shows that, where partners are able to set aside their own agendas for the good of the partnership, trust and sustainable relationships can be formed.


A combination of these factors will increase the likelihood of successful collaboration. For instance, evaluation of the New Deal for Communities identified a number of factors that distinguished more strongly performing partnerships (Office for the Deputy Prime Minister 2003). These included a stable and committed board, strong leadership, a strategically focused board, a partnership that is fully staffed with a skilled and committed delivery team, commitment from a wide range of partner agencies, and an involved and supportive community with confidence in the New Deal for Communities.

Although there is an abundance of literature relating to the principles of partnership working there remain significant gaps in our knowledge. For instance, in relation to the process of partnership working, the perceptions and experiences of participants in collaborative ventures have often been lacking. Evaluations of initiatives and programmes have tended to focus primarily on the achievements of the stated outcomes rather than the collaborative process (Mayo and Taylor 2001; Roussos and Fawcett 2000), but we still need to understand more about the nature of outcomes and the links between these and process issues.

These gaps relate to the ways in which research questions have been framed. For instance, research has focused on factors required for successful partnership working but there is a lack of exploration of how these factors can be generated and sustained. More research might address questions such as: ‘What roles do leaders attempt to play and what is their rationale for taking on these roles?’ or ‘How is commitment fostered?’ In a more practical sense we might ask: ‘Who decides what level of resources are required [human and financial] for effective partnership working?’ and ‘What strategies have been used to ensure these are available?’

These principles for successful collaboration apply to all partnerships for health improvements. It is important to note that the various principles are interlinked, and that concentration on one aspect of successful partnership working is likely to feed into other aspects. For instance, good leadership can ensure that resources are accessed for effective sustainability.
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Table 2: Factors related to successful partnership working

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<th>Author</th>
<th>Study</th>
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<tr>
<td><strong>Alexander et al. [2003]</strong></td>
<td>Qualitative study of four partnerships from the Community Care Network Demonstration Programme (USA). Case studies were selected to provide variation in propensity for sustainability and a total of 115 semi-structured interviews were conducted with a range of partners.</td>
<td>The authors identified five aspects of the partnerships that were associated with sustainability: outcome-based advocacy; vision–focus balance; systems orientation; infrastructure development and community linkages.</td>
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<td><strong>Barnes et al. [2003]; Mackenzie et al. [2003]</strong></td>
<td>National evaluation of health action zones (HAZs), examining change within zones with specific reference to building collaborative capacities. Research involved: monitoring of 26 HAZs through interviews, document analysis and performance monitoring; case studies.</td>
<td>Collaborative action is dependent on building ownership of the activity, building the capacity of the partners to engage, resourcing over the longer term, building up trust and understanding of the differing priorities and approaches of partners. Leadership had an important impact on the collaborative success of individual case studies. Core leadership competencies included communication (including cultural competence), meeting facilitation, negotiation and networking skills. Operationalising HAZ in rural areas presented particular challenges for partners in terms of involving communities.</td>
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<tr>
<td><strong>Blamey [2003]; Blamey et al. [2004]; Blamey et al. [2004a]</strong></td>
<td>Evaluation of a Scottish Executive national health demonstration project 'Have a Heart Paisley', based on evaluation of the theoretical framework, quasi-experimental survey in intervention and comparison areas; multi-method case study.</td>
<td>143 community projects were funded and many individuals have gained personally from their involvement as participants or community volunteers within Have a Heart Paisley. There were barriers at the outset such as community reticence due to previous negative experiences of community-targeted projects. The project has been less successful at engaging and sustaining the involvement of community representatives within the more strategic mechanisms. The presence of different grades and authority structures across partner organisations had a negative impact. Barriers to partnership working in the programme included leadership styles.</td>
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<td>Author</td>
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<td><strong>Communities Scotland (2005a)</strong></td>
<td>Evaluation of social inclusion partnerships, focusing on practical and operational issues to assist 11 area-based and 14 thematic social inclusion partnerships and community planning partnerships. Evaluations were tendered by individual social inclusion partnerships.</td>
<td>Poor information systems affected the functioning of the partnerships, and difficulties have been encountered in some social inclusion partnerships due to poor communication between board members and staff.</td>
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<tr>
<td><strong>Crow et al. (2004)</strong></td>
<td>Outcome evaluation of three ‘Communities that Care’ demonstration projects, based on school surveys administered prior to and following implementation.</td>
<td>The presence of a dedicated project worker has been identified as a key facilitator of partnership working. Partnerships worked best where structures and processes allowed for working between the strategic and the operational levels – in particular, the speed of implementation increased. Involving a range of personnel at both operational and managerial levels is important.</td>
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<tr>
<td><strong>DTZ Pieda Consulting (2003)</strong></td>
<td>The final evaluation of the Scottish Executive’s ‘Working for Communities’ programme, assessed the extent to which individual programmes met objectives. All 13 pathfinder projects were studied to evaluate the programme as a whole, central project management and administration. This was by means of desk-based research; consultation of project co-ordinators, stakeholders, community representatives and the Scottish Executive; and by analysis of expenditure.</td>
<td>The evaluation found the role of co-ordinator to be crucial to the success of the project, in terms of maintaining momentum, increasing the active involvement of partners, and keeping projects focussed on core objectives. However, it also acknowledged that the combination of community development and strategic influencing skills needed for the co-ordinator post was hard to find at the level of remuneration proposed, and not all co-ordinators had the full range of skills needed.</td>
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<td>Hudson and Hardy</td>
<td>The authors developed a toolkit for assessing partnership, drawing on research including a review of general literature on collaboration, and a study of inter-agency collaboration in community care which was commissioned by the Department of Health and undertaken by the Community Care Division of the Nuffield Institute for Health. It has been piloted with performance management professionals and used in facilitation workshops to review and plan the process of partnership working.</td>
<td>The assessment tool is based on 6 partnership principles: development of clarity and realism of purpose; ensuring commitment and ownership; developing and maintaining trust; creating clear and robust partnership arrangements; monitoring, measuring and learning.</td>
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<td>Mackenzie et al.</td>
<td>Independent evaluation of Starting Well based on a quasi-experimental comparison of two intervention areas with a socio-demographically similar area. The health and development of children up to 18 months involved in the intervention was compared with children of families receiving statutory health visiting.</td>
<td>The project steering group did not succeed as a mechanism for strong partnership working around the child and family health problems experienced in poor communities.</td>
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<td>Palmer</td>
<td>The Partners in Health evaluation examined four pilot projects to understand training needs to develop health promotion in the voluntary sector, focusing on partnership working.</td>
<td>It is useful to employ a variety of communication methods, as effective communication goes toward acknowledging the work of partners and ensuring partnership members feel valued. Agreement amongst the pilot partnerships that lack of honesty, especially about resources, staffing levels and plans, could be extremely damaging to relationships within the partnership. Trust had to be earned and this was done through a great deal of contact.</td>
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<td>Platt et al. (2005)</td>
<td>Process evaluation of six Scottish healthy living centres, examining the centres’ approaches to improving the health of disadvantaged groups and reducing health inequalities. This involved two rounds of fieldwork over a year employing a range of qualitative methods.</td>
<td>Where the functions of partners’ employees had changed over time, key stakeholders felt that dedicated leadership functions would have assisted decision-making and strategic planning.</td>
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<td>Roussos and Fawcett (2000)</td>
<td>Review of 34 studies (thus covering 252 collaborative partnerships). Most of the studies reviewed used experimental or quasi-experimental research design and assessed the effects of a wide range of community health aspects.</td>
<td>Different leadership skills may be more useful during different stages of partnership development. For instance, earlier on, facilitation and listening skills will be needed to engage a diverse and representative membership. At a later stage when a partnership has developed a strong identity and community presence, negotiation and advocacy skills may help bring about changes that are less feasible politically but important to a partnership’s mission. The more the outcome matters to community members, grant makers, and influential leaders within and beyond the community, the more likely there will be human and financial support for progress towards those outcomes.</td>
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<td>Russell (2001)</td>
<td>Evaluation of the New Commitment to Regeneration (NCR) pathfinders from April 1999, covering the first two years of the NCR (Phase 1, Pathfinders).</td>
<td>The evaluation identified the following key elements for strategic partnership: strong leadership; trust amongst partners; an independent staff team; a common understanding/knowledge base; capacity to focus on overarching priorities; co-ordinated planning processes; integrated action plans across partners; integrated community consultation, development and participation strategies; increased synergy in accessing and deploying resources; mechanisms for review and evaluation; scope for innovation; and parallel processes to build capacity within member organisations.</td>
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**Table**: Summary of Studies on Community Health Improvement

**Author**: Platt et al. (2005)

**Study**: Process evaluation of six Scottish healthy living centres, examining the centres’ approaches to improving the health of disadvantaged groups and reducing health inequalities. This involved two rounds of fieldwork over a year employing a range of qualitative methods.

**Findings**: Where the functions of partners’ employees had changed over time, key stakeholders felt that dedicated leadership functions would have assisted decision-making and strategic planning.

**Author**: Roussos and Fawcett (2000)

**Study**: Review of 34 studies (thus covering 252 collaborative partnerships). Most of the studies reviewed used experimental or quasi-experimental research design and assessed the effects of a wide range of community health aspects.

**Findings**: Different leadership skills may be more useful during different stages of partnership development. For instance, earlier on, facilitation and listening skills will be needed to engage a diverse and representative membership. At a later stage when a partnership has developed a strong identity and community presence, negotiation and advocacy skills may help bring about changes that are less feasible politically but important to a partnership’s mission. The more the outcome matters to community members, grant makers, and influential leaders within and beyond the community, the more likely there will be human and financial support for progress towards those outcomes.

**Author**: Russell (2001)

**Study**: Evaluation of the New Commitment to Regeneration (NCR) pathfinders from April 1999, covering the first two years of the NCR (Phase 1, Pathfinders).

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<tr>
<td>Scott and Thurston (1997)</td>
<td>The data from ethnographic interviews were analysed to develop a framework to enable partnership development.</td>
<td>When partnerships were being developed, a broad base of recognition and support for a particular health domain reduced the work required to maintain a partnership initiative, therefore increasing the likelihood of sustaining a partnership.</td>
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<td>Tucker et al. (2005)</td>
<td>External Evaluation of Healthy Respect. The evaluation focused on sexual health outcomes (employing surveys and focus groups), mapping partnership working and networks (interviews and document analysis), and implementation of projects (case studies).</td>
<td>Partnership development was not consistent and some potentially key agencies were under-represented. Voluntary sector involvement enabled Healthy Respect to benefit from work grounded in local communities, and to link with key agencies and individuals at an early stage.</td>
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<td>Voluntary Health Scotland (2002)</td>
<td>This was a non-random survey of health partnership representatives, with reference to their perceptions of the level and effectiveness of intersectional partnership working.</td>
<td>Partnerships were defined in various ways and there was often confusion about the differences between voluntary organisations, volunteers and the public. The voluntary sector is commonly not provided with adequate information and there is a general feeling within the sector that extra capacity is required to respond effectively to consultations.</td>
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<tr>
<td>Weiss et al. (2002)</td>
<td>Data were collected via postal questionnaires from 815 informants in 63 partnerships.</td>
<td>Results of regression analysis conducted with partnership-level data indicated that partnership synergy was most closely associated with the effectiveness of partnership leadership.</td>
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Continuing the focus on process issues, this chapter addresses the fourth of the research questions that shape this review: How effectively do collaborations for health improvement work in engaging the community as partners? Research and reports on existing initiatives suggest a number of guidelines for good practice.

KEY POINTS

- Knowing why the community is involved, or has been engaged, in partnership activity is relevant to being able to explain the level and nature of that involvement. It is worth remembering that community involvement can serve the interests of various parties including the policy-maker, the practitioner, the individual and the community.

- Communities have varying traditions, skills, structures and internal relations. An assessment of community conditions is essential as preparation for community engagement. Lead-in time for partnerships is crucial.

- Capacity-building and skills development applies to professional staff within partnerships as well as to communities. Partnerships should consider working with a community empowerment plan that develops over time, and employ at least one member of staff dedicated to community development and engagement work. This person needs to have influencing skills to achieve most for the community.

- Partnerships need to work with existing community structures and experienced activists, but also develop strategies to engage hard-to-reach groups and minority cultures.

- The community’s contribution to a partnership has to be valued and their influence demonstrated. Openness and honesty about things that cannot be achieved is essential to maintaining trust with the community. The community should not feel less powerful than other partners making financial contributions.

- Communities appear to have had little influence over the strategic decisions and directions of partnerships. It has been suggested that communities are more comfortable working at the operational level, but the evidence is anecdotal.

- Partnerships that engage with the community and involve them in the work of the partnership need to be flexible. This relates both to accepting that key aims and objectives may have to change over time as the community’s interests and assessment of its own needs develop; and to the fact that partnership structures need to be flexible, allowing for varying levels of community involvement over time.

- Many of the factors affecting community engagement in partnerships are inter-related. Thus, the length of lead-in time may affect the ability to develop skills and capacity among the community and voluntary sectors, which in turn may affect their status within the partnership and therefore their ability to have strategic influence.
THE CONTEXT AND RATIONALE FOR COMMUNITY ENGAGEMENT

Collaborative partnerships have become an increasingly popular strategy for community health improvement (Roussos and Fawcett 2000). Within the Scottish context, policy documents have placed partnerships between communities, the health service, local authorities and the voluntary sector at the core of promoting better health in Scotland, and has emphasised the importance of partnership working at all levels as a vehicle for successful health promotion (Scottish Executive 2003, 2003a). Most recently this has been taken forward through the development of community planning partnerships and community health partnerships.

APPROACHES TO COMMUNITY ENGAGEMENT

The approaches that have been put into practice to encourage community participation are varied, as are the methods employed to improve health within community-based initiatives (e.g. McCollam et al. 2004). The examples that follow echo this point.

Paisley Heart Awards
This was an innovative scheme that enabled local communities to develop skills in relation to learning about lifestyle factors. Individuals learned about the health effects of lifestyle behaviours and as they passed each level of the course they moved on until they reached their gold award. The scheme recognised the commitment of local people to reducing heart disease in Paisley and attracted large numbers of people.

Source: Have a Heart Paisley (2003)

Working for Communities Pathfinders
The Media Unit in the Great Northern Partnership used a particularly innovative way of engaging the public to influence service providers. From a base in a local community centre, the unit worked with small groups and individuals, helping them to research and articulate local concerns. Video was used to gather local views, as well as capturing evidence of local problems and conditions. The unit then worked with the community on editing to produce a professional video. The videos were an effective way of highlighting the concerns of the community to service providers.


GOOD PRACTICE FOR COMMUNITY INVOLVEMENT IN HEALTH IMPROVEMENT

A set of ‘good practice guidelines’ aimed at increasing successful community participation in health initiatives was developed by Smithies and Hampson (1999). These were based on a series of regional and national workshops, meetings of an expert panel and questionnaire responses received from 230 existing projects across England. Although this methodology was based on views expressed by a non-random sample of those working in the field, it offers a starting point for examining what is known about good practice in involving communities in the health field. A series of factors that had helped or hindered community participation efforts was identified. Aspects of their guidelines have clear similarities with the principles for successful collaboration discussed in the previous chapter. An abbreviated version of their guidelines is shown in Box 2 (see opposite).
Box 2: Community participation for health: good practice guidelines

Clear and realistic role and remit – projects need to work within a wide definition of health, establish health as an important community issue, and need to have a realistic remit based on the time and resources available, as well as the history of community/users the project is working with.

Adequate and appropriate resources to meet the project remit – secure, adequate and long-term funding are required, as well as appropriate premises, staff with community development skills and committed and properly supported volunteers/activists.

Adequate and appropriate management and evaluation to support the project – effective and supportive management by people with time, skills and experience; clearly defined structural arrangements between projects and key agencies; community involvement in project management and decision-making; and adequate monitoring and evaluation to inform project planning/development.

Recognition of the importance of the wider environment within which projects are operating – building on past experience of communities and local agencies while harnessing local political support and linking projects to new national policy developments; strong interagency links and partnership working at local and district/city wide levels.

Building in long-term sustainability – linking community health projects into the wider change agenda; projects need to be able to show results; community capacity should be built in terms of skills, networks etc.; organisational development for local agencies to make sure they have the knowledge to support effective community participation work and build the needs of the community into their planning; and seeking sustainability should be an integral and ongoing part of project work.

Source: Smithies and Hampson (1999)
AGREEING PARTNERSHIP AIMS

It has been argued that an explicit statement of shared vision, based on jointly held values, is a prerequisite for successful partnership working [Hudson and Hardy 2002]. There is some evidence suggesting support for this in relation to partnerships involving communities. A Scottish review found that ‘good’ involvement of users and the public is built on shared principles and values, arrived at in consultation with all stakeholders [Ridley and Jones 2001]. Any clear differences of values, principles or perspectives amongst partners need to be addressed prior to partnership development [Palmer 2003]. Health aims need to be recognised, owned and supported by all partners.

Other relevant considerations include working with a wide definition of health, and the importance of linking community health projects to national policy developments and into the wider change agenda of local agencies for sustainability reasons.

With the increasing role for community agencies in partnerships for health improvement care should be taken to select partner representatives who possess the skills and knowledge required to advance the partnership toward a shared vision [Scott and Thurston 1997]. Scott and Thurston [1997] also identify that it is of paramount importance to acknowledge that potential partners will seek specific benefits from participation in a partnership that these must be recognised through a clear discussion of how each partner may benefit. When developing a vision, it is crucial that partnerships and their members are sure it is realistic and attainable for the individuals and organisations participating.

The process used to develop a partnership’s vision and mission may be as important as the product, as full and representative participation in planning may help generate and sustain participation [Roussos and Fawcett 2000]. This process can be rewarding if done well but also has the potential for difficulties, for instance, in ensuring the participation of all partners in planning. Periodic review and renewal of the vision and mission may help a partnership adapt to emerging community concerns and create opportunities to address them [Palmer 2003].

PREPARATION: UNDERSTANDING COMMUNITIES

Doing the ‘groundwork’ or preparation before attempting community engagement is essential. This involves a number of aspects of understanding the communities concerned, e.g. awareness of what constitutes the community; undertaking a community needs assessment; understanding a community’s history and dynamics and its tradition of participation, including who is involved, who is powerful and where the sub-divisions lie within a community [DTZ Pieda Consulting 2003; Matka et al. 2002; Palmer 2003; Platt et al. 2005]. This may give a useful indication of what is necessary, desired or indeed inappropriate from the community’s point of view.

In many situations, partnership working will not be entirely new. Thus, potential partners may need preparation time in which they can sort out past problems between them; appreciate their interdependencies; and develop the skills required for partnership working and often, in the case of communities, the confidence required for effective engagement [Palmer 2003].
It is also important to undertake a skills audit to see where support or improvement is needed, for example in policy familiarity, negotiation skills, public speaking, handling meetings etc. (Matka et al. 2002). Through understanding participation within a community, a new partnership may be able to build upon existing community activity.

CAPACITY-BUILDING AND SUPPORT

Ensuring that organisational capacity is retained over the long term is required for stable partnerships to develop. Capacity-building aims to increase self-sustainability, enabling the identification and solving of problems through more effective use of existing resources. Capacity can take the form of financial resources, human resources, or administration and management systems. Capacity-building is required within both the community and voluntary sectors: to be able to participate in partnerships; to do so at different levels; and to be able to sustain partnership working over the medium to long-term. Questions remain concerning the capacity of various stakeholders to take joint action (Hall et al. 1996; Benyon and Edwards 1999; Hudson et al. 1999).

It is important that the skills for engagement and participation are developed within communities (Matka et al. 2002; Palmer 2003; Roussos and Fawcett 2000). Efforts are being made to improve the capacity of community health and regeneration initiatives to engage with communities. For example, the Empowering Communities Fund introduced in 2001 aimed to strengthen community participation in partnership structures (Ekos Limited 2004). It enables eligible partnerships to take forward practical arrangements for community engagement. The Community Learning and Development programme aimed to develop ‘a way of working with communities to increase the skills, confidence, networks and resources they need to tackle problems and grasp opportunities’ (Scottish Executive 2003d: 23). The Community Voices programme will also support community planning partnerships to deliver community engagement activity in the most disadvantaged areas in Scotland by helping people from disadvantaged backgrounds to contribute to regeneration of their own communities (Communities Scotland 2006). This ongoing support and capacity building within Scottish communities has significant potential to contribute to involving communities.

Capacity-building or appropriate staffing approaches are also required within partnerships and among professional staff. The capacity-building needed within organisations for professionals and practitioners to ensure genuine partnerships over time can be extremely challenging (Barnes et al. 2003). Studies of the three National Demonstration Projects (Blamey et al. 2004; Mackenzie et al, 2004; Tucker et al. 2005) showed the importance of partnerships employing dedicated staff to facilitate community engagement and defining the levels of community support to be provided. Where processes of community engagement and support were outsourced to consultants or left to the discretion of partnership staff and not properly defined, such processes were less frequent and less integrated into the partnerships’ work.

Partnerships with a dedicated staff member who combined community development and strategic influencing skills worked best.
The Community Learning and Development programme aimed to develop:

a way of working with communities to increase the skills, confidence, networks and resources they need to tackle problems and grasp opportunities

(Scottish Executive 2003d: 23)
As a single example of how a community health initiative has worked toward sustainability we look to the experience of Islay and Jura (Community Health Exchange, 2001). The islands in Scotland suffer unique difficulties and are in decline due to a number of factors affecting the local economy. The health needs of the community were recognised by Argyll and Clyde Health Board and a fixed-term health promotion project was set up in 1996 with the aim of strengthening the infrastructure for health promotion by creating a health alliance from the community, voluntary and statutory sectors. An evaluation showed the project was very successful and has acted as a catalyst in strengthening community-based action in improving health and in working across traditional boundaries. Following this demonstration of success the project was successful in obtaining further funding from the New Opportunities fund to become a healthy living centre. The Islay HLC is now a key partner in local structures. For instance it is a member of the 'Health and Well-being' Theme Group of the Argyll and Clyde Community Planning Partnership (www.argyll-bute.gov.uk/).

If, as is implied by the authority given to the concept, community empowerment is accepted as an influence upon community health and well-being, then partnerships of various kinds should consider how their community engagement processes could facilitate community development and empowerment. This may mean providing opportunities and assistance for communities to be able to identify their own needs and priorities, thus enabling community participants to contribute to strategic decision-making rather than being restricted to issues of implementation. Findings from this review suggest that partnership initiatives would benefit from working with a community development and empowerment plan comprising a set of progressive steps towards such empowerment.

INCLUSIVE ENGAGEMENT AND REPRESENTATION

Initiatives must be appropriate to their context (Arblaster et al. 1996). As illustration, we can look to the large number of breakfast clubs that now exist in Scotland, which are perceived as one of the fastest growing forms of community food initiative in Scotland (Scottish Community Diet Project 2004). Their aim is to improve the diet of young children and also their oral health. Research in Scotland has highlighted that the key to a successful breakfast club is involvement and engagement. This includes engagement of the school and support by pupils, parents, teachers and support staff. The clubs create opportunities for children not only to start the day well in a nutritional sense but also to engage with other children and adults present. The key point here is that without the relevance of this approach to engagement for the target groups, the benefits would be limited only to provision of breakfasts.

As part of the need to ensure that the right mix of groups are targeted, there need to be methods of engagement for hard to reach groups where required. A number of innovative outreach approaches have been used. For instance, staff in one HLC worked with service users to overcome challenging behaviour and provided free food as an incentive for people to come along to a venue (Platt et al. 2005). Provision of affordable domestic services such as washing machines is also being tested as a way of attracting individuals living in
bed and breakfast accommodation. In other areas childcare facilities were provided to ensure parents could attend projects. However, some HLCs were also open in voicing doubts that they were in fact reaching the people most in need (Platt et al. 2005). While initiatives do recognise this gap in service provision, there are clear implications for the availability of resources to engage with communities, particularly those hard-to-reach groups where more concentrated and time-intensive approaches are required.

West Lothian Social Inclusion Project devoted extra resources to enable effective engagement work with the most excluded parents and young people in the area who were less likely to participate in traditional forms of community engagement. The work, combining service delivery and personal development, was able to encourage groups to express their views and priorities. For instance, support for groups of parents of pre-school children at risk of social exclusion was provided by a project-funded parent action worker, employed by the Broxburn Family and Community Development Centre. Source: Fairley (2004)

An important point to raise here is the extent to which the practice of community engagement is sensitive to cultural differences. A number of initiatives have worked at ensuring interventions are culturally appropriate. For instance, the Minority Ethnic Carers of Older People project opened in 2001 in response to difficulties experienced by minority ethnic older people and their carers in accessing mainstream services (Community Health Exchange 2005). The centre offers a range of services to support carers which includes a multi-lingual advice and information service. It is important that partnerships build upon the experience and knowledge that already exists, particularly through existing groups such as community councils, ‘tenants and residents’ associations, community forums and existing community-based projects (Glasgow Community Planning Partnership 2005). The early experiences of community health initiatives suggest that some challenges lie ahead in gaining true representation of communities within community health partnerships. For instance, the year-to-year funding base limits the level of commitment that community health initiatives can give to their local community health partnership (Community Health Exchange 2004).

Particular challenges also face the voluntary sector. Weir (2005) highlights an important issue relating to the capacity of the voluntary sector to participate in community health partnership committees. For instance, community health partnerships need to consider how resources can be allocated to organisations to ensure that committee positions are accessible to all candidates from the voluntary sector and not just those who can afford the time to participate. Weir (2005) also argues for the importance of making the process of selection of voluntary sector members to the committees of community health partnerships as open, democratic and accountable as possible. This question of how voluntary sector representatives on partnerships can be genuinely representative of the voluntary sector is an issue that has dogged the sector for many years and sometimes hindered their role and influence within partnerships.
**EQUITY AND STATUS BETWEEN PARTNERS**

Partnerships work best where each partner is perceived, collectively and individually, to have an equivalent status, irrespective of some having more of some resources than others (Hudson and Hardy 2002). The community’s contribution to a partnership needs to be recognised and valued, and not seen as any less important than that of partners controlling financial resources.

According to the model developed by Lasker and Weiss (2003), a key consideration, in particular for collaborations for health where the community are partners, is the question of how participants are involved, and whether they have real influence in, and control over, the collaborative process. Where consultations are concerned, the evidence points toward a lack of real community influence (Ridley and Jones 2001; Tucker et al. 2005). Individuals and groups can begin to feel disillusioned and alienated by the consultation process, which could be seen as tokenistic rather than a move towards genuine user involvement in service development. Communities need to be made aware of whether and in what ways their views and input have been treated and acted upon.

It is crucial that expectations within partnerships are well managed and, where issues raised by local communities cannot be tackled, that this is fully explained in order to maintain trust. In addition to the effectiveness of methods for collaboration, equity is affected by the extent to which communities are physically represented alongside the other partners. (Tucker et al. 2005).

The extent to which community partners contribute to setting the objectives within a partnership has implications for the equity of partnership working. One of the ways that community partners commonly contribute to agenda-setting is through taking part in needs assessments: such assessments have been carried out by a wide range of organisations and community groups across Scotland. For instance, a number of sexual health services for young people in Greater Glasgow have developed a holistic approach to service delivery based on extensive consultations with local agencies and young people (Lawson and Mackinnon 2003).

During 1995 the local community in Castlemilk were faced with a rising number of teenage pregnancies and suicides of young people (www.healthspot.org.uk). Having recognised these serious issues, the community urged local services to take action in helping to tackle these problems and a range of other health-related issues that affect the lives of young people. This prompted a consultation exercise involving young people in the area with the aim of assessing the extent of peoples’ health related needs (Lawson and Mackinnon 2003). From this a service was developed and Castlemilk Youth Health Spot opened in May 1998. The service wanted to develop a multi-agency response to the holistic needs of young people.
S-Club Tuesday first opened in 2001 in the Community Health Shop Healthy Living Centre in Barlanark. The Community Health Shop is a healthy living centre funded through the National Lottery’s New Opportunities fund (www.glasgow.gov.uk). When the Community Health Shop opened it was agreed that a youth sexual health group would be set up. This was in response to the local consultation carried out during the development of the Health Shop. All the young people who responded to the consultation indicated sexual health services to be a priority. A steering group was formed for the young people’s sexual health service, with representation from operational service staff, Eastern Glasgow Local Health Care Co-operative, Greater Glasgow Health Board Health Promotion Department Youth Team and Glasgow City Council Community Education Services. A consultation evening was also held with young people who identified their priorities for service delivery. S-Club Tuesday developed as a sexual health drop-in service where young people can access advice, support and information and attend workshops to discuss issues important to them.

Source: Coia (2001)

In addition to the roles played by various partners, there are resource constraints to be taken into consideration in terms of equitable partnership working. There are many hidden costs relating to networking and partnership opportunities, which are likely to place burdens on voluntary sector organisations, both financially and in terms of time (Tucker et al. 2005).

**APPROPRIATE STRUCTURES AND LEVELS OF COMMUNITY INVOLVEMENT**

Studies indicate that the role of the community partners may change over time. Considering community involvement in community planning, Atherton et al. (2002) argued that in the early stages of planning only a limited proportion of the population will be ‘participation ready’, and even fewer will be ‘implementation ready’. The authors recommended that this so called ‘advance guard’ of the community and voluntary sector should be involved immediately, as long as they are well informed about realistic timetables for ‘cascading’ information to the wider community. Crucially, these ‘ready’ organisations are distinguished as key allies that can help organisations reach others who are not ‘participation ready’, or to stimulate involvement amongst individuals who are dormant.

Similarly, Chapman et al.’s (2001) study of community participation in Social Inclusion Partnerships argued that treating community partners equitably and flexibly is vital. Thus, a key lesson was that structures for participation should remain transparent, flexible and open to increasing participation over the lifetime of the partnership. Furthermore, the authors emphasised a strong infrastructure and appropriate resources to support community engagement. The research also identified several key principles for encouraging active community participation in partnerships: trust; equality; clarity of roles and responsibilities; agreement to listen; power sharing; accessible and transparent decision-making structures; empowerment; training, skills development and education for all partners.
In our view it is key that partnerships are clear about the level of community involvement they intend, and also what level of involvement is appropriate and realistic for individual community members. This often comes down to whether operational or strategic level collaboration is more desirable or viable. While all three National Health demonstration projects highlighted partnership working as a success, the results in relation to engaging with communities have been mixed (Blamey et al. 2004; Mackenzie et al. 2004; Tucker et al. 2005). Efforts have been made in many health improvement initiatives to engage communities at a range of levels, and this has been found to work better at an operational level (Ayana and Blamey 2003; DTZ Pieda Consulting 2003; Matka et al. 2002).

An example where the realities of involving communities were taken into account was in the ‘Working for Communities’ programme. Involving communities was given high priority and a range of engagement methods were employed to ensure this happened, including participatory appraisal, community conferences, youth summit, and consultation events. This work acknowledged that a flexible approach to community involvement allows people to participate in ways that suit their circumstances and level of interest and one of the most successful aspects of the ‘Working for Communities’ pathfinders was that they provided different and flexible opportunities for communities to become involved (Brown 2003).

Even where communities have been actively involved in strategic level processes, participation was limited, not least because formal rules constrained the extent to which accountability for health services and policy can be expressed downwards to local communities (Sullivan and Skelcher 2002). More recently, after reviewing plans and reports from joint health improvement partnerships and regeneration outcome agreements in Scotland, Bauld et al. (2005) reported that only half made explicit reference to how communities had been engaged in shaping priorities. We cannot tell to what extent this was due to the problems of formality and accountability described by Sullivan and Skelcher, or due to a lack of familiarity in working in ways which engage and empower communities.

The Voluntary Health Scotland Partnership Development Initiative aims to establish strategic partnerships between the voluntary and statutory sectors at all levels for health improvement and health care in Scotland. Voluntary Health Scotland has been committed to the development of community health projects and has been able to put forward the role of the voluntary sector in further developing involvement in services by supporting the development of ‘Patient Focus Public Involvement’. Voluntary Health Scotland highlight that although there is already strong support for the inclusion of the voluntary sector in planning for health care and health improvement at a strategic level in Scotland, it must be able to exert its influence at the strategic level in the planning process. It also acknowledges that in order to do this the voluntary sector needs to further build capacity and to provide a voluntary health infrastructure that will allow the voluntary sector to be represented at the planning table.

Source: Voluntary Health Scotland (2003)
There is some indication that the operational level is favoured by community partners. For instance, one community-based HLC had problems with the ability and willingness of community members to take decisions on issues like funding and employment rights (Platt et al. 2005). One reason cited for this was that local community members had not been given sufficient support by key partners during the decision-making process. A similar point is made in the boxed example opposite regarding the capacity of the voluntary sector to play a strategic role in local health partnerships.

There are clearly ambiguities and uncertainties in the evidence about whether the community would/could/should play a strategic and/or an operational role in partnerships for community or health improvement. Perspectives on this depend partly on what services or activities one is talking about, and on how the participants define the term ‘strategic’. Whether or not a skills deficit among community representatives, or a lack of institutional networking capacity among voluntary sector representatives, do indeed, or should, prevent such partners from playing a strategic role is also questionable and worthy of investigation and debate.

MEASURING PARTICIPATION

The literature on measuring participation has focused predominantly on quantitative issues of who participates, and how often. Mapping of the Scottish Executive’s civic participation activities in 2004 indicated that almost 200 policy initiatives had incorporated some form of participation, with the most common form of activity being written consultation (Nicholson 2005). Despite this level of activity, a survey of public attitudes to civic participation showed low awareness of mechanisms used by the Executive for consultation (Hope and King 2005).

Community engagement appears to be seen as both a means to achieving particular goals, and also as an end in itself. Therefore, it has been suggested that success can be measured in terms of the propensity to effect change, as well as the empowering impact on individuals and communities and the quality of the decision-making process (Morrissey 2000).
There are some discouraging findings with regard to effecting change and empowering communities. Taylor (2003) cited studies which have shown increased participation at the level of implementation within small-scale projects, but showed less evidence of involvement at the agenda-setting stage. Similarly, the Audit Commission (1999) found that three quarters of ‘best practice’ local authorities did not use the results of community consultation procedures in their eventual decision-making. Newman et al.’s (2004) qualitative research on participation within deliberative forums (such as user-based forums or community-based organisations that are drawn into consultation processes) provides useful insight into the perceptions of different stakeholders. This study highlights constraints on the development of collaborative governance based on the perceptions of strategic policy actors on the ability and motivation of members of the public to get involved in participatory structures. As Taylor (2003) noted, pluralism does not equal equality of access.

In terms of the quality of the decision-making process, success can be measured according to the mix of people that are attracted, which in turn has an impact on the credibility of the process. Research has suggested that there is a tendency toward community activists, often referred to as ‘the usual suspects’, becoming involved within area-based initiatives (Goodlad et al. 2004). This suggests that the ‘average’ citizen’s interests are not necessarily being represented.

Furthermore, traditionally excluded groups, including those on low incomes, members of black and ethnic minority groups, disabled people, young people, women, homeless people, and members of faith communities, tend to be under-represented in community involvement (Goodlad et al. 2004). Studies have provided some insight into why this occurs. For instance, the construction of ethnic identities has been found to constrain certain forms of local community participation, (Campbell and McLean 2002; Campbell et al. 2004). This is despite recognition of the importance of diversity within communities (e.g. Home Office 2004, 2004a). Attention has also been drawn to the experiences of disabled people in gaining access to governance structures. A key strand of this literature has been the conflict between preference for self-representation among this group, and the tendency for disability charities, often led by people who are not disabled, to be given primacy in participatory structures (Drake 2002).
### Table 3: Community engagement in health improvement partnerships

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<tr>
<th>Author</th>
<th>Study</th>
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<tr>
<td><strong>Ayana and Blamey (2003)</strong></td>
<td>Evaluation of Scottish Executive national health demonstration project ‘Have a Heart Paisley’. Based on evaluation of theoretical framework, quasi-experimental survey in intervention and comparison area; multi-method case study.</td>
<td>A number of different methods of community engagement were used but engagement at a strategic level was the least successful. The locality team members for the initiative were only involved in four of the 11 strategy groups and therefore had a limited involvement. The representatives’ role on the strategy group was not always clearly understood. However, the community bids committee representative was perceived to be involved in a meaningful way (e.g. in decision-making and influencing the way the budget was spent) within the strategy group.</td>
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<p>| <strong>Barnes et al. (2003); Barnes et al. (2004); Matka et al. (2002); Sullivan and Skelcher (2002)</strong> | National evaluation of health action zones, examining change within zones with specific reference to building collaborative capacities. Research involved: monitoring of health action zones through interviews, document analysis and performance monitoring; and 5 case studies. | The health action zone programme became more of a top-down programme than initially anticipated, exposing clear limitations of community involvement even in more participatory areas, with little evidence that strategic decisions were shaped by communities or service users, although respondents felt that the experience had legitimised their role in local governance beyond that of service delivery agents. The authors concluded that health action zones cannot be characterised as a community-led initiative. Communities need support in developing skills and confidence before they can become active partners, and this takes time and resources. |</p>
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<th>Author</th>
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<tr>
<td><strong>DTZ Pieda Consulting (2003)</strong></td>
<td>The final evaluation of the Scottish Executive’s ‘working for communities’ programme, assessed the extent to which individual programmes met objectives. All 13 pathfinder projects were studied to evaluate the programme as a whole and central project management and administration. This was by means of desk-based research, consultation of project co-ordinators, stakeholders and community representatives and Scottish Executive and by analysis of expenditure.</td>
<td>Pathfinder co-ordinators were successful in engaging with the community and identifying its priorities, but found it more difficult to achieve the strategic-level influence that was needed if new models of basic service delivery were to be achieved. Pathfinders were not given enough time at the outset of the programme to consult with the community, establish appropriate structures, refine their approach, and appoint a co-ordinator.</td>
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<td><strong>Hope and King (2005)</strong></td>
<td>This research gathered information on public attitudes to, and experiences of, issues related to civic participation. Questions were included in the first wave of MORI’s Social Policy Monitor – a multi-client survey carried out among a random sample of approximately 1,000 adults across Scotland. Fieldwork took place between January and April 2005.</td>
<td>Few people felt well informed about the work done by political representatives: knowledge of local councillors’ work was highest and that of MEPs’ work was lowest. The two main barriers to participation were low awareness of opportunities to take part in consultation and skepticism about the value of consultation.</td>
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<td><strong>McCollam et al. (2004)</strong></td>
<td>Review of current mental health practice involving identification and development of 22 case studies of mental health improvement practice.</td>
<td>A lot of activity took place outwith traditional service settings, and in a variety of contexts, not just those with a central focus on mental health. This highlights that mental health improvement work is being recognised as the responsibility of the wider community as opposed to the more traditional NHS-based service delivery.</td>
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<td><em>Nicholson</em> (2005)</td>
<td>This research included a survey to identify civic participation activity undertaken by core Scottish Executive departments in 2004. The survey was supplemented by 11 telephone interviews.</td>
<td>Overall, 191 different Scottish Executive policy initiatives were identified as having been supported by civic participation activities in 2004. The activity most commonly reported was the written consultation. A gap was identified in involvement of members of minority ethnic communities/faith groups and their representatives.</td>
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<td><em>Palmer</em> (2003)</td>
<td>The Partners in Health evaluation examined four pilot projects to understand training needs to develop health promotion in the voluntary sector, focusing on partnership working.</td>
<td>Lead-in times could be a period of up to a year, particularly in the case of multi-agency partnerships such as social inclusion partnerships.</td>
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<td>Platt et al. (2005)</td>
<td>Process evaluation of six Scottish healthy living centres, examining the centres’ approaches to improving the health of disadvantaged groups and reducing health inequalities. This involved two rounds of fieldwork over a year employing a range of qualitative methods.</td>
<td>Some areas were not being adequately prepared to set up facilities and procedures, while delivering activities at the same time. Other areas were able to deal effectively despite these difficulties. In two case study sites, matched funding from partners was released prior to the healthy living centres’ Big Lottery Fund money, and this enabled a pre-operational phase to be built into planning during which practical details could be smoothed out.</td>
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<td>Ridley and Jones (2001)</td>
<td>Unsystematic literature review including material published primarily in the UK that examined theories and involvement in initiatives across the health and illness spectrum, and reflected on the effectiveness of different approaches.</td>
<td>While views of local patient and community groups had been gathered for their local Primary Care NHS Trusts, these groups rarely, if ever, received any feedback on decisions that had been taken, or what influence the views of patients and the public had on the decision-making process. Reduced motivation for individuals and communities to engage in the future was also noted.</td>
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<td>Author</td>
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<tr>
<td>Roussos and Fawcett (2000)</td>
<td>Review of 34 studies (thus covering 252 collaborative partnerships). Most of the studies reviewed used experimental or quasi-experimental research design and assessed the effects of a wide range of community health aspects.</td>
<td>Training and support are needed to implement and sustain collaborative partnership.</td>
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<tr>
<td>Tucker et al. (2005)</td>
<td>External evaluation of Healthy Respect. The evaluation focused on sexual health outcomes (employing surveys and focus groups), mapping partnership working and networks (interviews and document analysis), and implementation of projects (case studies).</td>
<td>Participation and consultation with young people and parents were considered to be placation as opposed to genuine participation. It was also found that the issues raised by young people in these consultations were not actually dealt with. Under-representation of key community agencies undermined partnership working, with power seen to be held by the larger agencies. The evaluation acknowledged the hidden costs of new networking opportunities, and the added volume of work and activity which was more costly for small voluntary organisations, some of whom subsidised their involvement in the project.</td>
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8. THE EFFECTIVENESS OF COMMUNITY-BASED INITIATIVES FOR HEALTH IMPROVEMENT

This chapter takes the review a stage forward, looking at the outcomes of collaborative initiatives that involve communities: specifically the community health improvement outcomes of such initiatives. This addresses the fifth of the research questions (outlined on page 13). How does ‘involving the community’ contribute to the goals of community health improvement initiatives?

KEY POINTS

- It is extremely difficult to establish a connection between collaboration involving communities and health outcomes for communities at aggregate level.
- A major difficulty lies in the measurement of community health. Aside from broader methodological issues such as the design and implementation of survey research, there are complications in matching area-level health data to community-based health interventions.
- It is also difficult to attribute any change in community health to a particular intervention because of the influence of broader economic, social and cultural trends. There are particular problems linked to area-based initiatives which seek to improve health alongside addressing other concerns.
- There is more evidence on intermediate health-related outcomes as health improvement initiatives can address short- to medium-term concerns more easily. In addition, intermediate outcomes related to healthy neighbourhoods are more readily measured.
- Partnership working involving communities in a meaningful way has benefits for the delivery of health improvement efforts.
- Health-related benefits, such as increased confidence and control, can be identified among individuals taking part in community-based health improvement efforts. These benefits can be significant for those individuals. However, research has been less able to demonstrate population health gains at the level of community.
RESEARCHING COMMUNITY PARTICIPATION AND HEALTH IMPROVEMENT

There have been several recent reviews that look at the connection between community participation and the achievement of positive health (e.g. Smithies and Hampson 1999; Hills and Blackburn 2001; Barr and Hashagen 2000, Scottish Community Development Centre 2000; Bauld et al. 2001; Petticrew and MacIntyre, 2001), and readers are directed towards these reviews for further detail. Making the connection between collaborations involving communities and the impact on the aggregate health of communities is extremely problematic, however.

Previous chapters have reported the difficulties associated with measuring community health. The results of a search on the impacts of community-based initiatives for health improvement reflect the presence of these difficulties in the sense that there is a paucity of material on long-term health gains. The emphasis instead is on intermediate outcomes that lead to healthy neighbourhoods because these are easier to achieve and to measure.

We turn now to two of the major weaknesses of the available research evidence: measurement of health at community level; and attributing success to community-based interventions.

MEASURING THE HEALTH OF COMMUNITIES

In assessing the outcomes from community involvement in local partnerships, it is important to distinguish between the following two perspectives on health and communities.

Community health: this is the aggregate health position of a local community, typically measured in terms of prevalence rates for specified illnesses, recovery rates from illness, or in terms of premature death rates.

Healthy neighbourhoods: this is a description of the extent to which the residential context provided by a locality supports or damages community health. It may not explain the state of a community’s health since this may have historical causes, but it should tell us whether physical and social conditions in an area are likely to contribute to the improvement or deterioration of current aggregate health status. This assessment of healthy neighbourhoods could follow the lines set out at the end of Chapter 4. As already indicated, some aspects of healthy neighbourhoods are better measured than others. But all elements of the healthy neighbourhood should be amenable to change by partnerships involving the community. These changes could be considered intermediate outcomes towards a healthier community and thus should be monitored and considered alongside the community changes, political decisions and resource inputs required to produce them.

There are problems with grouping areas and drawing conclusions about differences between them. Roussos and Fawcett (2000) highlight the key issue of lack of accurate and sensitive indicators for many community health outcomes. Whilst collecting data on changes in the health of individuals is relatively straightforward, it becomes more difficult to assess the impact of health improvement initiatives at the community level. For instance, population-
level data on health outcomes does not reflect change in community health due to small-scale local initiatives. Evaluation of such initiatives tends to rely on measurement of individual level behavioural change in health behaviour. However, Roussos and Fawcett [2000] suggest that, 'because behaviour change often occurs sooner than with more distant population health outcomes, measures of risk and protective behaviours, such as self-reported eating habits or direct observation of lower-fat food purchases, are often appropriate means to evaluate the contribution of a partnership to community health'.

Another difficulty concerns methodological difficulties associated with the collection of survey data (for instance in terms of the level of accuracy and generalisability that can be claimed). As an illustration, the independent evaluation of Have a Heart Paisley (Blamey et al. 2004) reported on a population survey that aimed to detect any changes in CHD related disease status, key risk factors or behaviours at a population level. However, the low response rate to the survey made it difficult to draw any firm conclusions.

A separate issue, in relation to large-scale, complex interventions, is the difficult task of co-ordinating the collection of health data in different areas. As an illustration, social inclusion partnerships have shown a high degree of variability in effective collection of the monitoring data required of them by the Scottish Executive. A national evaluation of former programmes across nine areas found that health outcomes could not be measured in five of these areas (Scottish Executive 2001).

**ATTRIBUTING CHANGE TO A PARTICULAR INTERVENTION**

It is difficult to observe significant community-level changes in health behaviours within the context of secular trends that are demonstrating population-level health improvement (Merzel and D’Afflitti 2003; Blamey *et al.* 2004). Studies must acknowledge the difficulties associated with attributing changes in health outcomes of a population to a particular initiative or programme. These include a lack of consistent evidence of health outcomes that are positive (Bauld *et al.* 2005a); and for initiatives which seek to address health as one of several concerns, the difficulty of picking out the specific health impacts (Atkinson *et al.* 2006). A key point raised by a review of area-based initiatives (Atkinson *et al.* 2006) was that achieving a more precise measure of spending and understanding of health outputs and impacts was blurred by the involvement of area-based initiatives in wider actions which may have been indirectly linked to health and well-being such as increasing employment, improving housing, reduced crime and an improved environment.

A related point is that health improvement can be achieved via many indirect means. Improved health may result from programmes and initiatives which address issues related to any of the determinants of health contained within holistic models of health. As an example, initiatives to tackle antisocial behaviour problems in two specific areas of Dumfries (Dumfries and Galloway Community Planning 2004) were associated with health gain in two ways: reducing antisocial behaviour, thereby making the communities safer and reducing stress; and increasing levels of physical activity among young people (COSLA 2005).
One of the most significant obstacles is that changes in population health outcomes can take years to become visible, yet many partnerships are relatively short-term initiatives (Bauld et al. 2005a). The type of outcomes that have been observed, therefore, have tended to emphasise intermediate outcomes which are measurable. These include improved social support networks, levels of participation and trust in a community. These indicators do not represent a change in community health but they might offer mechanisms by which community health is ultimately improved. Caution in interpreting findings must be exercised due to the long-term nature of population health change.

**EVIDENCE OF IMPACT ON HEALTH**

Arblaster et al. (1996) conducted a systematic review of the literature on interventions to reduce health inequalities including those that involve community support and participation. From this review the authors identified a series of factors, which they suggest contribute to successful outcomes in improving the health of disadvantaged groups (Box 3). Although this review included studies aimed at specific sub-groups within disadvantaged communities, the principles may have wider application.

**Box 3: Factors that contribute to successful outcomes in improving the health of disadvantaged groups**

- Intensive approaches
- Community commitment
- Multi-disciplinary approaches
- Multi-faceted interventions (e.g. combining education and legislation)
- Face-to-face interactions (e.g. individual support for smoking cessation)
- Settings appropriate to the context
- Prior needs assessment to inform intervention design
- Ensuring interventions are culturally appropriate
- The importance of the agent in delivering the intervention
- Training those delivering the intervention
- Support materials (appropriate for context)
- Developing skills (e.g. lifestyle knowledge)
- Provision of material support and resources
- Provision of prompts and reminders to attend
SUSTAINED ENGAGEMENT OF COMMUNITIES

Evidence and project experience suggests that community-based health improvement projects are more likely to be successful in reaching target groups and developing and sustaining the intervention if they have invested in community engagement (Bauld et al. 2005). However, it is clear from this review that these outcomes are contingent, upon a range of factors including the focus of the initiative, the identity of the individuals involved, and the method of engagement used.

DEVELOPING APPROPRIATE SERVICES

There is some evidence that partnership working and involving communities can have a positive impact on the delivery of health improvement efforts. This suggests that engaging with community members in a meaningful way is an important determinant of success in terms of developing relevant and appropriate services and activities (Bauld et al. 2001). On the basis of their review, Roussos and Fawcett (2000) suggested that the extent to which collaborative partnerships affect population health differs according to the community and systems change it facilitates in terms of amount, intensity and duration.

HEALTH IMPACTS AT INDIVIDUAL AND COMMUNITY LEVEL

Perceived improvements for individuals involved in collaborative health improvement work have been reported (Bandesha and Litva 2005; Cuffe and Cherkaoui 2004). These are predominantly associated with the raised confidence levels and increased control experienced by individuals involved in supporting intervention. The associated increases in general well-being are positive outcomes for general health.

The experiences of volunteers involved in the Building Healthy Communities programme in Dumfries and Galloway indicated increased individual well-being. This was set up in 2001, built around the concept of ‘healthy living centres’ (Dumfries and Galloway Community Planning 2004). A key element is to provide support aimed at members of the community dealing with anxiety, stress and depression and use it as basis for developing range of appropriate healthy initiatives. The recruitment and deployment of community health volunteers is central to this project aiming to create a graduated hierarchy of opportunities, i.e. from being a participant in the activities that the project generates at a pace that suits the individual. These volunteers are supported through training and learning opportunities to work with the project, (Dumfries and Galloway Community Planning 2004), and they have experienced increased confidence and acquired skills in the process (Cuffe and Cherkaoui 2004).
Research suggests that community-based health promotion programmes have been unable to achieve anything more than modest changes in behaviour and health across a community, with impact often being restricted to a few individuals (Merzel and Aflitti 2003; Blamey et al. 2004). However, it also acknowledged that the impact of smaller community-based health improvement efforts could be considered significant to those they affect. Improvements in the well-being of individuals involved in community-based initiatives may have broader impacts on individuals’ social networks and wider community. However, as discussed in Chapter 8, there are difficulties in attempting to measure community level health change.

One example of research that examines community-level impacts (albeit perceived impacts) as well as individual level ones is qualitative research on the perceptions of community participation and health gain in a community project for South Asians living in the UK (Bandesha and Litva 2005). This study demonstrates variations in the perceptions of professional and beneficiaries of the project in terms of community related outcomes, highlighting a further layer of difficulty in establishing whether an initiative has led to positive change.
Table 4: The impact of community-based initiatives on health

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<thead>
<tr>
<th>Author</th>
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<td>Atkinson et al. (2006)</td>
<td>This systematic review gathered national evaluation documentation relating to government funded area-based regeneration initiatives in the UK since 1980. It examined whether health impacts had been intended and, if so, how they had been measured.</td>
<td>In the overall review, even where health was identified as a funding theme within government-run evaluations of area-based regeneration programmes, there was very little evidence in evaluation documents that any health impact had been identified.</td>
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<tr>
<td>Bandesha and Litva (2005)</td>
<td>Qualitative research on the perceptions of community participation and health gain in a community project for South Asians living in the UK.</td>
<td>General agreement was found amongst community participants and professionals that gains included increased knowledge and skills and raising self-esteem. There was, however, a difference of opinion around the impact of the project in terms of social cohesion. Professionals believed participation in the project enhanced the sense of social cohesion in the community, whilst lay informants had made new friends on the project, but did not feel the project had made any difference to the community at large.</td>
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<tr>
<td>Bauld et al. (2005a)</td>
<td>National evaluation of health action zones, examining change within zones with specific reference to building collaborative capacities. Research involved: monitoring of 26 health action zones through interviews, document analysis and performance monitoring; integrated case studies.</td>
<td>Local authority level data from 1997–2002 were analysed for a range of health indicators relevant to health action zone activities. Between 1997-2002, these areas appear to have outperformed other areas in relation to a number of indicators that are related to their programmes and national policy priorities. First wave health action zones in particular, which had an extra year to make an impact, appear to have seen more positive changes in relation to all cause mortality and coronary heart disease mortality than other areas. Findings, however, were not consistent across indicators. The variable picture made it difficult to draw any firm conclusions about the short-term impact of health action zones.</td>
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<td>Cuffe and Cherkaoui</td>
<td>An evaluation of the community health volunteers scheme ‘Building Healthy Communities’ brought together volunteers to explore what differences, if any, the project has made to those individuals’ health and well-being.</td>
<td>While the evaluation included a small number of volunteers, it offers an indication of the potential personal and wider family and community impacts that a project like this can have. Life before ‘Building Healthy Communities’ was described as isolated, lacking support networks, and feeling of little value. Some of the changes brought about by participation included increased confidence, finding a voice, a sense of belonging, development of skills and access to training, increased motivation, a sense of purpose, friendship, hopes and ambition, and a greater sense of security.</td>
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<td>Merzel and D’Afflitti</td>
<td>Systematic literature review of 32 community-based disease prevention programmes in the USA between 1980 and 2001.</td>
<td>Community-based interventions have shown just a modest impact, due in part to the small scale of the interventions, and the tendency for interventions to target individual behaviours rather than broader policy and normative change that might have community-level impacts.</td>
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<tr>
<td>Roussos and Fawcett</td>
<td>Review of 34 studies (thus covering 252 collaborative partnerships). Most of the studies reviewed used experimental or quasi-experimental research design and assessed the effects of a wide range of community health aspects.</td>
<td>There was insufficient evidence to make strong conclusions about the effect of partnerships on population-level outcomes.</td>
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The difficulties around evaluation of the outcomes of community-based initiatives to improve health include how to reasonably define success, and selection of appropriate health outcomes for projects. The problems with evaluation discussed in Chapter 8 highlight the issue of attribution of outcomes which are likely to emerge over the long-term. Understanding of community health outcomes is also blurred where community-based initiatives address the wider concerns which may have been indirectly linked to health and well-being such as increasing employment, improving housing, reduced crime and improved environment. Of course, if we consider interventions which impact on these wider determinants to be central to improving health by creating better environmental and service contexts, this point loses its significance. From this perspective, the general reference to ‘evidence underpinning community-based approaches’ covers many different dimensions.

**KEY POINTS**

- Despite an increase in the number of community-based health programmes, there remain difficulties with their evaluation.

- Echoing some of the points made in relation to the impacts of health improvement collaboration which involves communities, there are difficulties associated with measurement. In particular, there are various approaches to measuring community involvement, and successful outcomes.

- Alternatives to traditional evaluation methods are being developed, and the use of a number of evaluation tools designed to capture a variety of types of data is increasing. These may offer increased validity of results as evidence from different sources is brought together.

- Different sectors tend toward particular cultures of evaluation: for instance the inspection culture of local authorities and the project monitoring approach of the voluntary sector. The purpose of evaluations is reflected in the sort of information that is gathered and the way it is used.
Organisational capacity to undertake evaluation is frequently lacking.

Reports of much small-scale evaluation are inaccessible, or difficult to obtain. This means that lessons are lost from a good deal of relevant information. Structured approaches to information-gathering are required to remedy this position.

**CHALLENGES**

There are a number of challenges for the evaluation of community-based initiatives that should be considered within this discussion. Although the challenges impact on all complex community initiatives, which might include smaller projects, these challenges are particularly pertinent to the evaluation of larger scale initiatives such as the National Health demonstration projects and health action zones. These issues have been discussed in detail by various authors (Connell and Kubisch 1998; Judge and Mackenzie 2002; Mackenzie and Blamey 2005), and the main considerations that were identified are summarised as follows:

- They have multiple and broad goals and are therefore not well suited to evaluation methods that rely on a small number of key outcomes.
- They are highly complex learning enterprises with multiple strands of activity operating at many different levels from the small project to the most strategic cross-agency, area-based approaches.
- Many activities and intended outcomes are difficult to measure.
- Improving health outcomes that are socially determined takes longer than the lifespan of an initiative and its evaluation.
- Communities are complex and it can be difficult to disentangle all factors that have an impact on community health.

Given these challenges, it is essential that evaluation strategies are both appropriate to the context of the initiatives being assessed, and feasible in terms of capacity for evaluation. A summary of key issues highlighted by Hills (2004) is provided in Box 4 (see overleaf).
Realistic expectations and resources
A common example of a lack of realism in community-level health evaluation is the expectation that a relatively small-scale intervention will have a measurable impact on morbidity or mortality from conditions that take many years to develop, and have many different causes. Unrealistic expectations also arise where evaluations are expected to produce results that would be possible only with a much greater investment of money and expertise.

Realistic views of the nature of community-level interventions
An evaluation will miss the main point of an intervention if it fails to take into account the underlying rationale for the programme or activities taking place, e.g. confusion between the evaluation of specific activities that are part of a programme, and the programme as a whole. Evaluation needs to take into account the level and centrality of community participation in the development of the programme, i.e. community involvement is essentially a value commitment as much as evidence-based practice.

Realism about the capacity of the community to engage in evaluation
More advanced evaluation strategies require considerable involvement from workers and participants in community projects. Securing this kind of engagement requires considerable skills from evaluators, as well as sensitivity to the underlying dynamics and politics of the activities taking place.

Realism in evaluation practice
Good practice should include a note of caution about what can be achieved in different circumstances. There is a case for asking what constitutes not just a ‘high-quality’ evaluation, but also a ‘good enough evaluation’.

DEVELOPMENT AND USE OF APPROPRIATE MEASURES OF SUCCESS

In relation to outcomes, much of what we have as measures of population or community level outcome are aggregated measures of individual well-being. There is, however, promising work by Health Scotland developing population indicators for mental health and well-being which should contribute to the current debate [see www.phis.org.uk/].

Since the Government has been promoting and assisting in the ongoing assessment of communities, we should consider the relevance of this work. It is important to consider how these new measures might be applied to judge whether communities are flourishing and what some of the associated anxieties of this process might be [Chanan 2002]. In the case of social inclusion partnerships (SIPs) for example, the SIP core compulsory indicators were found not to be suitable for all, having greater application to area-based SIPs than thematic SIPs. For instance Dundee’s Xplore thematic SIP for young people did not use any quantitative data to measure progress. Instead they developed a set of indicators based on qualitative methodologies that were approved by the Scottish Executive. Whilst it is felt that the SIP did achieve many of its objectives, the evaluation found that ‘there is a sense that Xplore has undersold its own progress through its inability to report hard data to external bodies’ (Blake Stevenson Ltd 2004).

Crawford (2005) discusses the importance of broadening out evaluation for community-based interventions as they are often judged by unrealistic outcomes that are not achievable due to the constraints and pressures placed on interventions through funding. ‘Perhaps we need to think more about making the important measurable rather than making the measurable important’.

PLANNING/TOOLS

Models of evaluation that are often used for community-based health promotion projects include the Logical Framework Model, and the Realistic Evaluation Model. A number of evaluation models and toolkits have also been developed specifically for community-based groups [See appendix].

If complex community-based health initiatives are to generate useful learning then there is a need to look beyond traditional approaches to evaluation. Theory-based approaches to evaluation are viewed as a potentially useful means of evaluating processes and outcomes in community-based programmes that have not been adequately addressed by existing approaches [Judge and Mackenzie 2002]. What is required is an approach that takes into consideration that community-based initiatives are not happening in a vacuum. Evaluation needs to be more flexible and creative.

Models that have been built upon a community development focus include the Learning, Evaluation and Planning (LEAP) framework and the ABCD guidelines, which emphasises evaluation as the key to effective practice. The emphasis on these two models is to improve programme planning and generate community learning, rather than focusing on evidence of impact.
The LEAP model of evaluation is a practical toolkit for planning and evaluation (Scottish Community Development Centre 2000). This is a framework that ‘aims to help those who work in community health settings to plan and evaluate their work in partnership with one another and with members of the community they seek to help’. LEAP is targeted at community-based groups delivering complex initiatives. Healthy living centres were encouraged to use the LEAP framework for evaluation (Platt et al. 2005).

Where LEAP was used, some healthy living centres found it was a useful framework for planning and evaluation, and for providing some consistency of reporting across projects. However, other healthy living centres did have some difficulties using this framework (Platt et al. 2005). This highlights the point that even where practical tools are available to projects there is also a support and development need. It is necessary that appropriate resources are available to projects to enable successful implementation of frameworks such as LEAP, ABCD and theory-based approaches. Within this approach, evaluation and learning occur across the entirety of the community health improvement process. Evaluators work with local stakeholders to elicit their rationales and strategies and sharpen their interventions, targets and plans. Lessons from this process become part of the community resources available to refine and develop the health improvement process in the future.

**DRAWING ON DIFFERENT SOURCES**

It is evident from this review that large scale evaluations can be problematic and do not necessarily provide all the information we need to develop community health improvement efforts. It has also become clear that local evaluation is often not as well resourced and access to localised project information is limited. However, in order to build a full picture and knowledge base it is necessary to capture a range of appropriate information and learning.

To exemplify this we look to the ‘Have a Heart Paisley’ initiative. An independent evaluation was carried out in addition to an internal evaluation. There were a number of difficulties and limitations of both strands (see www.phis.org.uk/hahp/default.asp), such that little could be stated about the quality, intensity and reach of the community interventions (Blamey et al. 2004). However, while the independent evaluation was unable to draw any firm conclusions in relation to the impact of the programme on the community, this should also be considered alongside the insights gained through the ‘stories from the heart’ exercise. This used the LEAP framework to capture the stories of local people who had been involved in community projects funded by ‘Have a Heart Paisley’ (Sloan 2003). This approach was used as project organisers felt that traditional evaluation methodology was not capturing the real benefits and effects of the involvement of community groups who were running and managing their ‘Have a Heart Paisley’ projects, and of those participating within these community-managed projects. Through a variety of participatory
approaches representatives from community projects told their story in a variety of ways both in the run-up to a showcase event and on the day of the event. Both staff and participants viewed the exercise as being very successful in capturing the whole spirit of the process of the community projects. The process was also perceived as being empowering for participants (Sloan 2003).

These are two very different scales of and approaches to evaluation and both have their relative merits. While funding bodies consistently look for evidence of 'impact' in quantitative sense, it is clear that other forms of learning can also be valuable. Although the collection of monitoring data and other 'hard' outcomes of initiatives are necessary, it could also be useful to capture more of the so-called 'softer' benefits of these initiatives.

**CAPACITY FOR EVALUATION**

Further challenges relate the capacity of a group or organisation to carry out evaluation. The evaluation of the healthy living centres programme in Scotland highlighted this point. As there was no emphasis on evaluation at the bidding stage and the funding body did not provide support for evaluation activities, there tended to be prioritisation of performance management over local learning (Platt et al. 2005). Lack of expertise and knowledge of evaluation has also been shown to be a problem for other community-based initiatives. In a recent review of learning from community-based initiatives, informed by an international seminar series, a literature review and in-depth case study work conducted across five complex, community-based initiatives in the UK (including health action zones, New Deal for Communities and the National Strategy for Neighbourhood Renewal), Coote et al. (2004) found that many local practitioners lacked the necessary skills and resources to evaluate local practice and that their own learning and skills were not being captured. The authors also found that local practitioners were too busy ‘getting things done’ to reflect and learn, and that they lacked opportunities to learn from policy-makers, researchers or other experts. An important conclusion was that local practitioners and communities must be able to contribute to the evidence base. The second phase of the healthy living centres evaluation will explore how the initiatives continue to evolve. A key aspect of this will be to look at how community learning and development structures have evolved (Platt et al. 2005), and this could provide some key insights for the future.

The need to build evaluation capacity within organisations and communities is gaining recognition at a national level. The National Demonstration Projects Evaluation Task Group (2004) highlighted important variations in the evaluation culture across sectors: for instance, the voluntary sector was seen to be very familiar with critical reflection and producing reports for funders; local authorities were seen to have an ‘inspection culture’ and were used to producing committee reports when necessary; while the NHS was seen to have a more ‘academic' approach. This is an important consideration within the context of this review as community health improvement efforts invariably cross a range of sectors.
DISSEMINATION AND APPLICATION OF EVALUATION FINDINGS

A review of joint health improvement plans and regeneration outcome agreements indicated that evidence-based practice appears to be piecemeal, with limited systematic identification and appraisal of interventions that have been proven to work elsewhere under similar circumstances (Bauld et al. 2005). Evidence on the health impacts of area-based initiatives at a national level has been shown to be hard to unearth, even in programmes where health was a key feature of the regeneration initiative (Atkinson et al. 2006). In the context of rising interest in the health impacts of area regeneration programmes in England, Wales and Scotland this has clear implications for institutional ‘policy-learning’ over time.

There is a significant amount of information in the form of ‘grey literature’ which is not scientifically peer-reviewed. This may be difficult to access and to interpret. It often takes the form of local case studies, which may not be widely generalisable but do provide accounts of conditions in particular places or for specific population groups. Such studies may be quite influential to local thinking about regeneration and health. There is a need to access grey literature and hard-to-access publications from voluntary and community organisations and projects in a systematic way in order to achieve a clear picture as to the extent to which, and what sorts of, lessons can be taken from this material. The hidden nature of this material requires an intensive approach to gathering material.

Recent evaluations of community-based initiatives have primarily been for the purpose of project accountability to funding bodies and for development, not as a vehicle for creating knowledge that can be generalised. Hills (2004) found this has led to a style of evaluation and lack of publication that are not open to those searching for an evidence base. Indeed, this point resonates with the findings of the current review and the need for more systematic evaluation, dissemination and review of evidence in order to provide greater access to evidence for practitioners, policy-makers and the research community. Hills suggested that difficulty in accessing published accounts reflected the relatively peripheral place that community-based intervention has occupied in UK health policy until more recently.
In this conclusion to the literature review, we focus on the need to fill certain gaps in knowledge.

UNDERSTANDING COMMUNITY HEALTH AND WELL-BEING

The measurement of health within communities focuses predominantly on physical health (mortality and disease) and on the level of provision of health services. It would be helpful if community measures of mental health and of subjective well-being could also be developed. This could highlight places where community level interventions might affect health, as well as identifying any places where there is a mismatch between physical and mental health and well-being.

The associational patterns and causal mechanisms between social cohesion, poverty and health inequalities, and mental health and well-being need to be examined at the city regional scale. This will help us to establish whether arguments founded upon national and international research are applicable at a more local level. There are good grounds for thinking that, in a meritocratic society, social comparisons and pressures to succeed and conform will operate at a local level so that feelings of exclusion and inadequacy could impact upon the health of poor communities.

Some aspects of local neighbourhoods and communities which impinge upon community health and well-being are poorly measured. These include empowerment, accessibility, local cultures, and area reputation. Without measuring these aspects of a community, we rely upon static measures of those things that can be easily ‘delivered’ locally, such as improvements in services and environments. It may well be that more resources should go into community development, but research cannot indicate this need very well until some of the social and cultural aspects of communities are better measured.

SOCIAL CAPITAL, HEALTH AND WELL-BEING

There is a common assumption that social capital is a good thing and will have beneficial impacts upon a community’s health. However, the mechanisms which operate between social capital and health have only been set out theoretically rather than explored through research. If these links can be explored we might find out whether people in different communities use social capital for different ends or with different effects. In the absence of this research, somewhat unrealistic expectations may be expressed about what social capital can provide for poor communities.

Social capital should facilitate support and empowerment for individuals and groups. It helps them cope with difficulties and provides the ability to use social resources and collective capacity to successful ends or to solve a community’s problems. However, this depends upon communities having a mixture of bridging, bonding and linking social capital, yet we do not know the extent to which the mix of different types of social capital varies in degree between communities.

A study of the types of social capital held by individuals in different communities may indicate, for example, how social capital as currently configured maintains inequalities. In some cultures and communities, social capital may have negative impacts on some people. For example in some communities the use of strong social networks to enforce norms of behaviour may constrain social integration or social advancement; in other communities strongly bonded gangs may engage in damaging activities or inflict a
drug dealing and crime culture on those around them. Again, this calls for a contextually sensitive study of the effects of social capital, drawing on in-depth interviews and observation rather than large-scale social surveys.

PARTNERSHIP PROCESSES
It is assumed that partnerships are empowering for individuals and organisations because they develop creative synergy to find new ways to solve problems through combining skills, competencies and resources. However, more research which further demonstrates how such synergistic outcomes have occurred in partnerships with different members would be useful. It may also overcome scepticism about whether or not statutory bodies in partnerships can operate outwith and beyond their usual practices and procedures. Trust is a key component to successful partnership working. Yet we did not find many studies of trust in such circumstances. Research which could show how trust between the community and other organisations in partnerships is developed and maintained would be useful in demonstrating whether and how local needs can be met alongside organisational goals.

COMMUNITY ENGAGEMENT IN HEALTH IMPROVEMENT PARTNERSHIPS
Partnership working has impacts upon community and voluntary sector organisations which often lack spare resources to put into partnerships. An assessment of these impacts and costs may indicate whether this is a sustainable approach if expanded to other areas of activity and service delivery in the future. There is conflicting argument and evidence about whether community sector partners want to be involved in strategic or operational decision-making within partnerships. Some clarification of the meaning of each of these aspects of partnership working would help future partnership arrangements, as well as evidence about community preferences and abilities in relation to each.

Communities are not homogenous entities, and partnerships face the challenge of trying to engage both the more vocal and the more hidden members of communities. The degree to which partnerships, or their community sector members, manage to make connections with all elements of the community is worth exploring. The barrier to this may be the fact that some groups are hard to reach; it may be that some groups are more powerful within communities and thus ‘drown out’ others; resources to engage more widely may be a constraint; or the organisational infrastructure may be lacking locally to enable this to happen. Research could tell us which of these factors was the most important in constraining engagement with all elements of a community, if it is indeed constrained.

IMPACTS AND OUTCOMES OF COMMUNITY INITIATIVES FOR HEALTH IMPROVEMENT
Several issues are highlighted here which have implications for further research: clarity about the type of outcomes that are defined in health terms (i.e. improved well-being or changes in factors that are linked to ill health); how to measure these outcomes (i.e. relying on self reporting or the perception of those involved in community health improvement initiatives or members of the community versus more objective indicators). Research should combine studies of particular communities with contextual or ecological measurements of health within the wider urban or regional area, and the
communities therein. This will enable researchers to assess whether local initiatives contribute to health gains beyond what is improving as a result of wider policy actions and social changes, as well as to gauge the extent to which local actions help reduce health inequalities across communities.

Studies of community understandings of what constitutes a healthy or unhealthy community, and of communities’ views on what is affecting health locally should be undertaken in a range of Scottish communities. Not only will this help identify local influences upon health, but it will also begin to address the question of whether there are local community cultures in which health issues are considered in different ways from mainstream or conventional understandings.

Individual gains from participation in community-based health improvement partnerships should be explored, covering both immediate impacts upon the individuals concerned and secondary effects through these individuals upon the members of their own social networks and the wider community. Active individuals with an interest in health improvement may act as catalysts for wider impacts which have yet to be considered.

Quasi-experimental research, which would add to our repertoire of investigative tools for studying health impacts, should be expanded. Such studies, comparing intervention and comparison areas (no areas are static enough to be controls), would enable researchers to identify the added value of community-based initiatives, over and above the effects of other activities, particularly targeted at deprived communities.

Longitudinal community-based research programmes should be established so that we can assess the relationships between intermediate health outcomes [those that help create healthy neighbourhoods] and longer-term community health improvements.

**EVALUATION**

- A range of evaluation tools are available, and thought should be given to the most appropriate forms of evaluation for a particular initiative. Important lessons can be taken from evaluation of community-based health improvement, but the variability of approaches to evaluation, in terms of research methods and purpose for the evaluation mean that it can be difficult to draw conclusive results. Research could attempt to investigate to what extent different models and tools of evaluation can provide useful assessments and learning for communities, practitioners and policy-makers.
PART III:
QUALITATIVE RESEARCH
This part of the report presents the findings of qualitative research that addresses the second broad aim of this study: to explore partnerships and relationships within community-based initiatives and programmes designed to strengthen and improve community health and well-being. The research was carried out in two stages comprising interviews with key players to highlight current views on the engagement of communities in health improvement, and case studies that explored the processes involved in community participation within two contrasting partnership arrangements.

**Scoping interviews**
This stage of the research aimed to gather views from a range of key players in the health field, both from the statutory and voluntary sector. Interviewees were asked to comment on their experiences of community involvement in health. They were also questioned about the process of engaging communities, both in terms of improving community health and in terms of empowering individuals. The findings are presented in terms of:
- the context for community engagement in partnerships
- the foundations of community engagement
- outcomes of community-based partnerships.

Along with the findings of the literature review, the ideas and perceptions gathered during this interview phase have fed into the design of the case studies research.

**Case studies**
This stage of the research is based on two qualitative case studies that compared various aspects of contrasting models of partnership arrangements. Findings from this research are organised according to the following themes:
- the nature of partnership working with community involvement
- influences on collaboration with communities
- partnership remits
- the extent of meaningful community participation.
SUMMARY OF FINDINGS

The following summarises findings from the scoping interviews and case studies.

- The current institutional environment can be characterised as one of increasing complexity in terms of partnership arrangements. This comes with potential to create an added burden on partners.

- There is, nonetheless, an optimism about the opportunities which are opening up due to the changing policy environment and the ways in which practitioners are embracing the idea of community engagement in health improvement activity. There is a sense that policy notions around the value of community participation are gradually filtering down to practice level.

- This is accompanied by a recognition of the difficulties of encouraging effective community participation, but despite this the aims of community development are perceived as being worthwhile.

- Some vital ingredients for effective community participation in partnerships for health improvement are time, trust, respect, skilled facilitation, and a willingness on the part of statutory partners to forge balanced relationships and address their own skills shortages.

- Meaningful partnership working requires mutual benefits for all partners.

- The importance of ownership of partnership processes is recognised across the board, and there are examples of attempts to empower community partners within each of the qualitative case studies. Much of the emphasis within partnerships is around community development to enable effective engagement by communities. This is, to an extent, at the expense of less achievable aims connected with seeing community-based plans and ideas through to completion.

- Experience indicates that voluntary sector and community partners are much more heavily involved at the operational level as opposed to playing a part in strategic-level decision-making.

- The management of expectations is key for successful partnership working between statutory and voluntary sector, and community partners. This works in different directions: representatives of the community must make clear what level of participation is desired, and statutory partners should specify the role that they expect community partners to play.

- By bringing together partners from different sectors, and with particular interests, it is possible to broaden awareness of the array of influences on community health and well-being, and to draw on resources that can be used to address these various influences.

- The difficulties of evaluating partnerships that involve communities are well established. However, there can be perceived health-related benefits for the members of communities who participate, in terms of personal self-esteem.
11. SCOPING INTERVIEWS

Interviewees were active in a variety of roles. Some had expertise in fields directly related to health, but others were drawn from organisations with a broader interest in the community and voluntary sector, or issue-based organisations that viewed health improvement as a by-product of their work (e.g. environmental action group). Although their experiences were particular to their specific roles and backgrounds, there was a great deal of overlap in the comments that were made, and the following summarises the points on which there was mostly consensus during interviews, unless otherwise indicated.

CONTEXT FOR ENGAGEMENT IN PARTNERSHIP WORKING

- In terms of the extent of engagement in partnership working by communities and their representatives, there was a sense not only that this was increasing, but that the terms of engagement were being constantly re-assessed in ways favourable to greater levels of involvement.

- The current statutory environment was perceived as offering new opportunities for communities to have a real say in issues that affect their health from a range of perspectives: from defining health issues and feeding into policy developments, to the range and quality of service provision. As an illustration, one interviewee praised the requirement within the legislation for the new community health partnerships to have a representative from the voluntary and community sector on all steering groups.

FOUNDATIONS FOR COMMUNITY INVOLVEMENT

- Ownership of the process by communities and their representatives is widely seen as being key, and this will invariably take a long period of time to develop. Initially, there needs to be some mechanism whereby community representatives can freely voice their views and experiences. This is recognised as a difficult issue, not least because communities often have preconceptions around the practical value of participation. This is of particular significance given the existence of negative connotations around statutory consultations, which have been seen to offer little by way of change.

- The approach to involving communities should be respectful to participants, recognising that they are giving up their time voluntarily, and that they too have other commitments to be balanced.

- A key concern mentioned by several interviewees was the need to ensure that the people that are becoming involved are not relied upon too heavily: i.e. there should be a range of individuals that share roles rather than having the same dominant characters appear in different contexts.

- Care should be given to the sort of language that is used to promote community engagement, avoiding jargon and buzzwords which may give the impression that an initiative is likely to be short-run.
The skills required to facilitate engagement include the ability to listen, understanding of group dynamics, ability to take issues forward to appropriate agencies, networks or individuals, and, not least, the ability to communicate on a range of levels. These skills suggest that the practice of community development needs to be at the centre of agency-led initiatives, and not thought of as an add-on to proposed or existing work.

The idea of community development may be new for many people involved in the statutory sector, and there needs to be a willingness to admit that new skills may have to be acquired and worked at. Equally, training and support may be necessary for community representatives who are new to partnership working.

OUTCOMES OF COMMUNITY-BASED PARTNERSHIP WORKING

In addition to the process issues mentioned above, careful consideration should be given to the type of outcomes that are desirable, but also what is achievable. Commonly, initial interest in new initiatives will be seen to fall away if there is no visible benefit for participants.

There was common agreement that participation in itself can produce health benefits. This might be by way of increased confidence and feelings of control at the level of the individual, which can then be channelled back into the community as individuals are empowered to support others.

EVALUATION OF COMMUNITY-BASED PARTNERSHIP WORKING

There was broad recognition that measuring the value of community-based health improvement is an incredibly difficult task, made worse by lack of baseline evidence.

Community health improvement outcomes are difficult to attribute to a particular point of intervention. Some interviewees acknowledged that a difficulty in measuring these sorts of outcomes is that they occur over an extended period of time and most evaluations deal with the short-term benefits of community engagement.

Some of the more tangible measures of success mentioned include improved employment prospects within local neighbourhoods, improved housing, cleaner environments and green spaces, increased community participation, and reduction in health inequalities.
CASE STUDIES: MODELS OF COMMUNITY PARTICIPATION

Two case studies were selected in order to examine different models of community participation in health improvement. These are based around two health projects which demonstrate particular sets of relationships with statutory and community partners. Exploration of these partnership arrangements aims to contribute to the existing literature by providing insights into the understandings of different stakeholders within the selected case study sites.

Firstly, each case study setting is described, including the structure of the relationships between the selected health projects and their partners, project aims and activities, and sources of funding. Analysis thereafter focuses on the relationships between different partners, and the perceptions and expectations of people working at different levels within the partnerships with regard to: their respective roles; what they expect to achieve through participation in the partnerships; the nature of relationships between partners; the extent to which objectives and values are shared by different partners; and the degree to which the partnerships are community-driven.

This analysis addresses the third and fourth research questions which concentrated on both the role and effectiveness of communities and community-based initiatives in broader partnerships for health improvement (see page 13). The focus of the case studies therefore is on the processes of community participation in partnership approaches, rather than the outcomes of community involvement.

CASE STUDY PARTNERSHIPS: AIMS, ACTIVITIES AND INSTITUTIONAL STRUCTURES

Table 5 illustrates the different institutional layers that exist within each of the case study settings. The two models are similar in that they each cover three institutional levels. The key differences which form the basis of the analysis that follows are the aims and activities of the health projects at the centre of the institutional arrangements. The community-based health initiative situated within the first case study (C1) provides services to the community and supports other service-providing projects (such as the child safety initiative) while the health project in the second case study (C2) is designed to promote community participation and create structures that enable community participation in decision-making around health issues. The forums in C2 operate on an informal basis, having no separate constitutions.

Table 5: Institutional levels within the case studies

<table>
<thead>
<tr>
<th>Case study 1</th>
<th>(C1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic development agency</td>
<td>(EDA)</td>
</tr>
<tr>
<td>Community-based health initiative</td>
<td>(HP1)</td>
</tr>
<tr>
<td>Supported projects (including child safety initiative)</td>
<td>(CSI)</td>
</tr>
<tr>
<td>Case study 2</td>
<td>(C2)</td>
</tr>
<tr>
<td>Council for voluntary service</td>
<td>(CVS)</td>
</tr>
<tr>
<td>Health project</td>
<td>(HP2)</td>
</tr>
<tr>
<td>Community forums established by the health project</td>
<td></td>
</tr>
</tbody>
</table>
CASE STUDY 1

As illustrated in Table 5, case study 1 (C1) is based on partnership arrangements for community-based health improvement that comprise the economic development agency (EDA), a community-based health initiative (HP1) which is managed by the EDA, and a number of separately constituted projects that are supported by HP1. This is further illustrated by Figure 3 (see opposite).

HP1 at the centre of this arrangement began as a small community-based health project geared toward local health needs. The project has been described as ‘very much community-led’ in its initial form, providing responsive and accessible services to the community. Following some success, the project received funding that enabled expansion over a larger geographical area. HP1 currently has three key sources of funding although one of these sources (social inclusion partnership) is now being tapered, by prior agreement, and picked up by the remaining funding bodies: council and health board.

Project staff are employed by the EDA, whose mission is to stimulate economic growth for the benefit of the people and businesses of the area. It was established in the early 1990s and supports a number of projects in addition to the health initiative. HP1 has a steering group of locally-based individuals and members of the community which guides the direction of the project, and is built upon the principles and values of community development. It is committed to reducing inequalities in health within a defined geographical area, both by supporting community action and enabling effective inter-agency working on health. HP1 aims to ‘enhance the social and economic benefits to the local community by increasing skills, knowledge, capacity building and by providing employment for local people’.

The health initiative is engaged with a broad range of statutory and community organisations across a variety of activities. It also supports a number of locally based community projects, providing information and guidance. One of these projects has been included in this study to explore relationships between HP1 and supported projects. This is a local child safety initiative (CSI), established in 1996. The initiative provides information, advice and home safety equipment (e.g. stair gates, fire guards and smoke alarms) to low income families with a child under the age of two, or any child with a disability. Due to huge demand, the CSI has grown to support over 300 families a year. The service is managed and delivered by local volunteers. The project has recently produced a three-year business plan, the project received SIP Key Fund money and has recently opened new premises as a central project base. Funding also comes via a range of statutory, private and charitable organisations including housing associations, Children in Need and a local football club. A community safety partnership provides all the safety equipment to the CSI. A dedicated project co-ordinator is now employed and local volunteers are currently being recruited and trained as project staff and home safety advisors. These advisors will assist with the home visits programme for the assessment and fitting of home safety equipment. Health visitors and social workers also play a key role in referring families to the CSI. As the CSI has developed it is now largely based on referrals from health visitors, and this is perceived by a number of respondents as a positive partnership development for the initiative.
Figure 3: Case study 1

Economic development agency (EDA) → Community-based health initiative (HP1) → Child safety initiative (CSI)

Steering group → Management committee

- Employment and management support
- Support and guidance
- Project governance
The project aims to:

enhance the social and economic benefits to the local community by increasing skills, knowledge, capacity building and by providing employment for local people.

(HP1)
CASE STUDY 2

The second case study (C2) focuses on the partnerships that have been enabled by a health project (HP2) operating within a council for voluntary service (CVS). The CVS employs a health development officer, whose role is to generate links between local voluntary and community groups with an interest in health, and practitioners and policy-makers.

Two strands contributed to the development of HP2. Firstly, there was high demand from local voluntary and community organisations involved in health for support from the CVS. Secondly, participants at a chronic pain management conference organised by the local authority acknowledged a lack of community involvement in decision-making in this area. As a result a funding bid was developed jointly by the CVS and Voluntary Health Scotland and HP2 received pilot funding from the Big Lottery Fund over two years. It is now three-quarters of the way through this period and beginning to seek continued funding.

The project is situated within the local CVS, but has its own steering group which provides guidance to the development officer in putting into place structures and activities to support community involvement and representation. The steering group is comprised of representatives from the CVS, NHS, local authority, Voluntary Health Scotland, and practitioners from two local health care co-operatives that operate in the area (see Figure 4 opposite).

The initial work of the project involved a mapping study to identify registered groups with activities related to health in the CVS area. These groups were invited to attend events such as health fairs, conferences and workshops, and around 50 are now registered members of the Health Project.

In practical terms, these events aim to contribute to:

- identification of local health issues and needs which are fed to the Steering Group
- dissemination of information on available services
- promotion of networking by local voluntary and community groups.

The project also facilitates community involvement through a small number of geographically based forums which have been established by the development officer. Although relatively early on in their development, these forums have drawn considerable interest to date from a range of voluntary and community organisations. The forums aim to give local communities a voice with regard to health issues in a broad sense. Additionally, the project aims to facilitate a flow of information from the community via these forums to practitioners and policy-makers via the project worker and members of the steering group.

These case studies illustrate two models of how community involvement in health projects can be enabled and supported, highlighting the complexity of structures surrounding community-based projects. C1 can be characterised as a nested model wherein various projects are supported by HP1, which in turn is supported by the EDA. C2 offers a model which mediates between partners at either end of the scale: statutory agencies and voluntary and community organisations.

So, while C1 involves three organisations which have clear lines of accountability to each other that further provision of services to the local community, the focus of C2 is a structure which has been developed with the explicit aim of improving communication between statutory bodies, voluntary organisations and communities.
Figure 4: Case study 2

Local and national strategic partnerships

Local council for voluntary service (CVS)

Health project

Steering group

Employment and management support
Support and guidance
Project governance
Flow of information

Health forums
PARTNERSHIP WORKING AND COMMUNITY INVOLVEMENT

This section explores the nature of the relationships between different partners involved with the two case study settings, drawing out the relevance of the different institutional arrangements.

For C1, the structures that exist between the three institutional layers are perceived to provide a stable base from which community presence can be sustained. The CSI is supported by its own management committee, and by HP1, while HP1 is in turn supported by the organisational and managerial structures of the EDA. Working relationships have developed over a number of years and were characterised as strong by a number of respondents. Continuity of staff at different administrative levels in the case study is regarded as key factor for successful collaboration and sustainability. The EDA, within the context of C1 operates as the employer of HP1 staff. In addition to administering contracts of employment, the company supports project staff development through annual reviews and provision of training. The company offers broad managerial support, whilst maintaining a ‘hands-off’ approach to the day-to-day running of the health project. Within this arrangement the lines of accountability are very clear, so that existing procedures do not undermine the ability of the managers and their team to run the project.

HP1 also has clear lines of accountability to its own Steering Group as well as to its funders. The latter is managed through joint monitoring arrangements between the funders involving biannual visits to the project. While there were some initial difficulties associated with establishing effective working practices in relation to the three-way funding structures, the funding setup was perceived to work well in terms of having a framework for monitoring and evaluation. Interviewees involved with HP1 describe a ‘good relationship’ with their funders. Representatives from the two main funding bodies do not attend internal HP1 meetings but do have many other ad hoc connections with the project through various other partnerships and networks within the area, for instance as part of the developments towards community health partnerships.

At the other end of the case study spectrum, relationships between the health project and projects which it supports have are based on long-term links, with HP2 providing much-needed support and guidance for the projects. While responsive to needs expressed by members of the communities, the extent to which financial support can be made available is relatively limited:

If someone’s representing the project we would certainly fund them to do that and enable them to be part of that...but as voluntary projects go we’re not rich by any manner of means, but we’re resourceful, and we find cheap and free ways to do things...and that is relying on a lot of the skills that the staff at [HP1] have in order to be able to deliver on the agenda.

The main way in which HP1 has supported the small community-based project, CSI, has been in terms of non-financial resources. Key HP1 staff were involved in the CSI when it began. As the CSI has grown and strengthened, the role of HP1 remains supportive while taking a step back as the CSI gains independence. The CSI is accountable to its own management committee, which is made up of people working in the local area in other community-based work.
Within C2, relationships are geared toward improving flows of information and effecting change to statutory priorities. This contrasts with the focus of C1 around support structures which enable direct service delivery to communities. There is evidence of good relationships having been built between the development officer and practitioners via participation in other partnerships at the strategic level (e.g. community planning partnership), as well as the contacts provided by the steering group. An important characteristic of the outcomes of these contacts is that there is mutual advantage for all those involved: for example the promotion of each others' activities where possible, which the development worker described as ‘taking partnership working to another level’. Similarly, with community groups: ‘It’s not uncommon for me to pick up the phone [and ask them to attend an event] and they’ll be there’.

Thus, rather than merely offering opportunities for communication between various stakeholders within the partnership arrangements, it has been possible to create means of dissemination beyond the case study boundaries. To date much of the effort has gone into putting the structures in place which will enable flows of information and bring people face-to-face. This is an essential starting point, which means that existing relationships can be strengthened.

**FACTORS THAT AFFECT COLLABORATIVE APPROACHES**

Interviewees in both case studies discussed a number of barriers and facilitators to collaborative working. These reinforce some of the findings of the literature review, and the key points are summarised in Table 6 (see below).

Table 6: Facilitators and barriers to community engagement in partnerships

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good relationships take time and experience to build</td>
<td>Lack of skills within communities for effective engagement</td>
</tr>
<tr>
<td>Collaborative approach</td>
<td>Partners promoting a particular agenda for their own benefit</td>
</tr>
<tr>
<td>Stable support structures</td>
<td>Changing policy agendas. Projects which are funding led are restricted</td>
</tr>
<tr>
<td>Clear accountabilities</td>
<td>by funders’ priorities which prevent activities to meet community needs</td>
</tr>
<tr>
<td>Continuity of staff</td>
<td>Increasing complexity: more varied institutional arrangements for</td>
</tr>
<tr>
<td>Creative use of available support/resources</td>
<td>partnership working</td>
</tr>
<tr>
<td>Trust is a key issue and facilitator of stronger partnership working</td>
<td>Previous negative experiences</td>
</tr>
<tr>
<td>Community development approach helps to build capacity</td>
<td>Lack of experience of joint working among statutory representatives as</td>
</tr>
<tr>
<td>Significance of personalities – commitment, enthusiasm and perseverance</td>
<td>well as representatives of the community</td>
</tr>
<tr>
<td>A greater recognition of the social and economic factors that affect health</td>
<td></td>
</tr>
</tbody>
</table>

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REMIT WITH RESPECT TO HEALTH

Members of the health forums within C2 viewed the remit of the health project as covering multiple health issues. The forums especially provided a valued opportunity to shape the issues that are being addressed. Key concerns for the forum members are identifying what associations and activities already exist in the community, and also identifying sources of practical and monetary support and finding out ways of tapping into these effectively. Although the project’s achievements are mostly around creating structures that facilitate flows of information, some effort goes into making changes in people’s lifestyles: for instance promoting physical activity through public events.

For both case studies, partnership working has led to an increasingly broad-based recognition of the relevance of both social and economic factors for health and well-being. For instance, the link within C1 between the EDA and the health initiative is seen as an important one for the project:

This has been a good development because nowadays the link between health and economic development is key, the links are well known and recognised...it’s now very appropriate that [HP1] is in there... it gets at the links between health improvement [and] economic development ... you can’t seriously deal with one unless you are dealing with the other.

Similarly, the way in which C2 has brought together community groups which focus on different influences on health has broadened awareness within individual projects of the range of mechanisms through which health can be tackled.

HP2 takes on board issues identified by the community groups and local individuals who attend the various forums and events. For instance, debt problems and benefits issues have been identified as a major concern for many local people, with impact on health taking many forms ranging from mental health issues to lack of access to leisure services and food markets. Many of the events arranged by the health project now include representatives from money advice teams and credit unions. The development officer commented: ‘These are issues that might not readily be recognised as being “health” as such’. Yet these are being taken on board as a result of expressed community concerns.

EXTENT TO WHICH THESE MODELS REPRESENT COMMUNITY-BASED INITIATIVES

The actual nature of community involvement and the extent to which the projects in the case studies can in fact be said to community-based in both their delivery but also at a more strategic level is an underlying thread throughout this report. Having surfaced in the discussion of relationships among partners, this issue is returned to in more detail through exploration of the extent to which the experiences of those working at different levels within the partnerships demonstrates meaningful community involvement. This is done by considering the extent to which community representatives within each case study have a say in developing objectives, as well as the extent to which their voices are being heard, and they are being active at different levels.
For HP1, objective-setting is perceived to be an equal process by funding bodies and HP1 staff. While the core objectives of the initiative were set some time ago, these had been broadly defined and the project has, therefore, been able to retain the overall aims despite the considerable structural changes that have taken place since its original establishment. Yet the need for appropriate objectives (and with these, achievable targets) is well-understood and emphasised:

They are not target-driven. Initially though when we were first set up they certainly came down from the Scottish Executive in terms of reducing smoking by a certain amount, reducing cancer, reducing heart disease, but we were never going to make those targets, we were setting [HP1] up to fail, we said we have to change the targets and we have to change them now...we set the wheels in motion for changing that as we then had to go back to the Scottish Executive because you’re changing the objectives that you got your money for. But we would have failed a long, long time ago if we had not changed those initial objectives. We wouldn’t have met those targets, and neither should we have as a community development project, that’s not our job to do that, but we’ll certainly work with our partners in [the area] whose job it is to do some of that.

With regard to C2, the different perspectives of representatives from local groups and members of the steering group reveal the complexity of identifying an initiative as being ‘community-based’. The project aims to facilitate community participation by gathering information via the forums and various events and feeding this into the decision-making process. To this end it has developed links with a range of practitioners and is getting involved in local strategic partnerships. Members of the steering group are instrumental in feeding back this information to the organisations they represent. Equally, information is disseminated to the community groups who are then able to discuss the impacts and potential consequences for local groups.

As far as agenda-setting goes, the development officer selects the issues that form the overall themes of the forum meetings, which have included health-related behaviours such as smoking cessation, physical exercise, and provision of services including physiotherapy and podiatry. Commonly, these issues feed into the key priorities of the health boards and local health care co-operatives that the development officer has links with.

In terms of the project providing a meaningful level of input by the community partners, this is most strongly evidenced by the emphasis on gathering their views at events and through the forums. Members of the forums are finding these a valuable source of information, and using the opportunity to raise issues that affect them personally or that have been brought up by the groups they represent. This process facilitates a two-way interaction which enables practitioners to feed information to local groups, and to receive feedback on the concerns of these service users. At the heart of this approach is exploration of the views and experiences on each side of the table. By providing a level of transparency around the sorts of factors that affect decision-making within statutory services, it is hoped that understanding of the context of service delivery will be increased. Similarly, by putting forward individual experiences, ideas might be generated for improvements to delivery.
The forums are therefore providing an important mechanism for communities to put forward their views on the type and quality of services that are on offer. What happens once these views are aired is a separate issue. While the process is perceived in a very positive way, community representatives are aware that further along the decision-making process, this element inevitably becomes diluted, since decisions are ultimately made according to local authority and health board agendas. So, whilst some of those interviewed expressed concern that their points would not be taken further, they did nonetheless see this as a move in the right direction.

In C1 the role of the community varies between projects. The question over appropriateness of community-based initiatives and expectations of the community as to the preferred role in partnership working needs to be considered more carefully. As one interviewee outlines the desire of communities was not necessarily to take responsibility:

*It’s become more and more apparent over recent years that communities don’t want the responsibility, they want things to happen in their communities, but to leave the day-to-day running to organisations.*

A variety of methods of engaging communities were identified. This ranged from extracting information through consultations, questionnaires and attending local surgeries. The CSI was perceived by all respondents as a genuine community-based initiative. To a large extent this has happened through parents becoming volunteers in the project.

Within both case studies, an understanding of the appropriateness of community engagement is regarded as key factor: engaging with communities while at the same time recognising that there are wider strategic policy imperatives that will act as drivers. This requires management of expectations, and communication of these matters effectively so as to avoid promise of outcomes which cannot be delivered. This was especially evident in the health forums within C2.

These experiences are, inevitably, being impacted upon by changing policy agendas. For instance, the change from SIP to CPP – with the latter again only funded for an initial five year period – can impact on the ability to develop good working partnerships and continuity of staff working with the organisations. For some interviewees in C2, the changing structures of strategic partnerships is perceived as a barrier to participation insofar as the basis of power is changing and people may be reluctant to take on new commitments before knowing what their new roles and responsibilities are to be.
LEVELS OF INFLUENCE

When all of the partnership levels are taken into consideration, each case study includes elements of community development alongside engagement at strategic level. For C1, the health initiative has a community development role in terms of supporting community-based projects, with the project manager working at a strategic level to negotiate work with key partners about the delivery of health improvement agenda in partnership with community, voluntary and statutory organisations. As one respondent stated:

*I think the main role is to work with community representatives to determine what the health issues and needs are, focusing on the social model of health; supporting and facilitating those discussions, signposting people to other organisations that can assist development of projects; working with partners to highlight that it is about local people’s health needs and not about what comes out of some Scottish Executive directive.*

There are some indications, however, that understandings concerning community involvement and a community development role, might not be entirely shared by external partners active at a strategic level. This related to two issues. Firstly, the extent of a true understanding of a community development approach amongst strategic members working in partner organisations is seen as being variable. It was acknowledged that, while some people within statutory bodies do have a very clear understanding of community development, others do not. Secondly, a distinction emerged between areas in which it is seen to be appropriate to have communities directly involved at a strategic level (e.g. decisions relating to economic development), and areas where engagement by communities is essential (e.g. identification of community health need).

However, there was a consensus that externally situated strategic partners do listen to the various actors within C1 about community development issues. Respondents agreed that HP1’s experience has equipped it with credibility and a reputation to communicate openly with partners and the local community. It is significant that this is also in relation to the limits of community involvement.

In relation to C2, the incorporation of both community development and strategic level concerns is central to the role of the health project. HP2 has been successful in making links both at the strategic level via the sustained efforts of the development officer and members of the steering group to connect with local and national partnerships, and at community level through events and the establishment of health forums. A key element of the project’s remit is to bring practitioners and community groups together to discuss each other’s experiences. By acting in a facilitating role between these two groups, the project aims to bridge community and practice issues. Here, as with C1, there is an emphasis on bringing the spotlight on to community-defined health issues, as well as increasing awareness among the community about health risks and available services.

The material presented here is intended as an exploration of issues relevant to the process of partnership working that involves community-based initiatives. We do not suggest, therefore, that the findings based on these cases alone are generalisable to other partnerships.
13. RECOMMENDATIONS FOR FUTURE RESEARCH

We focus here on themes, highlighted by the qualitative research undertaken as part of this study, which should be taken into account in further research.

THE PROCESS OF COMMUNITY-BASED PARTNERSHIP WORKING

Much of the available literature on collaborations that involve community partners focuses on the process of partnership working, and the case study research reported here contributes to this by exploring the relevance of institutional arrangements for partnership working. Some themes have emerged which deserve further investigation, not least the extent to which communities have a meaningful level of input. This is a complex issue, and it has been addressed in a variety of ways. The case studies highlighted the variety of ways in which communities participate in partnerships.

A question that might be considered in more depth is: To what extent do communities want to be included in health improvement initiatives, and what role do they wish to play? This consideration could take the form of more intensive qualitative research to examine the expectations of community and statutory partners in terms of what level of involvement (strategic or operational) by communities is appropriate, the ways in which community inputs fit in with the role of the partnership as a whole, as well as the consequences of conflicting roles and expectations.

OUTCOMES OF COMMUNITY-BASED PARTNERSHIP WORKING

The difficulties associated with measuring outcomes have been discussed elsewhere in this report. Although the qualitative case studies did not attempt to assess the outcomes of the activities going on in each setting, they did address perceptions of what could be achieved. This relates to questions of what constitutes community health and health improvement, and what sorts of factors affect community health. This hints at the complexity of outcome measures, and suggests there needs to be much greater clarity around the nature of outcomes that are being measured (e.g. are short- or long-term health changes being measured?).

In terms of gaps in current understanding, we might examine: the relationship between intermediate and longer-term outcomes; the added value of bringing in community partners; whether the interrelated goals of health improvement and economic development (as indicated within case study 1) are common elsewhere; and the effects of loose versus fixed structures for community participation.

CONTEXT FOR ENGAGEMENT IN PARTNERSHIP WORKING

Of course, any further research will be conducted as current developments in the policy environment are played out. Both the review of literature and the experiences of the case studies in the current research have highlighted the difficulty faced by partnerships on the ground when major policy changes are implemented. As highlighted by the scoping interviews reported here, evaluation of the new community health partnership structures will indicate whether the optimism highlighted in the key player interviews is justified, or whether the changes in fact have less positive implications than is hoped.
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APPENDIX: RESOURCES

This appendix is not intended to provide a comprehensive list of available resources. It simply highlights a small number that are relevant to practice and development within the context of this study.

RESOURCES FOR PRACTICE


This toolkit first sets out the key principles for successful partnership working based on work within four case study areas. These aim to ‘provide readers with helpful and straightforward advice, rather than theoretical concepts and are grounded in the experience of the practitioners involved in the pilot projects’.

The toolkit highlights the key principles and offers a set of advice for achieving these. These are then incorporated into the practical steps to successful partnership working which take practitioners and stakeholders through each step of a partnership from initial decisions, through developing a programme of work, monitoring and evaluation and facilitation of the process.

B Partnership Toolkit

The Partnership Toolkit was developed by Greater Glasgow NHS Primary Care Trust, Glasgow Council for the Voluntary Sector, Glasgow Healthy Cities Project and the University of Glasgow. It provides a resource for staff and individuals involved in partnerships working, to access materials and information which will help in the development of local partnerships and in turn make ‘a contribution to improved public health’.

Available at: www.partnershiptoolkit.org.uk/home.htm


The overall aim of the handbook is to help a range of local community practitioners to improve their shared understanding of community development approaches to tackling health inequalities. The handbook supports this process by:

- outlining suggested models for local training programmes
- giving ideas, materials, checklists, exercises and examples that can be used in local training programmes – or as useful aids to community development and health work at local level
- signposting to other useful materials, resources and supports
- giving case examples of how local training programmes have actually worked.

This book details a full course for workers from a variety of backgrounds who want to use, or are already using, a community development approach to their work in reducing health inequalities. Workers can join the course and work through a range of units that provide a background to the approach and course, and helps develop practical skills for community development. A portfolio is also completed for career development purposes.

This resource provides an important opportunity for capacity building for community development approaches to health improvement and tackling health inequalities.

Available at: www.publichealth.nice.org.uk

E Scottish Centre for Regeneration

Scottish Centre for Regeneration work with ‘others to ensure decent housing and strong communities across Scotland’. A useful resource provided by the SCR (SCR) are their ‘How to...’ guides which aim to assist those involved in community regeneration to become more effective practitioners through looking at approaches that can be taken to community engagement, partnership working and achieving effective outcomes. They have also produced a series of ‘learning points’ to pass on lessons learnt from people working and talking together. This includes highlights of what works and what didn’t and aims to encourage good practice and networking.

Available at: www.communitiesscotland.gov.uk
RESOURCES FOR EVALUATION


This is a framework that ‘aims to help those who work in community health settings to plan and evaluate their work in partnership with one another and with members of the community they seek to help’.

The LEAP approach to community health and well-being is based on the following assumptions:

- Evaluation should be an integral part of promoting community health and well-being.
- Both the providers and the users of a community health programme should take part in its planning and implementation.
- The main aim should be for continual improvement in effectiveness and efficiency.
- Future work should be informed by lessons learned.

G The Scottish Community Development Centre: ABCD model of evaluation

Achieving Better Community Development (ABCD) is a model of evaluation based on community development principles. It provides a framework for planning and learning from community development interventions (SCDC). The framework provides flexibility for working at policy, programme or project level, using a range of appropriate methods.

Available at: www.scdc.org.uk

RESOURCES FOR MEASURING IMPACT


This study was commissioned from the Community Development Foundation by the Active Communities Directorate (then Active Community Unit) and Research Development and Statistics Directorate of the Home Office. The report examines the application of measures of community, concluding that the full picture of community life can be captured by measuring factors associated with six areas:

- Individual attitude and action
- Levels of involvement in local activity across the community and voluntary sector
- Involvement in governance
- Contribution to public services and local economy
- Equity issues – inclusion, diversity and cohesion
- Forms of official support for community life and involvement.
I New Economics Foundation (2000) 
Prove it! Measuring the Effect of Neighbourhood Renewal on Local People. Groundwork, The New Economics Foundation and Barclays PLC.

The handbook highlights that ‘the temptation is always to measure what’s measurable, rather than what is important’. It describes a way of measuring the effects of projects on local people and on the relationship between them and their quality of life. The method, involving local people in choosing indicators and collecting data, has been tested across the country.

Communities count!

A step by step guide to community sustainability indicators for people working in community development, environmental work, Local Agenda 21, local authorities, voluntary organisations, business and education.

Available at: www.neweconomics.org

SUPPORT AND GRANTS

K The Poverty Alliance (2005) 
Community Planning Toolkit. The Poverty Alliance, Communities Scotland and SCVO.

The toolkit was developed from a project undertaken by the Poverty Alliance between that aimed to look at how community groups, and particularly people experiencing poverty and social exclusion, could become actively involved in the community planning process. The Toolkit is intended to help community groups get a better understanding of how community planning works, to give some practical ideas on how to get their message across in the community planning process and how they can use the process to tackle poverty and social exclusion where they live.

The toolkit was developed for community-based organisations to:

- identify poverty issues in the community
- run discussion sessions with members of the community
- identify the key priorities for the community
- use the evidence collected to influence community planning partnerships.

Available at: www.povertyalliance.org/html/resources/commToolkit.pdf
L The Scottish Community Diet Project
The Scottish Community Diet Project aims to better Scotland's diet and, therefore health, by supporting work within low-income communities to improve access to and take-up of a healthy diet. This is done by:
- supporting both community initiatives and inter-agency partnership working
- offering a variety of resources including a grants scheme for community initiatives, toolkits and guides
- information exchange and facilitation of networks
- development of partnership working models
- support for action research and practice development.
Available at: www.dietproject.org.uk/

M The Scottish Community Action Research Fund
The Scottish Community Action Research Fund (SCARF) is provided by Communities Scotland and managed in partnership with the Scottish Community Development Centre (SCDC) to support community-based research. The fund enables communities to carry out their own research, develop knowledge about their community and improve skills and community capacity. The funding is intended for:
- skills training
- help and advice from experienced researchers
- fees for 'research mentors' to help plan and carry out the research
- payments for community members carrying out research
- publishing the research and holding events
- expenses, including travel and caring.
Available at: www.commuunitiescotland.gov.uk.
ILLUSTRATING APPROACHES TO COMMUNITY ENGAGEMENT IN SCOTLAND


This work is intended as a practical tool for anyone involved in community learning and development. It presents a series of case studies to show how community learning and development helps people to make real, positive changes in their lives and their communities. By using a common format to research, write and present case studies it helps to identify and highlight factors that were critical to success.

The work was commissioned in response to ‘Working and Learning Together to Build Stronger Communities’ as people expressed the need for practical support from the Scottish Executive for implementation of projects. Hence, this volume provides practical examples to others working in the field. All of the case studies demonstrate the importance of interdisciplinary partnerships for successful project delivery. A key element of all the case studies is also involving and building capacity within communities. For instance, the Voluntary Action and Community Planning project in East Renfrewshire has demonstrated how the voluntary sector can provide support for community engagement in community planning. A key lesson was that community planning will work best when the voluntary sector is recognised as a full partner and not just a recipient of community planning.

The Angus Glen Project demonstrated how an initiative in a rural community began with computer training and has resulted in capacity building and community action on social and economic issues. A key lesson from the project was that the developing confidence and effectiveness of the community groups facilitated an interaction with a broad range of agencies. This in turn reinforced community control and nurtured the community development process.