



“...Healthy Living Centres provide a real opportunity to improve health and reduce inequalities in health through local community action.....three key elements are:

- **an opportunity to mobilise community activity in improving health and reducing inequalities**
- a focus for bringing together health promotion in its widest sense across a broad range of interests which do not necessarily have a tradition of working together
- **the potential to improve access to mainstream services for those who for whatever reason do not currently use them, or to provide a better alternative to mainstream primary care.”**

(Health Services Circular HSC 1999/008 Jan 1999)

Aims

The aim of this report is to summarise the Evaluation of a Healthy Living Centre. It will explore and discuss outcomes from the evaluation as well as the evaluation development from conception through to implementation. The report will also outline the processes through which the relevant evaluation theory emerged and identify the core lessons learnt as experienced by the external evaluators from Bournemouth University.

The scope of this report does not extend to the on going findings of the evaluation of the project in terms of outputs and outcomes as they are available within other documents already produced throughout the lifespan of the project and the evaluation. (Healthy Living Project Evaluation Reports for the Board, Numbers 1-8, 2005-2008). A final report will also be available from the project available from the lead organisation **Bournemouth and Poole Teaching PCT**.

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PART 1 Introduction

1. Introduction

1:1 Policy Context and National Strategies appertaining to Public Health

Improving the nation's health and well being has been central to government initiatives for many years. Indeed, 16 years ago the white paper "*The Health of the Nation*" (1992) identified physical activity as a factor which may reduce mortality and ill health whilst contributing to a more healthy way of life for the nation. The Health Education Authority also addressed this in their 1994 publication "*Moving on: International Perspectives on Promoting Physical Activity*" whilst the Department of Health published "*Strategy Statement on Physical Activity*" in 1996.

The Acheson Independent Inquiry into Inequalities in Health Report (1998) highlighted the role of the community in health improvement.

"*Our Healthier Nation*" 1999 outlined the "killer" diseases, inequalities, and the healthy behaviours that would make a difference whilst later publications such as "*The NHS Plan*" (2000) set targets and action plans for the NHS to improve health and address inequalities.

"*Tackling Health Inequalities: A programme for Action*" (2003) addressed inequalities in health and highlighted what Primary Care Trusts, local government and local communities could do.

"*Game Plan*" (2002) saw the publication of a government strategy delivering sport and physical activity objectives with a focus on the significant health gains that can be achieved through active participation. "*At least Five a week*" (DOH 2004) suggested that no single organisation will have sufficient impact alone to champion an increase in physical activity throughout the nation. The document suggests "We will need concerted effort from a range of key partners – Government (at national, regional and local levels), leisure and sports services, schools and colleges, town and regional planners, transport planners and providers, architects, countryside agencies, the NHS and social care, voluntary and consumer groups, employers and the media. All will need to work in a coordinated and comprehensive way to influence the way we live." (DOH 2004, p.iv)

Of particular relevance, is the work of Derek Wanless whose reports highlight the links between physical activity and health and in particular their impact on the National Health Service. The two significant reports are "*Securing our future health: taking a long term view: final report.*" (2002) and "*Securing good health for the whole population: final report*" (2004).

In the 2002 report, Wanless outlined a key role for the government in ensuring that the public has access to the information necessary for decisions pertaining to health matters. He examined future trends and identified factors determining the long term needs of the National Health Service. The report highlighted the considerable difference in expected cost depending on the productivity of the National Health Service and crucially how engaged the population became with their own health. Three scenarios were outlined within the report, slow uptake, solid progress and fully engaged. In the pessimistic, "slow uptake" scenario patients do not adopt healthier lifestyles, the NHS is unresponsive with low levels of technology uptake and low productivity. Life expectancy rises marginally but older people do not live in good health. In the "solid progress" scenario, the health service is responsive and efficient, people look after themselves better and life expectancy rises considerably. In the most optimistic "fully engaged" scenario, people are much healthier, live longer and enjoy a highly efficient health service. (Association of Chartered Accountants website, 2004).

The second report by Wanless focused on measures needed to improve public health whilst the first assessed the resources required for long term provision of health services.

" Although there is often evidence on the scientific justification for action and for some specific interventions, there is generally little evidence about the cost-effectiveness of public health and preventative policies or their practical implementation. Research in this area can be technically difficult and there is a lack of depth and expertise in the core disciplines. This, coupled with a lack of funding of public health intervention research and slower acceptance of economic perspectives within public health, all contribute to the dearth of evidence of cost-effectiveness. This has led to the introduction of a very wide range of initiatives, often with unclear objectives and little quantification of outcomes and it has meant it is difficult to sustain support for initiatives, even those which are successful. It is evident that a great deal more discipline is needed to ensure problems are clearly identified and tackled, that the multiple solutions frequently needed are sensibly co-ordinated and that lessons are learnt which feed back directly into policy..... There are practical difficulties but they should be capable of being overcome to produce high quality, convincing evaluations of public health interventions. To achieve the objective of allocating funding more efficiently between health care and public health, it is vital that similar analytic methods are used for both." (Wanless, 2004, p5)

"However, there are opportunities to generate evidence from current public health practice, which has much potential for use as natural experiments. If evaluation became an explicit component of their implementation, it would inform the evidence base for public health" (Wanless, 2004, p6)

The plethora of government documents can perhaps be seen as confusing, identifying strategies, evidence base, recommendations and subsequent policies. Eg. "5 a week" was a report from the chief medical officer on the impact of physical activity and its relationship to health "Choosing Health?" was a consultation document to improve people's health, "Choosing Health? Choosing Activity" was a consultation document on how to increase physical activity thus improving health, "Choosing Activity" was the action plan following on from "Game Plan" which set out the strategy for delivering government sports and physical activity objectives. "Delivering Choosing Health: making choices easier" was the deliver plan outlining the key steps to enable "Choosing health :making healthier choices easier".

All these documents however acknowledge the need to improve the nation's health and to facilitate and empower individuals to assume responsibility for their health.

In summary, the current drive to engage the British nation in health promotion activities is clearly not a new concept. All government documents since 2000 have focussed on addressing the state of the nation's health and strategies for improvement.

The development of Healthy Living Centres is one such strategy.

1:2 Healthy Living Centres (HLC) – Background Context

1:2:1 1998...

Healthy Living Centres have been described as part of the government's overall public health strategy, in 1998, Tessa Jowell Minister of State for Public Health, stated "Healthy Living Centres must belong to the communities that they serve, and must not be parachuted in from Whitehall. What they must do must be meaningful to and valuable to the people that use them. They need to be involved in the planning and operation of projects. They need to have a role in steering their work...I see them as projects which have an understanding of what affects the health of the community – an understanding based on dialogue with people in the community as well as expert knowledge....I see them moving beyond the old simple public health model of individual behavioural inputs – smoking, diet and so forth – leading to adverse health outputs.....and what I really hope is that the centres will have a rounded vision which encompasses the psychological dimensions of health – which seeks to work with local agencies to alleviate the problems

which feed a mentality of despair and which tries to build the self confidence, self-esteem and self reliance which is a bed-rock of good health” (Tessa Jowell, Seminar Report 1998)

The HLC Initiative therefore emerged as a £300 million grant programme for Healthy Living Centres across the UK, the centres to be accessible to a fifth of the population. They were primarily designed to help reduce the health gap between richer and poorer groups and improve health overall and were partly modelled on the inter-war health-improving initiatives of the pre-NHS era. I.e. HLCs aimed to influence the wider determinants of health, such as social exclusion, poor access to services, and social and economic aspects of deprivation that can contribute to inequalities in health.

The initiative focussed on target areas and groups that represented the most disadvantaged sectors of the population. Funding for the centres was initially through the New Opportunities Fund although projects were expected to find a proportion of their funding from partnership sources at the outset with inbuilt plans to demonstrate sustainability.

The initial described vision of Healthy Living Centres highlighted the flexibility of the centres meeting local needs, bringing about innovations and new initiatives but retaining issues of quality and excellence. Partnership working was seen as key and lead roles not necessarily from the NHS or local authorities but also voluntary, community and private sectors. There was no perceived need for there to be an actual centre as such but a focal point for co-ordination of services for example. (Jill Vincent, “Report of a seminar held on 2 April 1998”) Funding was often via regeneration or Lottery sources, rather than mainstream sources, and allows flexibility and experimentation.

1:2:22007

The Big Lottery Fund Annual Report and Accounts for the financial year ended 31 March 2007 confirms that £300 million was made available to support the creation of HLCs across the UK and that the programme was developed in collaboration with the Department of Health and with regional and local statutory and voluntary organisations. All funding has now been committed with 17 grants funded by open, competitive bid in total. This covers 350 HLCs across the UK: 257 in England⁸

46 in Scotland,

29 in Wales

19 in Northern Ireland.

0Centres support the Government's and devolved

Funding

Most HLCs have developed a broad mix of funding provided by health authorities, local authorities, charities, education authorities, European agencies and other area-based initiatives. 208 HLCs have 11 or more partners 34 are single organisations with large partnerships including health organisations, local authorities, and voluntary and community sector organisations. Most projects were funded for 3-5 years, with the final project due to end in 2009.

Priorities

The majority of HLCs reflect one or more national health priorities in their aims and objectives through on average between 3 and 20 activities. Activities can be directly health related or offering other types of support eg. Counselling, befriending, mentoring, arts, and creative pursuits such as gardening, food co-ops, complementary therapies and relaxation which also address health and well being. Changes in the offered activities may and can reflect changing community needs. Offered activities can be delivered by and include training for community members. It is of note that HLCs do not need to exist as actual centres but may operate as a network of activities.

2. Evaluation of Healthy Living Centres – Literature Review

2:1 National Evaluation– The Bridge Consortium

The Bridge Consortium (NOF Fund commissioned the consortium - The Tavistock Institute, University of Edinburgh, Cardiff University, Lancaster University, The Institute of Public Health in Ireland, London School

of Economics and Glasgow University - to carry out a four year evaluation of the HLC programme which focuses on health impact monitoring, issues of sustainability, partnership and social exclusion, and how delivery of the initiative by the Fund has impacted on these.

2:1:2 The consortium's approach to evaluation.

The table below summaries the consortium's approach to evaluation.

Table 1 The Bridge Consortium Summary approach to evaluation

Challenges for Evaluation	Evaluation Objectives	Main Evaluation Activities
The size and diversity overall of the programme	to evaluate HLC programme success in terms of the aims of NOF and Healthy Living Centres themselves	Health Monitoring System: survey of HLC users
Multiple programmes and initiatives taking place in HLC areas.	to contribute to the evidence-base regarding the successful strategies to improve health and reduce health inequalities;	40 case studies
Difficulties in measuring outcomes - particularly in the short term.	to assist HLCs and their partners to learn from overall programme experience in order to develop their capacity and improve their practice; and	Policy analysis
Several simultaneous evaluations taking place at any one time, namely programme evaluation, national evaluations, and local evaluations.	to help NOF with the management and development of the programme as well as with future programme and policy development	Workshops with HLCs and local evaluators
Meeting other demands for information eg. Annual Monitoring Reports, development and support programme surveys.		Survey of all centres (2006)
		Use of information from parallel evaluations: Database of intentions and baseline info on all HLCs (DoH evaluation) Annual monitoring data Data from development and support activities Local evaluations

The consortium identified common elements within HLCs, namely:

- Broad based approach to health – to improve 'health and wellbeing' and address wider determinants of health
- Aim to promote innovation and responsiveness to local situation
- Targeting of disadvantaged areas and groups
- Intention to reflect and complement national and local public health plans and priorities
- Partnership working

- Community engagement
- Sustainability

2:1:3 Variations in Programme Delivery across HLCs

The consortium also acknowledged key variation in programme delivery across HLCs and the wide range of HLC activities.

Table 2. Summary of Variations in Programme Delivery

Key Variations in Programme Delivery	HLC Activities	Broad programmes of HLCs often include
Lead agency: NHS 24%, LA 23%, partnerships 10%, vol and community sector 33%	Addressing health behaviour: e.g. health information and advice, physical activities, healthy eating activities, stop smoking projects	Social opportunities and emotional support, activities to encourage self help and mutual support
General 'vision of health': whether targeting life style, service development, community capacity building or wider health determinants (poverty, unemployment etc.)	Addressing lack of services: health care and screening, support and counselling, services for children and families, older and disabled people	Activities to address some of the causes of poverty - poor literacy skills, and lack of information about benefits and services which might provide assistance.
Structure: whether a physical centre, a network or 'hub and spoke' model	Social activities (addressing social isolation and social exclusion)	Engagement of individuals in the work of the centre through consultation structure, volunteering, joining the staff, or developing and running groups and activities of their own.
Focus: whether a geographical neighbourhood, a particular group (older or young people, ethnic group) or particular issue (mental health, physical exercise, diet and nutrition).	Addressing poverty and unemployment (training, work experience, credit unions, benefits advice)	Building close working relationships with other local groups and organisations, including local statutory sector.
Level of involvement with statutory sector (NHS, local authority)		
Approach to community involvement		

2:1:4 Local Evaluations

The consortium also identified common themes for *local evaluations*, addressing the following:

- 1) Engaging with the community - local involvement in the HLC, working with different groups, provision of different activities, improving health awareness
- 2) The management and organisation of HLCs - effective management structures, steering groups, financial arrangements, staff recruitment
- 3) Partnerships - impact of partnership working, relationships between HLCs and partners in relation to resources/skills, policy, funding and learning
- 4) Sustainability - plans for sustainability (particularly regarding finances and complementary or competitive position), social learning and innovation
- 5) Understanding the wider context - relationship of HLCs to national and local policy, local health plans, and existing research resources

2:1:5 Widening the Brief for HLCs

The consortium clarified further the rationale for the funding of the HLC programme, as it had become clear that many HLCs were building on existing projects/activities. "Funding programmes provide shape to the projects because even if the project already exists, it will bend its work to give priority or emphasis to the funding programme. This programme gave the projects a wide brief on health." (Hills, D 2005) That wide brief could include the following:

- 1) Improving access for particular groups to access health services and activities.
- 2) Providing affordable access to complementary therapies and mental health sessions. Prevention rather than crisis approach.
- 3) Providing a platform to coordinate the community and local organisations responses around health inequality issues
- 4) Providing ways to tackle economic and environmental issues. Food co-ops, credit unions, employment training, benefit advice, advocacy etc.
- 5) Improving the community's skills and confidence, providing social as well as health benefits, encouraging local people to get involved, and in some cases run the HLC services themselves

2:2 National Perspective on Local Evaluations– Health Education Authority

Meyrick and Sinkler (1999), commissioned by the Department of Health, produced a seminal document for Healthy Living Centre Evaluation at a local level. They suggest that at the outset of the evaluation consideration needs to be given to:

- 1) Identifying what is needed from the project by those intended to use it
- 2) Deciding how the evaluation will meet those needs.
- 3) Identifying what outcomes will identify that the needs have been met.

The authors confirm that the form the evaluation may take will vary between each HLC, and the methods employed will reflect those differences eg. Use of monitoring data, or more qualitative data using participant reflections and feedback.

A key theme within the document is user involvement. "A key principle of the HLC initiative is involving the community in the planning and management of HLC work and thus they should be involved in it's evaluation" (Meyrick and Sinkler 1999, p.8) The benefits described include the following:

- 1) Helps to ensure that the project is meeting community needs.
- 2) Strengthens a feeling of community ownership and alliance with the project.
- 3) Enhances health through skills development.
- 4) Contributes to the sustainability of the work beyond the project lifetime.

2:3 General Perspectives for HLC Evaluation

Monitoring and evaluation have been described as critical for the strategy of the whole Healthy Living Centre initiative questioning whether they "work" ie. achieve their goals, and do they offer "value for money". Jill Vincent suggests that for effective evaluation, there needs to be agreement as to what is important and views from different perspectives, she goes on to suggest:

1. How does the HLC help participants and individuals
2. How does it help projects
3. How does it help the Healthy Living Centres initiative as a whole

(Jill Vincent, "Report of a seminar held on 2 April 1998")

The same speaker proposes a necessary move from traditional methods of evaluation to a more qualitative approach. Indicators and measures of success must be related to the project's own [agreed] aims and objectives

Meyrick and Sinkler (1999) identify 3 main reasons to evaluate HLCs:

1. To inform programme planning – identifies “what is working and what is not”
2. Provides funders with evidence of success
3. Provides feedback for those involved – community members, service users and project partners wish to know what the HLC is providing and also provides the opportunity for further contribution to the project. Findings may also inform other similar projects ie. Provides the opportunity for dissemination of learning.

Vincent (1998) suggests process measures might include the project's success in reaching its target group and the quality of the experience when they were reached. Outcome measures proposed included impact on employment, educational attainment, and action on debt or psychological effects such as self-esteem and self-efficacy. If agreed as outcomes, targets such as improving transport, diet, income, or reducing loneliness can also be used in the evaluation.

Summary

The Bridge Consortium demonstrate a general approach to HLC evaluation with the consideration of health impacts, sustainability, partnership working and the addressing of social exclusion. Their chosen methods included case studies, user surveys and policy analysis. They also acknowledged the importance of the broad spectrum of activities within HLCs and the need for innovative practice responsive to local populations especially within the more deprived areas. Community engagement and sustainability were seen as common elements within HLCs.

A key finding was the many and varied types of HLCs across the country – there was no standard format for delivery.

HLCs were also seen to be able to address wider issues such as access to health services, tackling economic and social issues, improving community skills and confidence with the resulting benefits for health. These issues are also factors contributing to inequalities in health. The importance of user initiated and led activities was also acknowledged.

The need for user involvement is also identified as key when considering local evaluations – which, similar to the projects themselves need to be responsive and address the needs of the individual HLC.

3. Local Context - Brief Profile of Boscombe West and Springbourne

The ‘Indices of Deprivation 2004’ document was published in Spring 2004. Overall, Bournemouth is ranked 94 out of 354 local authorities across England where 1 is the most deprived and 354 the least deprived. This puts it just outside the most deprived quartile. The Index also ranks the 32,482 Super Output Area (SOA) across England. The Indices are split into seven domains and these have subdomains including a children/young people sub-domain. The extent of deprivation varies across the Borough. There are 32,482 SOAs in England and the most deprived in Bournemouth ranks 477 while the least deprived SOA in Bournemouth ranks 28,904. There are nineteen SOAs in Bournemouth that rank in the top quintile of most deprived SOAs in England. The most deprived SOAs include areas of Boscombe, Central Bournemouth, Kinson, West Howe and Townsend. Central Boscombe is the most deprived area in Bournemouth (www.bournemouth.gov.uk)

Despite being only a few miles from Poole, one of Britain's most expensive seaside resorts, tourism in Boscombe has been in decline in recent years, with many hotels and guest houses closing down. Boscombe West, a thriving neighbourhood at the turn of the century, has seen an unwelcome upturn in antisocial behaviour in recent years, much of it linked to drug abuse and related crime and prostitution. Along with Springbourne, originally built to accommodate the town's artisans, many of its problems have been exacerbated by a rapid population turnover. A survey in 2003 found 36% of residents had moved in the past two years. Thirty-nine per cent (compared to 7% nationally) rent from private landlords, many in houses in multiple occupation (HMOs). HMO tenants are proportionately more likely to be offenders than owner occupiers but also more likely to be victims of crime living in bed-sits with common entrances, poor

security and no insurance.

Unemployment in the Boscombe area is much higher than the rest of Bournemouth and in common with many seaside towns, a high number of those in work depend on seasonal jobs in hotels or catering. And while homelessness is down according to official counts, it persists - particularly affecting drug users and people with mental health problems

The East Cliff and Springbourne ward borders the sea with a resident population of 10,061 in 4,701 households, and an average household size of just over two people. The largest ethnic grouping in this ward is the 'White-Other' ethnic group accounting for 5% of the population. The area also has a larger proportion of the 18-44 year olds but a smaller proportion of 45-64 year olds than the borough as a whole. There is a significant proportion of households in privately rented accommodation although the majority of households are owner-occupiers. The major property type is flats, both purpose built and converted. There is a larger proportion of lone parents than in England and Wales but a smaller proportion of dependent children. Around a third of households do not have a car and a much smaller proportion have two or more cars than in other areas. The number of people living in overcrowded conditions is more than double that of England and Wales. (http://www.bournemouth.gov.uk/Partner/CommunityPlan/AreaProfiles/East_Cliff_and_Springbourne.asp)

Springbourne and Boscombe West Neighbourhood Management identify Neighbourhood Management priorities which convey a pen portrait of the area. Their focus is cited as on the following:

- Reducing concern about drug dealing and associated problems - a concern of 64% of residents
- Enhancing the quality and visual appeal of housing in the area - a survey identified 465 properties considered eyesores and 160 in need of repair
- Tackling environmental blight - 66% of residents said litter and rubbish were a problem, with abandoned cars mentioned by 61%
- Improving support for children with additional needs in schools - 46% of 10- to 11-year-olds had moved to the area after starting school elsewhere
- Reducing crime - in 2002/03, there were 372 reported domestic burglaries, 73 street robberies and 479 cases of vehicle crime
- Helping people secure stable employment - unemployment in the area, at 7.7% much higher than the rest of Bournemouth (4.6%)
- Stabilising the neighbourhood. Creating the conditions that will encourage residents to set down roots here - a survey found 23% of residents had lived at their current address for less than one year.

Issues faced by residents include rundown, neglected housing - 160 properties in disrepair, 465 eyesores, high proportion of privately rented homes in shared or converted houses (39.2% against 4.4% nationally) with 34% of residents sharing a bath or shower and toilet and lacking central heating, against 18% nationally. There are around 400 HMOs, representing 40% of all those across Bournemouth. On the indices of multiple deprivation Boscombe West ranks 1,787th out of 32,482 in one output area for 'barriers to housing and services'. The Boscombe and Springbourne locality has a highly transient population, with 23% living at their current address for less than a year. Litter and rubbish is cited as a problem by residents as is vandalism, graffiti, abandoned cars and noisy neighbours. (<http://www.creatingexcellence.org.uk/print-section-article92.html>, Oct 2004)

The issues cited above demonstrate the substantial social and health challenges for the residents of Boscombe West and Springbourne.

Despite the rather bleak portrait of the area, considerable progress had already been made by residents

and local organisations to tackle many of these issues effectively, the Healthy Living Project philosophy sat well within the regeneration framework already in place for the area with it's own, more specific focus, on health.

Further information about the locality can be found in the Appendix within the document summarising the census 2001 findings.

PART 2 Evaluation Theory

4. Evaluation and the Community, Theoretical Perspectives

Clarifying monitoring, evaluation and research.

There is often much confusion concerning the differences and/or similarities between monitoring, evaluation and research. Is it not uncommon to see these terms used interchangeably within general research and research methods and methodology literature. There are however clear differences between the three, broadly speaking, in terms of application, implementation, dissemination and use.

4:1 Evaluation

The generic goal of most evaluations, public and private sectors, is to influence decision making or policy formulation by providing empirically driven feedback. (McNamara, 1997)

“Evaluation is a methodological area that is closely related to, but distinguishable from more traditional social research. Evaluation utilises many of the same methodologies used in traditional social research, but because evaluation takes place within a political and organisational context, it requires group skills, management ability, political dexterity, sensitivity to multiple stakeholders and other skills that social research in general does not rely on as much.” (Trochim, 2006) Cornell states that evaluation is “The systematic acquisition and assessment of information to provide useful feedback about some object”

Evaluation can be described as a systematic endeavour and the term ‘object’ could refer to a program, policy, technology, person, need, activity, and so on. There is an acquiring and assessing of information rather than assessing worth or merit because all evaluation work involves collecting and sifting through data, making judgements about the validity of the information and of inferences we derive from it, whether or not an assessment of worth or merit results. (Trochim,2006). Trochim suggests that the major goal of evaluation should be to influence decision-making or policy formulation through the provision of empirically-driven feedback.

4:1:2 Evaluation Strategies

There are arguably 4 broad evaluation strategies: *Scientific-experimental models, management-oriented systems models, qualitative/anthropological models, and participant-oriented models.*

For the purposes of this paper the latter will be under discussion as it is perceived as most relevant to the current evaluation as it emphasises the central importance of the evaluation participants ie, it is a consumer orientated evaluation system.

4:1:3 Evaluation Types – Formative and Summative

When considering evaluation types, there are many to consider depending on the object for evaluation and the purpose of the evaluation. Patton (1997) has identified 100 different types!

The two main types of evaluation can be viewed as formative and summative evaluations.

Formative evaluations aim to strengthen or improve the object being evaluated by examining the delivery of the program or technology, the quality of its implementation, and the assessment of the organisational context, personnel, procedures, inputs, and so on.

Summative evaluations examine the effects or outcomes of some object, through summary they describe what happens subsequent to delivery of the program or technology; assessing whether the object can be said to have caused the outcome; determining the overall impact of the causal factor beyond only the immediate target outcomes; and, estimating the relative costs associated with the object. (Trochim 2006).

4:2 Evaluation and Monitoring

Monitoring and evaluation have two distinct but complementary roles. Table 3 summarises the most commonly perceived differences for practical use.

Table 3 Monitoring and Evaluation - Differences

Monitoring	Evaluation
Usually involves numbers	A systematic assessment of whether the stated aims and objectives of an intervention have been met.
Perceived as an ongoing process	It can address such questions as what difference does the project as a whole make and which activities make have the most impact. Self evaluation identifies "What we are doing, How well are we doing it? What are we learning from it?" (Shah, 2003)
There is a continuous and regular collection of key information and	
Assists in establishing whether a project is reaching an identified target group.	

(adapted from Shah 2003)

4:3 Evaluation and Research

A basic definition of the differences between research and evaluation can be described as follows: research is usually conducted with to the intent to generalize the findings from a sample to a larger population. Evaluation, on the other hand, usually focuses on an internal situation, such as collecting data about specific programs, with no intent to generalize the results to other settings and situations. *In other words, research generalizes, evaluation particularizes.* (Priest S (2001). Michael Patton states " Research is aimed at truth. Evaluation aimed at action. Conclusion orientated as opposed to decision orientated" (Patton, 1986)

4:4 Evaluation within the Community

Having considered the need for evaluation and gaining an understanding what evaluation means, there needs to be consideration as to the context of the evaluation.

Evaluation of complex community-based initiatives is an important facet of improving health and reducing inequalities in the UK (Sullivan et al.2004: Judge, 2000 as quoted in Sharkey 2006). Sharkey (2006) goes on to suggest that "Successful evaluation of community based initiatives is arguably a collaborative effort by all stakeholders." (Sharkey, 2006, p.3). This concept acknowledges the need to recognise the many players that have a key within the evaluation alongside the evaluators themselves. Bauld et al (2005) also draws attention to the principles of networking, shared learning as well as the theoretical stances embedded within partnership and whole system approaches to evaluation.

The development of participatory and partnership approaches to evaluation has seen an increase in the reporting of positive outcomes beyond the original evaluation scope eg. A developed sense of ownership of the programme under evaluation, community empowerment and control as community evaluators become change agents for their community and become acknowledged as experts in their own lives. (Sharkey, 2006)These positive outcomes can be achieved through an enabling environment such as adopting a participatory framework for evaluation. Sharkey (2006) identifies further positive outcomes from a literature review of international studies on evaluation methods, these include improved public participation, sustainability and better multi-disciplinary working. (Sharkey, 2006, p.3)

A key message within the Sharkey's (2006) paper is that evaluators working within community programmes "need to have the skills to support stakeholders involvement to be a safe and satisfying experience for them, as well as identifying objectives for a programme evaluation." (Sharkey, 2006 p.3)

A crucial skill for the evaluators to possess is that of **negotiation**.

The Boscombe West and Springbourne Healthy Living Centre can be described as a “Complex Community-based Initiative” (CCI) if the definition as described by Sharkey (2006) is accepted ie. It is “a programme which aims to promote change in individuals, families and communities; develop mechanisms for improvement and build community empowerment “.

The Healthy Living Project had the broad remit to reduce health inequalities in the local area, reduce barriers to health (such as accessibility, affordability and childcare costs) with the overarching theme of improving health and lifestyles within the community.

In more specific terms, the project sought to promote healthy eating, promote more active lifestyles and also provide general support and information for health and social issues. From the CCI perspective, the project sought to promote change in individuals, families and communities with regard to their health and by involving the local community as stakeholders in the project from the start to also promote empowerment and a sense of ownership.

PART 3 The Healthy Living Project

5. Emergence of the Healthy Living Project and the Evaluation

The following pages discuss the general and specific background to the Healthy Living Project in Boscombe West and Springbourne (localities in Bournemouth, Dorset).

5.1 Early Community Projects within Boscombe

Since the mid 1990's Boscombe and other recognised local areas of deprivation sought to address inequalities in health and pursue health improvement for local residents. Indeed, the original bid to the lottery fund for the Healthy Living Project emerged from the local community seeking to improve their health and lifestyles (Healthy Boscombe Business Plan, Bournemouth and Poole Primary Care Trust, January 2002)

The original project, the Boscombe Project, was a community based facility and arose from a review of Health Visiting Services in Boscombe with a simultaneous exploration of the needs of the local community circa 1997. It emerged funded by Bournemouth University, Dorset Healthcare Trust and supported by Abbey Life, Dorset Community Action, Boscombe Link, Boscombe Family Drop In, and the Springbourne Family Project.

This successful project and working partnerships became central to the original bid for the Healthy Living Project. The themes identified at that time for the community were inexpensive exercise classes for residents with crèche facilities, addressing healthy eating with access to low cost healthy food, and support and information especially in relation to parenting.

The Boscombe Project became part of a health improvement programme over 3 local sites, Boscombe, Townsend and West Howe, with each site having a project co-ordinator in jointly funded posts between Dorset Healthcare Trust and Bournemouth University. The Boscombe Team of workers was made up of residents, volunteers, local family workers, University Staff, private business staff and statutory agency representatives.

This project was based on health improvement through empowerment, community development, and social inclusion with the work effectively combining research, education and practice development targeting local health needs and service priorities. Moving the Boscombe project forward saw the development of the Academic Centre for Health Improvement and Evidence of Effectiveness (ACHIEVE) Project with the same working partnerships.

In summary, within the Boscombe locale, there had been successful initiatives in addressing health improvement and projects tackling inequalities in health with effective key working partnerships at their core.

5.2 The Boscombe West & Springbourne Healthy Living Centre

The Healthy Living Programme was set up in 2003 (funded by the Big Lottery Fund supporting the work of Bournemouth Teaching Primary Care Trust) to reduce health inequalities in the Boscombe West and Springbourne Area, the aim to reduce barriers such as accessibility, affordability and childcare, by offering appropriate support so that anyone regardless of age or status, can achieve a healthier lifestyle. It was seen as an initiative to encourage active lifestyles, healthy eating and provide information to the residents initially targeting those on low incomes, older people, single parents and children building on the previous successful joint public health project with Bournemouth University and local health trusts as exemplified by The ACHIEVE Project, and the Boscombe Project.

This programme bid, as with the project before it, also aimed to work in partnership with local GP Practices, Bournemouth Borough Council and network with local community groups and to be managed by a project manager who would report to a board made up of local residents and local organisations.

The bid was successful and the project was underway by 2003. In 2004 funding was secured for another

four and a half years to further develop services to include fitness classes, free weight management courses, food donation services, cookery classes and Christmas boxes for the homeless. Previous successful innovations included a Men's MOT Healthcheck, exercise classes with crèche facilities, food donations to local drop ins, creative movement and reminiscence in local care homes, community health walks, free fruit and vegetable donations to local groups and the creation of a school garden for vegetable growing Bournemouth Teaching Primary Care Trust cites the Healthy Living Project as an example of "Existing Good Practice in Health Improvement" alongside other developments such as the Bournemouth Health Network, the Pier Project and the Crime and Disorder Partnership.
(www.Bournemouth.gov.uk/News/press_office/Press_Releases/2004/November)

Bournemouth University was later commissioned to work with the project on an evaluation and began work in 2005; it was of note at that time, that the formal evaluation was not begun at the project's start. Prior to this there was an annual monitoring report sent to the NOF and the Big Lottery Fund including the projected spend for the project. At that time The Healthy Living Project Board received a report every two months and included the presentation of a Target Monitoring Sheet which was a basic audit and monitoring tool. The first targets were set by the Board addressing the locally targeted Super Output Areas, the second addressed 'what was working' and included sub groups such as environmental health, dieticians, and representation from the Littledown Leisure Centre in Central Bournemouth. The third set of targets included long and short term objectives and addressed issues about sustainability.

6. Introduction of the Evaluation

In September 2005, Bournemouth University was commissioned to undertake an evaluation of the Healthy Living Project.

The summary of activity was as follows:

"Bournemouth University will provide an evaluation of the Healthy Living Centre [Project] programme of services. The Healthy Living Project needs evaluative research that could have the potential to gain publicity and funding for the future while meeting the requirements of the Big Lottery Fund" (Hemingway, 2005).

The lead organisation for the Healthy Living Centre was the Bournemouth and Poole Primary Care Trust.

The ACHIEVE project successfully used the "Youth Work and the Curriculum Development Model" developed by John Huskins (see appendix) which, as described by Hemingway et al (2004), actively encourages progressive participation in decision-making and enables the move from dependence to independence by those involved therefore it seemed appropriate to consider using the model again for all those participating in the evaluation. The key groups initially identified for involvement with the evaluation were identified as the local community, the Healthy Living Project Board (members from the local community, the PCT, and from local voluntary and statutory sectors), and the Healthy Living Project Steering Group (members from the local community and staff).

The Evaluation Team members were agreed as being one researcher from the University (to co-ordinate and undertake the research) under supervision from the Project Lead, and [a] local residents working (ie. To be paid from the evaluation budget) as research assistants with training/development provided by the university. Involving residents in all aspects of the evaluation, not just as members of the Evaluation Team, was seen as imperative, as such a Healthy Living Evaluation Group was established to meet on a 6 weekly basis to feed into the evaluation, this meeting was open to all residents and attended by the University staff involved in the evaluation, the venue was neutral and local to the community, children welcome. Feedback from this group would be incorporated into the quarterly reports to the Healthy Living Project Board.

At the time of the initial drafts (Hemingway, 2004) for the evaluation outlined that there was a clear need for robust monitoring of the project to inform programme planning, provide funders with evidence of success and provide feedback for those involved. The rationale for strong community involvement was to ensure that the project met community need, to strengthen community ownership, enhance health through skill development (empowerment) and to contribute to the sustainability of the work the project lifetime. (Meyrick and Sinkler, 1999)

6:2 Literature Review

Prior to beginning the evaluation, the Evaluation Staff reviewed the literature and background to the Healthy Living Centre Initiative.

6:2:1 Local Evaluations

Having reviewed the literature and background, some of which is described above, the Evaluation Team were aware of the myriad of approaches to Evaluation of Healthy Living Centres, indeed there was no set protocol to follow. A considerable trawl of the literature was made to learn from other Healthy Living Centre Evaluations eg "Evaluation of Healthy Living Barnsley"(2004), "South Wye Healthy Living Community: An Evaluation of the Co-ordinating Role"(2005), "An Evaluation Resource for Healthy Living Centres" (1999),"Bromley by Bow Centre research and evaluation project: integrated practice – focus on older people" (2002-2005), "Healthy Living Centres in Greater Glasgow-Assessing the Impact; moving to sustainability" (2007).

There was no consistent approach to evaluation in terms of methodology however, all suggested the need to work flexibly to meet the needs of the project itself and to continuously involve the project and the wider community both to increase the likelihood of the findings being *of use* and thus *used* practically as well as enabling, empowering and building the capacity of residents. This literature review also highlighted the differing inputs, outputs and outcomes used as measurements for each individual Healthy Living Centre.

Platt et al (2005) also suggest that "evaluations should attempt to capture the indirect benefits of the intervention such as capacity building, training of users, employment, and other benefits (or otherwise) reported by volunteers" (Platt et al, 2005, p6) The Evaluation were mindful of incorporating these into the agreed evaluation aims and objectives.

6:2:2 Approaches to Evaluation – Considered Methods

At the initial Evaluation Steering Group meetings there were many discussions about the evaluation with the focus on the sharing of knowledge amongst the team – similar to that discussed within this document eg. The definitions and differences between monitoring, evaluation and research. The aim of the dissemination was to provide the team with as much information as possible to facilitate meaningful agreement on progress and strategies for the evaluation. Sharkey (2006) suggests this kind of dialogue is essential "All parties involved in the evaluation need to make choices about how to go about it, guided by aims, principles and impetus of the programme namely negotiated and shared." (Sharkey, 2006, p.5).

It was agreed in principle by the Steering Group that it would be beneficial to adopt what is described by Patton (2002) as a 'real world' approach to the evaluation, and that the evaluation needed to make a difference to the project and individuals, in a positive way. An underpinning theme for the evaluation was to ensure that *all* perspectives from those in the project were captured and raised for discussion. The meaningful involvement for all stakeholders – who were viewed as everyone who was / could be involved – was viewed as essential by the Evaluation Team therefore the open and transparent manner adopted for the evaluation was seen as trying to facilitate stakeholders being able to see a role for themselves within the evaluation and to begin the negotiation processes for the evaluators and stakeholders to work together.

Sharkey (2006) discusses "Negotiation Theory" at length within her paper, the scope of this paper does not allow for such a full description, suffice to say that the application of negotiation theory within the evaluation ensured addressing the need to empower, involve and collaborate with the project. It also highlighted the need for the Evaluation Team staff members to have considerable negotiation skills, interpersonal skills, and have an ability to work with the often emotional experiences for those involved with the evaluation.

The Evaluation Team fed back the findings from a literature search which was used to identify whether an

established methodology could be employed for the evaluation. Although the literature search did provide valuable information as to the theory and development of relevant tools/methodology, they did not suggest a set format that could be used for this evaluation. Reports such as "Research Methods for Policy Evaluation" (Purdon et al, 2001), and "Evaluation of community-level interventions for health improvement :a review of the experience in the UK" (Hills, 2004) were useful in facilitating focus on the needs for the evaluation for this individual project. The "Rough Guide to Learning for Healthy Communities through Evaluation" by the Community Development and Health Network of Northern Ireland proved useful for prompting discussions with the project as a whole as to the background, remit and processes for the evaluation. A recurring discussion between the Evaluation Team and the project is mentioned within the report and is quoted thus "...one of the most difficult stages of the evaluation journey is moving from the particular questions of performance in relation to objectives to broader issues of fundamental purpose that underpinned the project in the first place" (Community Development and Health Network of Northern Ireland, p.9). In the beginning the project focus for evaluation tended to be on outputs and use of monitoring data, however the Evaluation Team were keen to widen the perspective to include the core principles for HLCs which are described in the "Rough Guide" as:

1. Addressing inequalities
2. Involving the community
3. Additionality
4. Partnership working
5. Sustainability
6. Supporting health aims

The "Rough Guide" also outlined methods that could be used for evaluation, which were again used in discussions with the project and the Evaluation Steering Group. The guide makes clear the distinction between approaches to evaluation by giving consideration to issues such as :

- Issues about how people experience their engagement with the HLC, how they feel, think and act in relation to it, in which case you will wish to apply qualitative methods,
- Questions of 'how many', 'what proportion' 'how much' 'what financial cost', in which case, more quantitative methods are appropriate.

The methods suggested included observing, documentary analysis, listening through focus groups and interviews, and answering questions through surveys, all of which were agreed to and ultimately used for this evaluation.

In summary, the methodologies and approaches developed to meet the specific aims of this project blended Participatory Evaluation Research and Utilization Focused evaluation to ensure all stakeholders were involved and to enable and empower others with the project itself being able to use the findings on an ongoing basis.

7 Evaluation Team introduction to the Project

The Evaluation Team, especially the staff members, were aware for the need to immerse themselves, and be accepted within the project to implement the evaluation effectively. The staff researchers inducted themselves into the project by meeting existing staff and residents as well as members of the community. Relationships and networks were built up using telephone communications and emails. Time was spent with staff observing their work and day to day lives within the project. This relationship building was crucial to the evaluation process as was the developed understanding of what the project was "about" from all the perspectives available.

Another initial challenge was to have the evaluation valued as an entity, therefore motivational factors had to be discussed with the project both formally and informally. Discussions surrounded the value of the evaluation for the project eg. To provide collection of information on its performance to improve efficiency and effectiveness, provide financial information, encouragement of reflection on aims and objectives to clarify goals, demonstrating impact to encourage and motivate all those involved. The project was also

made aware of the possibility that the evaluation contributes to the project's ability to be a learning organisation – “one that learns from its experience to develop and improve” (Cupitt et al,2003 p.12) It was also essential to discuss with the project that evaluation resources were limited and needed to be focused in order to provide useful insights into the project’s activities.

7:1 Initial Evaluation Plan

The initial evaluation plan followed Meyrick and Sinkler’s (1999) proposal whereby there were set aims and objectives, identification of evaluation indicators, chosen research methods and a plan for dissemination and action.

The original areas identified for evaluation were as follows:

- 1) Provide a measurable analysis of the impact of Healthy Living Centre activities on the lifestyles of those taking part.
- 2) Gather information on how residents feel that individual initiatives have benefited their own health and well being and maximise community participation and ownership of the evaluation
- 3) Collect information from and the views of workers, and volunteers involved in the project.
- 4) Quarterly reports to the Healthy Living Project Board to include information on methods of evaluation, and a final report at the end of the 3 years of the project.

A mixed method approach was adopted as the most appropriate research method with which to obtain the evidence. It was expected that there would be ongoing collection of monitoring data and statistical returns to provide regular and ongoing information associated with working practices and delivery of services. There was also expected to be a another source for information, less routine, to provide descriptions and assessments of service processes, impacts and outcomes – methods perhaps to include surveys, scale measurements, interviews, reflective diaries, observations, documentary analysis and focus groups. The table below outlines the methods and activities for the evaluation as agreed within the Evaluation Steering Group.

Table 4 Methods and Activities for Evaluation

Method/Tools	Data Type	Approach
Questionnaires	Qualitative and Quantitative	Formal
Focus Group	Qualitative	Formal
Interviews with Staff	Qualitative	Formal
Documentary Analysis	Qualitative	Formal
Data Collection and Monitoring	Quantitative	Formal
Mapping of Activities	Quantitative	Formal
Observation/participation of Project Activity	Qualitative	Formal
Observation/participation of Staff within the Project	Qualitative	Formal and Informal
Attendance and participation at Board Meetings	Qualitative/Quantitative	Formal
Meetings and on communication about the evaluation with staff and residents	Qualitative	Informal
Attendance at residents meetings for observation	Qualitative	Informal
Facilitation of Away-Day to address evaluation issues	Qualitative	Informal
Informal visits to resident led projects	Qualitative	Informal

Having agreed the plan in principle, it was expected that by doing so the plan would guide the planning and

management of the evaluation, create a realistic and reasonable timetable, determine what information was needed to avoid unnecessary work and data collection, identify areas of difficulty and address, identify expected and unexpected successes, and finally, to be able to use the results in a useful way. (Meyrick and Sinkler, 1999, p.9)

After careful consideration and discussion with the Research Governance Department at the university, it was decided that it would not be necessary to seek ethical approval for this study, however, confidentiality and ethical issues were to be tabled at the relevant meetings.

The outputs were identified as being a collaborative and mutually beneficial evaluative research study resulting in a final report for the Healthy Living Centre Board and the Big Lottery Fund on completion of the project. The Evaluation start was September 2005 to complete October 2008.

PART 4 Healthy Living Evaluation Activities and Reports

8. An effective way to summarise 3 years of evaluation activities was felt to be a review of the eight reports prepared for the Healthy Living Steering Group and Board.

As described earlier, the methodologies and approaches developed to meet the specific aims of this project blended Participatory Evaluation Research and Utilization Focused Evaluation to ensure all stakeholders were involved and to enable and empower others with the project itself being able to use the findings on an ongoing basis. It should also be noted that the developing of effective relationships within the project was ongoing at this time for the Evaluation Staff as the process of immersion continued.

8:1 Initial Activities

8:1.1 Mapping

The mapping of activities and initiatives was the first exercise for the evaluation. This made use of the data already collected by the Project Administrator. The information provided data eg. as to the numbers of people attending the activities and from what local areas they came from. The type of information generated was similar to the following:

The majority of attendees were female, from the Boscombe areas and were most likely to attend the Exercise Classes or a Healthcheck Session.

Those who attended the Exercise Classes were more likely to attend another activity such "Health Walk" and "Weight to Go" sessions.

It was of note that at the commencement of the evaluation it was not clear from data previously collected by the project team whether those from the deprived areas of Boscombe and Springbourne were represented within the figures.

8:1:2 Questionnaire Design

It was agreed at the Evaluation Steering Group that a questionnaire would be an appropriate method through which views and opinions from residents and staff could be ascertained on a variety of issues pertinent to the project and the evaluation. The matters raised for inclusion concerned board meeting processes, budgetary issues, the level of community involvement, value for money, volunteer participation, and the overall impact of the project on the community.

The issues raised reflected residents' consideration of the aims and objectives set out for the project within formal monitoring documents eg for the Big Lottery Fund, GM02 - The three main target areas were addressing Physical Activity/Active Lifestyle, Healthy Eating, and Support Services.

8: 1:3.Long Term Evaluation

As had been agreed within the original evaluation plan, there was to be an evaluation of the long term impact of attendance at an activity over time on health which would address the issue of sustainability viz the cost saving health benefits of activities.

It was noted that during the process for the above activities it was recognised that there was still a lot of groundwork to be covered, in particular in identifying specific areas of the project for study. Agreement within the Steering Group and the project as a whole seemed difficult to attain, especially as the project, being responsive to the community's changing needs, was also changing, the evaluation became aware that the evaluation may need to be more fluid than originally expected, and be prepared to change over time eg. Modification of the markers for evaluation.

9. Evaluation Progress

9:1 The mapping of activities progressed into regular monitoring for the HLC Board and Steering Group, it was suggested that the evaluation take this forward and focus on the postcode areas of attendees, with a view to monitoring the representation of the more deprived areas in the locale

9:2 In April 2006 64 Self report questionnaires were distributed to Steering Group, Exercise Classes, the Board, volunteers and Breast Friends in. The focus generally was to gather information as to how residents felt that individual initiatives had benefited them, their families, their relationships with other residents and the wider community. The staff of the project were also sent questionnaires at the same time as the residents. Maintaining confidentiality was a key issue for all those who responded – i.e. It was made clear within the returned documents that they wished to remain anonymous (where possible) and confidentiality was to be addressed – with limited use of quotes.

Both sets of questionnaires addressed the same issues and concerns. (Full details available from the Healthy Living Project if required). A summary of the issues are as follows, in no particular order:

1. Develop a formal agreed structure/protocol for dealing with aggressive or unreasonable behaviour experienced within the project.
2. Address communication issues - considering all forms of communication –verbal, written, reports, agendas etc. developing standards for acceptable/unacceptable communications, ensuring clarity, enhancing inclusion and reducing opportunities for misunderstandings or ambiguity.
3. Consider and ensure that information flows freely and is available to all within the project simultaneously and not just within selected clusters.
4. Develop guidelines for the sharing and presentation of information eg. observer status at board meetings. Board papers, agenda items/minutes from meetings etc.
5. Develop a mechanism for acknowledging and addressing discord within the project effectively.
6. Foster/enable community development, including the development of individuals.
7. Raise HLP profile within the community.
8. Formalise and agree on decision making processes eg. ideas for project involvement/development etc.
9. Develop support and supervision within the workplace (and project as a whole) –both formal and informal strategies including agreed appraisal processes.
10. Identify and clarify roles within the project – including management structures for staff.
11. Recognise, acknowledge and address low morale within the project, for both staff and residents.
12. Clarify, identify and develop a strategy for project sustainability.

It was of note that overall, project staff and residents appeared to share many of the same concerns and opinions.

9:3 By the 6 month point the Evaluation Steering Group was established and had agreed in principle to focus on the long term impacts by concentrating on the community school/garden, the fruit trees project and the Breast Feeding Group. Issues to address were to include the cost, who attends these activities (including post code areas) and with what, if any, benefit. The evaluation steering group had also been involved in the development of the questionnaire and resident members had also been involved in the distribution.

9:4 The Staff Researcher working on the evaluation also spent time attending the Healthy Living Project Dentistry Service at the local night shelter in an attempt to evaluate the aforementioned service. This service was developed by the Community Project Co-ordinator (who left half way through the project's life –the post was left unfilled) who felt that the homeless within the area were in greatest need for the project's input therefore this development was a dental service for the homeless only. The researcher found it to be a service highly valued by users who preferred to talk about the benefits face to face at that time rather than be involved in any written activities, or meetings/groups at a later date. The users described the staff attending the service as being very experienced and aware of their lifestyle limitations on health and were

not judgemental, they appreciated the work done for them and described the benefits in terms of health – ability to eat again, and self –esteem – ability to smile and interact confidently.

This activity was extended into podiatry for the homeless and then successfully mainstreamed into the health services provided by the local Trust.

The homeless can be seen as example of a “hard to reach” group as reported by other Healthy Living Centres, however this project successfully engaged with them and managed to negotiate and work in partnership with other organisations to provide a very valued sustainable service. Similar partnership working was evident with the distribution of Christmas Boxes for the homeless involving local retailers and market stall holders.

10. Emerging Themes

10:1 Communication Issues

By the end of the first year of the evaluation, two of the residents involved in the evaluation had moved on to paid employment. The recruiting of new resident volunteers for the evaluation began, but proved difficult to achieve. One of the possible reasons may have been the issues surrounding communications within the project which can be seen to underpin the social capital factors of linking, bonding and social glue. (see later in the report for further explanation and theoretical detail), suffice to say that within the project between residents, staff, the Board and the Trust, effective communications were proving difficult. A key feature seemed to be the irregular format/policy for the sharing of information which impeded involvement as well as fostering exclusion and hindering unity and teamwork.

An “Away-Day” (to focus on communication issues and identifying formal processes for resident led project developments) for the project Board, and possibly staff members, was suggested with the Evaluation Project Lead from the University as the facilitator for the day, this took place in May 2006 and proved to be a successful event, although the suggestion for a follow-up session was not taken up.

Communications began to improve within the project as those in new appointments to the project (see 10:3) established their roles, and the Board appeared to become unified and worked well with the new chairperson in post. The project was successful in establishing a Market Stall as a successful enterprise, able to overcome challenges and obstacles under the new Board leadership and hard work and support from committed residents and staff.

The project itself was able to improve its profile (via one to one contacts at the stall and leaflet dissemination). Post code data from work at the stall demonstrated that more residents from the deprived areas were able to have meaningful contact with the project and further community engagement was successful.

The improvement in communications within the project saw discussions about a proposal for the development of a Healthy Living/Hub shop using the property being used for the Market Stall and discussions about the possibility for a Food Co-op run by residents.

10:2 Reaching the Target Groups and the Concept of Resident/Community Development

Monitoring had continued with a focus on uptake of the project activities by those residents living within the more deprived areas of the neighbourhood, it had become apparent that there was less uptake for those residents, the reasons for which were unclear. The idea of “the HUB” initiative emerged from these issues – which was to provide a local, accessible, focal point for access to the Healthy Living Project Activities and information.

10:3 Staff....Importance of Key Roles and Supervision/Support

At the end of 2006, An experienced community worker had been employed on a part time basis as a consultant to bring her expertise to the project. Local and national organisational changes within health and

social care saw changes in personnel at the local Trust with a new Trust lead for the Project Board. A new chairperson was also appointed to the project Board.

Following these changes subsequent developmental work with residents saw the development of a Market Stall initiative to promote Healthy Eating, Exercise Activities, and the project itself. The Market Stall was set within the heart of the local community sought to include those living in the more deprived areas.

The Evaluation Team established at that point also that there needed to be effective appointment to the key roles for the project with productive supervision and management – seen as central to competent practice. These roles included the senior staff appointed to the project and the Trust Lead and Board members.

By this point, three key themes had consistently emerged through the evaluation activities:

1. Communication Issues.
2. Lack of development opportunities for residents and staff.
3. Target groups not benefiting from the Healthy Living Project.

The Evaluation Team also recognised, that there was a need for reflection and re-focus on their roles as evaluators for the project, therefore a supervision session was set for the end of the year with a University senior academic and senior manager.

10:4 Enabling....through the Evaluation

By the start of 2007, two new residents had become involved with the evaluation. The Evaluation Team recognised that enabling and developing residents, either collectively or individually, is integral to successful participation in the evaluation. All interested community members were invited to attend the Steering Group Meetings to hear more about the work. The Resident Volunteers identified tasks within the evaluation in which they wished to take part and identified the training and support they would need at a time suitable to them given their other commitments. Payment was negotiated as either cash or food/book vouchers depending on the Resident Volunteer benefit status (if relevant). The Volunteer Residents had considerable skills and talents that were used both by the project and the evaluation eg. Photography skills, negotiation skills, observational skills, writing skills, group work skills and many more. The Evaluation Team noted that they needed to identify these skills with the volunteers, and provide encouragement and support to develop the confidence for volunteers to take these skills forward and use them effectively.

Throughout the Evaluation, general training and development (eg. Research or IT skills) had been on offer to residents as well as bespoke training for individual residents.

As has been described previously, The ACHIEVE project successfully used the “Youth Work and the Curriculum Development Model” developed by John Huskins (see appendix) which, as described by Hemingway et al (2004), actively encourages progressive participation in decision-making and enables the move from dependence to independence by those involved in community projects therefore it seemed appropriate to consider using the model again for all those participating in the evaluation. The table below highlights how the Boscombe community developed over time through the evaluation.

Table 5 Evaluation and Huskins' Model

Stage	Activity	Action Taken for Resident Evaluators	Action taken for the Project
Stage 1 Make Contact	Access: Information, opportunity	<p>Open community invitations to Evaluation Steering Group</p> <p>Time and locale suitable to residents, children welcome.</p> <p>Full information about the evaluation given, as often as necessary, in plain English.</p> <p>Full information about training and development given.</p> <p>Contact details given that were accurate and useable</p> <p>Evaluators attempted to operate in an open and transparent manner and be as friendly and approachable as possible.</p>	<p>Evaluators met with project staff and residents.</p> <p>Relationship building was seen as ongoing and necessary with all means of communication used eg. Email, telephone, face to face etc.</p> <p>Evaluators attended all relevant meetings with the project eg. Board meetings.</p>
Stage 2 Meet others	Expressing Needs	<p>Evaluators identified the skills that residents could bring to the evaluation and offered training and development where required.</p> <p>Support for resident evaluators was as available as was feasibly possible within working hours.</p> <p>Payment was in a form suitable for the residents eg. Perhaps food vouchers or book tokens.</p>	<p>The evaluators listened to the project's view as to the needs of the evaluation for the project - however this proved difficult at times as the needs expressed varied between different groups of residents eg, between the Board and the staff or other residents.</p>
Stage 3 Socialise	Trust	<p>Many issues of a confidential nature were raised in the relationship</p>	<p>Trust was difficult to establish for a myriad of reasons eg. Expectations of the evaluators as people, their roles, their status,</p>

		building with the resident evaluators - this was never compromised and facilitated a mutual genuine supportive, facilitative, and developmental learning relationship	their remit, and a perception their power. This improved over time, but was always a challenge. Informal exchanges became mutually bonding over time.
Stage 4 Taking Part	Participation	The residents took part in the evaluation undertaking tasks to great effect and made valuable and necessary contributions to the project. The work undertaken had more impact given the skills and attributes of the residents.	The project staff in particular, were very willing to give of their time and working knowledge of the project throughout the evaluation. They responded quickly and effectively to requests for information. The Board struggled at times with some of the evaluation findings and were reluctant at times to publicly share them. Residents often came forward with local knowledge and information they felt was pertinent to the evaluation - although the views sometimes were in conflict with each other!
Stage 5 Involved	Setting the Agenda	The resident evaluators made their own suggestions for evaluation activities and demonstrated a clear understanding of the working behind their work evidence by their verbal and written feedback.	The project as a whole was slower to grasp the fundamentals of evaluation - due to the communication difficulties and conflicting perceptions and opinions of some members.
Stage 6 Organise	Taking Responsibility	The resident evaluators facilitated a focus group independently and undertook an observational study.	The project staff and resident led projects used Service Level Agreements as part of the process with built in aspects of performance monitoring.
Stage 7 Lead	Independence	All the resident evaluators moved into employment and one also into higher education.	The resident led projects became autonomous and independent of the project and project staff. This independence saw reduced contact with the original project and restricted access to their monitoring data which would have made a valuable contribution to the evaluation itself.

The lack of volunteer members was seen as being an issue when addressing the second phase of the Evaluation – seeking to establish the long term impacts of the evaluation. The ongoing literature review was also demonstrating the long term impacts were very difficult to measure for Healthy Living Projects generally.

10:5 Enabling...within the Project – Starting to Build Capacity and Take Risks

The ability of the project to build capacity was becoming apparent as training and development for residents and staff was necessary to set up the Market Stall eg. Food and Hygiene Certification and Nutrition as well as business skills for seeking and establishing the lease for the shop. The employed Consultant provided support as well as expertise and guided the Board through taking the necessary financial and individual risks necessary to realise ideas.

Following on from this new development was the agreement to set up a recognised volunteer database, establish and develop new and existing relationships with volunteers and formulate a volunteer policy. The developments under consideration (Hub/shop. Food Co-op) were also viewed with possible opportunities to work alongside other local organisations and members of the community.

The Evaluation Activities continued to amass the above information using existing monitoring activities and documentary analysis of minutes from the assortment of meetings held within the project. The open and transparent nature of the evaluation permitted open dialogue both formally and informally with staff and residents.

11. The Final Progression

11:1 Volunteering

One Resident Member of the Evaluation Team was keen to take on board and explore the issue of volunteering within the project and was encouraged to run an Evaluation Focus Group for Volunteers involved in the project in the summer of 2007. After training and support, the resident successfully ran the group which was co-facilitated by the other Resident Volunteer for the evaluation.

Several key points emerged which are detailed in the table below.

Table 6 Project Volunteering

General Issues about Becoming A Volunteer In Any Community Project	Issues specific to the Boscombe Project
Volunteers offer time and practical assistance, therefore expect to "join in"	Volunteer and resident steering groups had been successfully used as a discussion forum to move forward ideas
Volunteers wish the experience to benefit themselves and others.	Lack of awareness as to how to become involved in the project as a volunteer
Volunteers want to achieve something - not "just be doing"	Difficult to feel valued as a volunteer.
Volunteering is ideal as a precursor to returning to employment after a period of ill health.	Training opportunities perceived as not available
Different personalities involved in community projects can make successful volunteering difficult - whether a project trying to establish meaningful volunteering, or the volunteers wishing to engage. Personality clashes can inhibit participation, especially if some community members are very vocal which can sometimes be interpreted as threatening.	Communications an issue within the project - volunteers did not feel listened to.
	Conflicting opinions and views amongst staff and residents - often dependent on the

| resident's role eg. Member of the community or |
| Board member. |

The findings were presented to the Board and some of the issues were addressed, not all were able to be considered given that the project was entering the final stages, however a Volunteer Policy had been developed, agreed by the Board and subsequently put into action.

11:2 Communication Analysis

As communications had been an issue throughout the project thus far, in May 2007 the Evaluation Steering Group decided to perform a communications analysis with the help of a Resident Volunteer for the Evaluation. The aim of this activity was to explore and identify issues within the project surrounding communications with a view to establishing "the lessons learnt". In the short term the objective was to raise awareness as to how communication difficulties may arise or have arisen in the past, and what measures may be taken from herein to improve and enhance existing communications. Prior to this activity and in response to the previous issues raised, the new Project Manager (the Community Consultant previously involved was approached and appointed early 2007) developed several policies for the project clearly outlining expected standards and processes for both behaviour and communications. These policies included:

1. "*The Code of Conduct at Meetings*" which sets out the expected level of behaviour of those people attending any meeting convened on behalf of the Boscombe and Springbourne Healthy Living Project".
2. *The Internal Communications Policy* which seeks to "to maintain a good working, social and personal environment, to promote efficiency, and to generate better understanding of the Project's objectives.....ensuring that no board member, staff member, volunteer or resident or other group are made to feel outside of the project."

The Evaluation Steering Group asked their Resident Volunteer Evaluation Team Member to observe communications within the project eg. At meetings such as Board meetings, written communications, and general interactions taking place within the project office in Boscombe using the above policies as baseline tools. The observations were written up for discussion with the Evaluation Team. A documentary analysis was also made of reports and minutes from meetings. Theoretical and practical support was provided by the team prior and during the activity. Written information was sent to the staff researcher for thematic analysis.

11:2:1 Communications: Findings

Investigation of the issues surrounding communication identified firstly, that the dynamics of the actual interactions were of concern and, secondly, that often the dynamics between individuals themselves and their role within identified groups caused difficulties.

A literature review of material relevant to the functioning of community groups, social capital and utilisation focussed evaluation addressed many of the issues raised within this activity not least that the Evaluation Team, as already stated, whilst needing to be immersed and involved in the project, also need to be clear as to their role and the boundaries that are set.

The theoretical framework for analysing the data used John Heron's Six Category Intervention Analysis.

Data collection began May 2007 on site at the Boscombe Office, communications were observed at various locations including the main "Link Office" (staff base), Roumelia Lane (Boscombe Whole Food Co-op Base), and Board Meetings as well as through informal channels and documentary analysis. Final data was collected July 2007. Personal interactions were recorded as well as written communications. There were no formal non-verbal communications recorded. It is acknowledged that there is an element of

researcher subjectivity in the methods employed. However, all findings were discussed amongst the Evaluation Team to reduce bias as far as possible.

Overall, the communications were seen as positive and effective, some possible explanation as to *why* they are viewed in that way uses the Intervention Analysis for interpersonal communication. The tool identifies that most commonly, information is passed on through the project from the staff and communications are generally supportive, informative and prescriptive in nature. Where necessary, cathartic and catalytic interventions were used appropriately. (summary of the theoretical underpinning is available within the full report available from the Healthy Living Project.)

Generally speaking the purpose or intention of the internal communications could be said to be to provide information and share knowledge willingly and to promote good working relationships through openness and transparency. External facing communications ensured members of the public could have their enquiries dealt with efficiently with the provision of the requested information and answers to questions, communications were clear and transparent. Partner organisations were also kept informed and included within decisions to be made.

The need for and use of cathartic and catalytic interventions could be seen to demonstrate the (often rocky!) emotional landscape within the project which has been clearly identified by those members of the Evaluation Team immersed within the project and from data gleaned through other evaluation exercises. This finding yet again reinforced the identified need for an adequate supervision and support network for all those involved within this community project.

Communications within the project overall were seen to have improved dramatically over time. The most common observation from the staff and the Evaluation team is that levels of conflict were greatly reduced and issues were now managed through open debate and with respect for others.

Possible contributory factors may have included:

- 1) Shared vision and commitment to goals as expressed by all those involved in the project at a variety of formal and informal meetings – evidenced by the recorded minutes of meetings and briefings.
- 2) Clear expectations and standards for behaviour and related communications outlined in a Conduct Policy, accepted and adhered to by all those involved in the project. Monitored and recorded by the Evaluation Team on an ongoing basis.
- 3) Communications in all forms aiming to be transparent as defined in the adopted Communications Policy- also monitored and recorded by the Evaluation Team on an ongoing basis.
- 4) Focus and encouragement on learning and development for all within the project perhaps contributing to the removal of barriers and sub group/cliques in conflict. A shared ideal of empowerment and sharing of skills to include, not exclude, others from meaningful involvement in the project. This can be seen to be evidenced by the processes developed for electing a new Chair and Vice Chair. As before, the documentary analysis reviewed by the Evaluation Team supports this observation as does anecdotal communications from a variety of sources.
- 5) Excellent communications skills and team working within the core staff members of the project, as reported by residents and volunteers.
- 6) Full participation from project members in the delivery of presentations, papers etc. to the relevant meetings, including those of partner organisations – this perhaps demonstrates the effective breaking down of barriers and power sharing between staff, residents and volunteers.

The resulting paper from this evaluation exercise identified possible communication themes for development of a community project such as this.

Recommendations to Address Communication Issues within Community Projects

The evaluation suggested that a blanket approach to improving communication does not suffice, a more defined approach is necessary. In essence, the development of a clearly defined communications skill base is needed to set the standards by which through training development and experience, **all** those involved with the project may then establish effective working relationships for the good of all those involved. It was also recognised that when working in partnership with different types of organisations and the community, communications can become difficult not least because of differing agendas, but also through differences in language and understanding eg. Usage of terms such as “stakeholder”, or “clinical governance”. It was therefore recommended that, when appointing to key roles within a project eg. Chair of the Board, Project Manager/Administrator, and the Activities Co-ordinator, the possession of the skills, or capacity/opportunity to develop the skills described below is considered.

Table 7 Levels of Communications Competence

1st Level	Basic Skills	Basic Communication Skills	Eg Showing and achieving listening etc. Using non-verbal behaviours to support. Using Plain English at all times. Communications being open, clear and transparent. Self awareness.	Useful at all times for effective interpersonal communication.
2nd Level	Advanced Skills 1	Planned Interactions	Eg Knowledge and experience of using Heron’s Six Categories	Useful for working with and supporting others within a role.
3rd Level	Advanced Skills 2	Identifying and working with difficult interactions	Eg Knowledge and experience of using Heron’s Degenerate and Perverted interventions	Useful for “troubleshooting” and dealing with/understanding difficult situations such as confrontation and conflict.

The use of John Heron’s work facilitates identifying “what is going” on in an interaction, but does not prescribe “what to do, or say next”, that remains up to the individual(s) concerned. Defining what is occurring may help projects experiencing communication difficulties to reflect rationally thus reducing the tendency to attribute personal blame and thus “scapegoat” individuals. It may also serve to reduce the emotional intensity of situations that have already or may occur. In identifying what may be occurring, the project as a whole can work towards effective resolution of issues. The skills described also offer strategies for support within the project either within a formal supervision setting or as a general supportive working environment for everyone.

Consideration of non verbal behaviours was identified as important throughout the evaluation as positive and negative non verbal behaviours have been clearly recorded as has their personal impact on others. Adjectives used to describe personal attributes are frequently mentioned such as warm, friendly, and open with a few negative attributes eg. Hostile, aggressive, manipulative and threatening. The use of the tools, may allow such negative expressions to be addressed in a non judgemental way and perhaps raise awareness in those to whom it may apply as to how their demeanour is experienced.

At the core of using the tools, is the awareness that it can be used to describe interaction NOT for passing judgement on an individual.

Additional pertinent knowledge about communications was gleaned not only from the evaluation processes and data itself, but also from Evaluator immersion within the project and the relationships that were established. This immersion, whilst essential, saw the blurring of boundaries and highlighted the need for the staff members of the evaluation to receive external supervision to reaffirm their focus and role – indeed, it was becoming very apparent to the Evaluation Team that their role within the project could become confused not just to the project but to themselves!

12. Staff Roles within the Project

As has been outlined earlier within the report, there were personnel changes mid way through the project. A new Project Manager was appointed, new chairs of the Board were appointed and also a new Trust Lead who sat on the Board. The Evaluation Steering Group noticed positive changes occurring within the project over time and wished to explore whether it could be attributed to this change in personnel. It should be noted that the Project Administrator had been in post since the beginning of the project and was regularly cited as a key staff member that could be relied upon to carry out tasks and tackle challenges for residents, staff and volunteers. It was therefore decided that the next evaluation activity would be to explore staff roles and develop emerging themes with the aim of identifying core skills and attributes necessary for staff roles within a community project.

The resulting document was not only based on the documentary evidence provided as a result of the formal structured observations made by the Volunteer Evaluation Team Member, but was also supported by the ongoing formal, informal and anecdotal feedback made to the Evaluation Team from all those involved in the Healthy Living Project thus far, as well as revisiting the responses to the questionnaires sent out previously to staff and residents.

The Volunteer Evaluation Team Member spent several days working alongside the two core office members of staff (Project Manager and Administrator) who were based at the central HUB (office) of the project in Boscombe to gain an overview and understanding of a “typical” working day for the staff. Time was spent until saturation had been reached and no new observations were being recorded. The staff members were happy to be observed and explained in detail the function of activities where not immediately obvious. Data was recorded and written up in a diary style and sent to the researcher at Bournemouth University for analysis/thematic exploration.

12:1 Similarity of roles and flexibility

Originally, the Evaluation planned to look at staff roles in isolation, however upon thematic exploration, it became apparent that the skills and attributes of both the roles being studied (Project Manager and Project Administrator) were remarkably similar. Indeed, the degree of overlap between these two positions in terms of personal and professional skills suggests a need for role flexibility and adaptability across the staff roles.

12:2 Importance of Staff Communication Skills

Communication and administration were significant elements within both roles as were developing and maintaining effective relationships with partner organisations and the community as a whole.

The supportive nature of staff personally AND professionally in their dealings with all those who come into contact with the project (regardless of role eg. Volunteer, Board member, resident, or member of the public) was found to be key, as was the demonstration of what could be termed “helping behaviours”. Staff appeared to be proactive in ensuring there were no barriers between staff and residents/volunteers, with approachability and availability key attributes.

Approach, Style and Attitude of Staff

The members of staff appeared to operate in unison, the working relationship seemingly enhanced by the similarities in approach, style and attitude to their daily workload as well as their shared skill base /attributes– a description of which includes the following list:

- 1) Good communication – clear, timely, relevant.
- 2) Adherence to issues of confidentiality
- 3) Flexibility in role sharing – willingness carry out aspects/tasks of others’ roles.

- 4) Willingness to share and transfer knowledge and skills
- 5) Ability to identify, acknowledge and address gaps in knowledge
- 6) Shared vision and goals
- 7) Sense of humour
- 8) Mutual supervision and support
- 9) Effective limit and boundary setting abilities for self and others – and role modelling of same.
- 10) Effective negotiation skills with others.
- 11) Recognition and adherence to deadlines.
- 12) Ability to identify and effectively problem solve WITH others
- 13) Ability and willingness to give constructive (and often difficult) feedback to others.
- 14) Willingness to share/devolve power
- 15) Ability to assess situations and make decisions autonomously when appropriate
- 16) Ability to take risks.

Both roles were seen to deliver and share information transparently and also to demonstrate well developed and effective listening skills. The ability to be innovative and convey ideas effectively to others would seem vitally important also.

The staff also showed a strong commitment to evaluation, evidenced by the willingness to share information and work with the Evaluation Team.

The second round of questionnaires identified further what the skills were important for staff to possess, as outlined in the table below. It is of note that there were no significant differences made between the roles as to the essential skills.

Table 8 Staff Skills : as identified by Staff and Residents of the Project

Personal Skills	Administrative Skills or Qualifications	Leadership Skills
Motivational skills	IT Skills	General skills of leadership
Ability to be tactful	Finance	Engagement skills
Ability to be diplomatic	Budget Management	Relationships building skills
Ability to be patient	Appropriate qualification and training for service/activities/training offered to the community.	Project Management
Ability to be "thick skinned"		Community Development
Ability to be empathetic		Volunteer Management
Ability to be understanding		Strategic Planning
Ability to communicate		Time Management

effectively.		
Ability to be		Interview Skills
approachable.		
To possess good		
listening skills		
Appreciation of		
the need to spend		
time with		
individuals on a		
1:1 basis.		

12:3 Relationships and roles between Staff and Residents

Project co-ordinators within the ACHIEVE project described difficulty in adapting to new ways of working and identified the necessary development of new skills such as:

- Negotiation
- Networking
- Accessing resources
- Listening to residents
- Power and control within interactions and within projects
- Taking Risks

These skills were also identified as important within the Healthy Living Project at various points in the evaluation. Responses within the first round of questionnaires sent out to staff and residents identified that there were issues appertaining to negotiation (and the ubiquitous “communication issues”) in terms of staff, resident and Board roles and decision making powers, networking in terms of with whom to work in partnership with and the conflicts involved, accessing resources in terms of accessibility of the office and staff, and listening to residents. **The latter being key, as it not only applied to staff listening to residents but residents listening to other residents also.**

Power was also an issue both in the ACHIEVE project and the Healthy Living Project, or rather the perception of it. The Board, the Trust and staff for the project were viewed frequently by residents as “having power” (however it was difficult to ascertain in the main what was meant by this) and were viewed as reluctant to share or devolve this power. However, again towards the final two years of the project, the evidence from the documentary analysis of the project and the second round of questionnaires was that power, not only for decision making, was being given to residents but risks were being taken and power given to residents themselves to establish individual and group projects. Perhaps contributory to this was the appointment of a new chair of the Board, new Trust lead, and a new project manager, all of whom possessed the necessary skill base to move the project forward. This is not to say that previous incumbents did not, or could not have developed those skills, there appeared not to have been the opportunity for them to display the skills or develop them due to the other ongoing issues within the project itself.

Taking Risks

The project latterly was able to take risks, financial risks and risks in individuals – again similar to the ACHIEVE project, it was not something that came naturally to everyone within the project. The Board and other residents became less reluctant to support other community members’ ideas for projects agreeing to sums of money, to go to groups and individuals for development. Staff invested time and effort with individuals, often working with less than precise set goals and outcomes. Responsibility was handed over

for entire projects with residents able to fulfil ideas and strategies their way, not as prescribed by staff or the Board. The residents themselves and also the rest of the community also took risks by agreeing to the projects. Accepting power also means accepting responsibility for issues, both good and bad. Prior to the latter changes within the project, blame and “fault” was often directed towards those perceived to have had power, this clearly could no longer be the case if residents and the community then took a share of that power. The second round of questionnaires demonstrated this clearly – “blame” and “fault” were no longer themes within the findings. The residents also took risks in the sense that they were will willing to take forward and invest themselves in their ideas, often other residents volunteered to become involved also as a result.

Importance of the Manager Role

The project manager that was in post during the final 2 years of the project used her experience to build on and establish new networks for the project activities and was able to identify and use existing resources around and within the project – inclusive of the existing skill base of the community.

Platt et al (2005) confirmed that staff are crucial to the success or otherwise of a Healthy Living Project – or rather their skills and capacity are vitally important. They also note, as was the case within this project “ With large and ambitious remits, and continuing pressure on HLCs to innovate, project management was sometimes difficult, and clear leadership became particularly important.” (Platt et al, 2005, p.4) They also note, again as was the case within this project, “ Overload on staff was, however, frequent, particularly when staff turnover was rapid, and training opportunities were too often seen as limited.” (Platt et al, 2005, p4).

The figure below encapsulates what the new Project Manager realised.

Figure 1 **Co-ordinating Role**
[pic]

(adapted from South Wye Healthy Living Community: An Evaluation of the Co-ordinating Role 2005)

Extending skills to others involved in the Project

In the final discussions on staff roles, the key elements for staff skill sets within the project were outlined, however, some of these skills and attributes could perhaps be seen as essential for **ALL** those involved in the project, regardless of role, for example, consideration should be given to the following:

1. Recognition of core elements to be valued and developed for all those involved in a community project such as this ie. Board members, residents, and volunteers.

Whilst it is recognised that for the strategic and organisational success of the project on a day to day basis the key “decision makers” and “workers” (again in any role eg. Food co-op, Board Member, volunteer) must have, or work towards having, the described skills, perhaps for successful group/community working from a social capital and social enterprise perspective, possession of /or constructive development of these skills are essential.

2. Provision of specific training and development in effective communications and skill sets for community groups such as this.

A key finding for the Evaluation Team at this point was a clear shift in the project's focus from fixed activities to resident led initiatives, and also the verbalisation of the drive to see sustainability in individual development and not just financial terms.

13. Project Ability to address Evaluation Findings

Despite the intention that the evaluation findings were to be used on an ongoing basis, the project seemed to have difficulty addressing the issues at times. The Evaluation Project Manager facilitated a half day session for the whole project to address all the issues that had been raised within the evaluation activities, this took place in 2006 supported by the dissemination of a Discussion Paper written by the Evaluation Project Manager.

The paper summarised the initial focus of the evaluation which had been to address the way the project worked with the local community, how and if it enabled the involvement and development of local community members and met their perceived needs. The strengths of the project were identified as the obvious commitment of local residents.

The issues raised at that time for discussion included that the initial focus of the project was to provide services rather than facilitate the development of individuals – this was highlighted as a common issue for all healthy living projects as identified in the literature. Suggestions were proposed such as providing support for writing a business plan, dealing with conflict, chairing meetings, IT training or writing notes.

Secondly, the issues surrounding communication were raised. In particular, a lack of shared vision and teamwork was mentioned as was the lack of acknowledgment for success as well as the more structural issues such as clear processes for discussing budgets, new projects/initiatives, and the education/training of staff, residents and volunteers.

14. Moving Forward.....

By the middle of 2007, the Project Manager had reviewed all the papers presented to the Board by the Evaluation Team and had drawn up questions for both the Board and the Evaluation Team. This demonstrated a renewed interest in the evaluation and a new perspective to use the findings for the good of the project as a whole. The Project Manager also attended most of the Evaluation Steering Group Meetings.

It was agreed that the Project Administrator would continue to provide the Board with the monitoring information required and it would cease to fall under the remit of the evaluation. It was also agreed that the targeting of the deprived post codes remained a challenge that could not be met within the existing life span of the project – and therefore the project should spend the latter part of its time developing new resident led initiatives and developing individuals and social capital. The Boscombe Food Co-op was established by this time and the Project Manager proposed “Pump Priming” as an initiative to take forward community ideas and thus invest in residents who had ideas for projects that would complement the themes of the project as a whole. It was envisaged as providing those residents who became involved with the project, the opportunity to experience taking control of projects and of ownership thus addressing the key theme of sustainability for individuals within the community. The assistance for residents was to include financial aid and support, general support, advice, and training. A training menu was developed and made available for residents and volunteers.

The project made concerted efforts to engage with the wider community by instigating social events with a health and/or volunteering theme. This also served to address issues such as isolation and socialisation for the community as well attracting new volunteers to the project.

New avenues for partnership working were also explored including joint working with a local leisure centre

and the local Trust for introduction to exercise classes.

The project as a whole came to realise the importance of trust within a community project, and acknowledged the need for trust at a practical level beyond the theoretical aspects appertaining to social capital within community projects – this was a key move forward for the Boscombe project.

15. The Final Stages of the Evaluation

By the end of 2007, individual resident led projects were up and running successfully although formal evaluation of these projects was proving difficult for the Evaluation Team to become involved with. Engagement with the involved residents proved difficult at times particularly in relation to formally gathering data related to project activities and volunteer involvement.

There were new training initiatives in place addressing finances, debt management, weight reduction and co-working with other funders such as Neighbourhood Management. The Food Co-op had grown to become “Urban Evolution”, a resident led initiative instigated as an “umbrella” organisation for all resident-led initiatives and was managed and run by residents with support from staff.

The Resident Volunteer Member of the Evaluation Team had established an individual project whereby he liaised with a local supermarket to distribute excess food to a local homeless shelter as well as taking on board the evaluation of the Podiatry Service for the homeless and developing information leaflets about the project as a whole. The second Resident Volunteer had left to pursue employment. Although the project as a whole was not actively recruiting new volunteers given the short time left for the project, the resident led projects were using volunteers effectively.

The Staff Researcher for the evaluation visited the Food Co-op to view a resident- led project in action and to suggest evaluation collaboration. The shop was very busy with customers buying the products and general shop processes. There were discussions regarding apparent issues surrounding a suggested lack of formal processes for realising ideas presented to the Healthy Living Project and the subsequent release of necessary funds. This, again, has been issue highlighted by the Evaluation in previous reports.

Throughout the lifespan of the project, the Activities Co-ordinator (a local resident who successfully qualified as an exercise instructor and was highly valued by staff and residents alike) gave regular feedback on the Exercise classes sharing her own developed evaluation feedback and resident led exercise initiatives – always successful and positively viewed.

The project Board members were by now few in number making effective collaborative decision making difficult and an efficient communication awkward at times.

The second round of questionnaires were distributed in January 2008 and the return as follows.

Table 9 Distribution and Return of Questionnaires

Description	Number Distributed	Number Returned	
Board Member	7	2	
Resident	47	7	
Resident Volunteer	11	2	
Staff	3	3	
Total	68	14 (20.5%)	

As before the return rate was low, however the questionnaires that were completed demonstrated that respondents had taken a great deal of time over their responses and all questionnaires were full of rich material. It was not possible to identify those residents who were involved in resident led projects as this

would have compromised their confidentiality.

The questionnaires were analysed together (the full results of this activity is available from the Healthy Living Project). The second round of questionnaires was originally viewed as providing a possible measurement of change over time, however it also provided evidence of the issues that were important to the project and the wider community as well as consolidating and providing further evidence for the evaluation findings thus far. As the literature reviews and searches were ongoing, the Evaluation Team noticed that the key findings reflected other HLC Evaluations and the theoretical underpinnings embraced within.

Key findings from the process and questionnaires were found to be as follows (in no particular order):

- 1) Individuals in senior positions within the project, especially staff roles, must have the necessary skills and attributes for a community project. This is essential from the BEGINNING of the project.
- 2) Training for staff and especially the community is imperative especially in order to successfully fulfil roles such as chair of the Board.
- 3) Partnership was seen as crucial and successful in the last year of the project eg. Working with Neighbourhood Management.
- 4) The changes in personnel were seen as having a positive influence and impact on the project.
- 5) There was still the concern that the project was not “visible” enough in the wider community, perhaps due to, or because of, poor advertising and dissemination of relevant information. There was thus a perceived lack of engagement with the wider community.
- 6) Communication issues were seen to have improved although still a challenge at times for some respondents.
- 7) The responses to the questions varied enormously depending on the contact the person had with the project, it was seen to vary between members of the same group also. This confirmed the suggestion that individual perceptions of the project varied from individual to individual. The responses also varied as to whether the respondent felt they had benefited from their contact with the project.
- 8) The exercise classes were highly valued and benefited all those who attended.
- 9) There was more focus on the project benefiting the wider community and less on its provision of services which reflected the overall change in focus for the project.
- 10) There was a perceived positive change in project processes for development of resident ideas to be taken forward.
- 11) Staff skills were viewed as important and appreciated.
- 12) The perceived lack of volunteer input was felt to be unsatisfactory.
- 13) Respondents did not feel that the “right” members of the community were benefiting from the services/activities on offer.
- 14) Those residents who had successfully developed ideas for projects were felt to be few in number and the same individuals each time.
- 15) It was felt there was still ineffective management of “difficult” residents by the project as a whole.
- 16) The PCT as the Lead organisation needed to, and has learnt, from its involvement with the project, in terms of taking risks both in financial terms and in individuals.

Overall, the responses from the second round of questionnaires were much more positive about the project, its activities and its benefits for the local community.

PART 5 Theoretical Focus – Reflections using the Literature

16. The Evaluation – Reflections on Theory and Background

Upon reflection over the past three years of evaluation activity, a change had become apparent in terms of participation within the Evaluation. One of the early tenets of the evaluation was that it was to be collaborative in nature with an ethos of openness and transparency. The early phases of the evaluation needed collaboration with the Board, residents and staff in order to collate the necessary data and feedback the resulting information ie. there was a collaboration between the researchers and the Healthy Living Project. This collaboration also generated new knowledge about the processes and strategies within the project resulting in an organised “Away-day” to address issues arising.

There were clearly many similarities in processes for the evaluation and Participatory Action Research.

- Staff and residents were involved in decisions as to the evaluation focus
- Staff and residents were involved in the design of the tools to be used.
- Issues arising from the initial phases of the evaluation were acknowledged and addressed.

The Evaluation Team utilised a number of appropriate research methods (the manner in which a particular project is undertaken, comprising one or more research techniques) and use a number of research techniques in order to achieve the identified aims and objectives. Examples would include data from case studies, focus groups, or documentary review.

(www.uwex.edu/ces/tobaccoeval/glossary.html.) Within the evaluation it was also necessary to formally collate quantitative (numerical) data, especially in the earlier phases to aid the establishment of satisfactory monitoring of project activities.

16:1 Participatory Evaluation Research

Participatory evaluation in the context of action research often takes the form of ongoing reflection throughout the course of the project. The process of regular reflection for the Evaluation Team, facilitated through formal and informal meetings and correspondence, allowed for increased participation within the evaluation for not only the members of the Evaluation Team itself but also the wider community. Indeed immersion within the project was identified as useful early on in the project evaluation

Participatory research methods are practised in various forms with the most widely practised collaborative research approach is participatory action research (Piercy et al, 1988)

Participatory Action Research (PAR) can be described as a research method that relies on an open iterative process between all participants within a reflective framework providing an opportunity for learning and change. Reason (1994) describes two possible objectives for this type of research “one aim is to produce knowledge and action directly useful to a group of people...the second aim to empower people at a second and deeper level through the process of constructing and using their own knowledge....This is the meaning of consciousness raising...for a process of self-awareness through collective self inquiry and reflection”. The method is underpinned by the essences of empowerment, partnership and participation.

The Evaluation could be viewed as using the method of Participatory Action Research as it has provided information about communication issues and decision making for the project to address as well as drawing on the knowledge of residents to both inform (eg. Questionnaire) and participate in the evaluation (eg. Focus group and observation). As Piercy et al (1998) suggests “one seeks to know the needs of the community and to translate them into actions that may be directly used by the community” (Piercy et al, 1998, p.3) PAR also uses collaboration between researchers and community members that empowers, motivates, increases self-esteem, and builds solidarity (Piercy et al) which was evidenced within the evaluation.

Percy et al (1998) describe another participative approach, cooperative experiential inquiry, which emphasizes experiential reflection over strict adherence to research methodology and is most closely

associated with the work of John Heron (1971, 1981, 1992) and Peter Reason (1988; Reason & Heron, 1995). Reason's (1994a) most recent discussions of participatory inquiry emphasize a participatory method that uses phases of reflection and action. Reason's participatory research model changes research subjects from "oppressive roles" to those of teacher, collaborator, and co-owner of research outcomes. The process leads to change in both the participants and the researcher. The Evaluation demonstrated that residents became teachers (of other volunteers for projects and the for the evaluators in telling the stories about the project), they collaborated and worked with the evaluation and as such co-own much of the material for the evaluation findings.

Piercy et al (1998) also discuss the power that traditional researchers may have in terms of their expert knowledge which could see them perceived as more powerful than their less knowledgeable research subjects, whereas for this evaluation the Evaluation Researchers could be described as Participatory researchers who "invite participants to generate, own, use, and share their knowledge and expertise; typically, the participants are empowered in the process (DeSantis, 1994; Fetterman, Kaftavian, & Wandersman, 1996, as quoted in Piercy et al, 1998, p4))".

16:2 Formative and Summative Evaluation/Dialogical Approach

It is acknowledged that the evaluation was both formative and summative in nature ie. To enable people and agencies to make judgements about the work undertaken; to identify their knowledge, attitudes and skills, and to understand the changes that have occurred in these; and to increase their ability to assess their learning and performance (formative evaluation). To enable people and agencies to demonstrate that they have fulfilled the objectives of the programme or project, or to demonstrate they have achieved the standard required (summative evaluation).

The characteristics of the processes involved to achieve the set objectives reflect those of a **dialogical** approach to evaluation.

- 1) Evaluation was viewed as an integral part of the development or change process and involves 'reflection-action'. Subjectivity is recognized and appreciated.
- 2) It attempted to be an 'empowering process' rather than a control by an external body. There was recognition that different individuals and groups will have different perceptions. Negotiation and consensus was valued concerning the process of evaluation, and the conclusions reached, and recommendations made.
- 3) The evaluator takes on the role of facilitator, rather than being an objective and neutral outsider. Such evaluation may well be undertaken by 'insiders' - people directly involved in the project or programme.

(Adapted from Joanna Rowlands (1991) *How do we know it is working? The evaluation of social development projects*, and discussed in Rubin (1995: 17-23)

16:3 The mixed method techniques used.

The mixed method approach to evaluation such as this consists of intentionally combining different evaluation tools and techniques not only to observe and to gather qualitative and quantitative information but to structure, analyse, and judge this information.

The re-issue of the initial questionnaire followed the tradition of a Delphi Technique which relies on the judgement of a panel of 'experts' (those involved in the project), using iterative processes taking place over a number of "rounds", it is described as being flexible, getting beneath the surface of issues, useful for addressing difficult issues and more structured than conventional interviewing. It asks for reflection on issues that have been raised and addressed within the first round.

The use of focus groups and interviews for information gathering purposes as well as regular documentary analysis have added to the body of knowledge as have the volunteer inputs of observation.

As described above the Evaluation also made use of reflective processes and also retrospective processes. Retrospective processes focus on assessing the results of implemented decisions in relation to goals in order to find out if they were fulfilled, and identify if not, what needed to be done so that similar errors are not repeated.

Evaluation of the Healthy Living Centre

20:1 Enabling

There was evidence of the evaluation enabling others eg. Staff Member wrote a paper for publication on the Dentistry Service for the Homeless, a Resident Volunteer organised and ran a focus group for volunteers, a Resident Volunteer observed staff and communications within the project generally as well documenting the findings for analysis. Staff in post need to be seen and act as “enablers” perhaps rather than staff, to facilitate trusting and learning relationships with the community on the project.

20:2 The need for the community to work together

The Evaluation Team whilst mindful of the abundant literature surrounding staff skills and empowering and enabling residents, it was felt that an additional key focus should be on facilitating the community to work together using staff skills to develop community members in becoming able to work effectively together – with a focus on communication as a key theme as it became very apparent that the word community does not necessarily infer an effective, functioning, cohesive group of members!

As well as the variety of skills that the evaluators needed, used and developed for this project, the skills of negotiation were paramount. The importance of genuineness should never be underestimated when building and maintaining effective relationships.

20:2 The shared evaluation difficulties

The evaluators became aware through the constant review of the literature that it was difficult for all Healthy Living Centres to reach and engage with those “hard to reach” groups of the population and that it very difficult to measure long term impact of the centres in the traditional medical model framework of health benefits.

20.3 Funding

Budget considerations are crucial from the start particularly with regard to the *time* needed for true participatory evaluation. The staff evaluation budget should reflect the following:

- 1) Length of time taken to establish the necessary effective working relationships
- 2) Length of time taken to recruit Resident Volunteers
- 3) Length of time taken to review the literature on an ongoing basis
- 4) Time taken to be available for support, training, and facilitation.

20:4 Further opportunities for evaluation..

The evaluators were aware that comparing and contrasting much the project during the three year evaluation was made difficult because of the change in personnel and shift in the national health and social care contexts, and also that it would have been very beneficial for the evaluation to have been involved with the project from the beginning and to have had access to the newly established resident led projects for the purposes of evaluation.

Finally the evaluators took away this key message - within the Sharkey’s (2006) paper is that evaluators working within community programmes “need to have the skills to support stakeholder involvement so as it is a safe and satisfying experience for them, as well as identifying objectives for a programme evaluation.” (Sharkey, 2006 p.3).

Part 6 The Outcomes: An Overview

For the final few months of the evaluation, the staff members of the Evaluation Team focussed on the literature based on the evaluations from other Health Living Centres to mark comparisons and contrasts.

17:1 Impacts

The table below compares and contrasts the impacts of the Boscombe Evaluation findings with those at a national level – the Big Lottery Fund Evaluation.

Table 10 Comparing and Contrasting Impacts - The Final Evaluations from the Big Lottery Fund and the HLC Boscombe.

HLC Summary Impacts Big Lottery Fund Dec 2007	HLC Summary Impacts Boscombe 2008
HLCs help people to become healthier safeguard the health and well-being of their regular users	Evaluation feedback from participants attending all exercise classes and the "Lose Weight" sessions especially, demonstrated that there had been a positive impact on both physical and mental health - leading to life changes/gains eg. Employment, healthy eating, regular exercise.
Regular attendance at HLCs has a protective effect on physical and mental health, enabling the health of users to remain stable over an 18-month period.	Evaluation feedback from activities demonstrates that participants felt that there had been an improvement in mental health - eg. Relief from symptoms such as anxiety depression, and disorders with eating. Other effects described were boosted self esteem, increased social circle, and more self confidence.
HLCs provide activities that relate to current government objectives, particularly in areas such as exercise and diet, but also smoking cessation, coronary heart disease, HIV/AIDS, family support, and support for people with mental health problems.	This project successfully provided services aimed at increasing (and maintaining that increase) in physical activity for participants - both due to the provision of the classes themselves and also in motivating the participants to be more physically active in their everyday lives.
	The evaluation feedback from participants regularly cited improvements participants described "feeling better about themselves". Although there was no specific mental health focus (until the "Lose Weight: Gain Life" course) the activities provided also did impact on specific mental health conditions - participants described improvements, most commonly, in depression and anxiety disorders which concurs with current evidence about the impact of exercise on mental health.
HLCs successfully attract their target communities by combining health and social benefits in the activities they provide.	Participants reported health and social benefits from attending activities, especially the establishing of new social networks for fun and support, thus successfully reducing social isolation for many - especially females with young

	<p>families. The informal social gatherings for the local community were also appreciated eg. Meetings for volunteers, although social in nature, also provided the function of gathering the community to focus on issues relevant to the project and them.</p> <p>It was difficult at the outset for the project to target the most deprived areas within the locale.</p>
<p>HLCs use a variety of successful strategies to involve local people in project planning and delivery, enabling them to tackle the issues that affect their lives.</p>	<p>Residents were involved in the HLP Board and set up their own Steering Group for the project. However, although the local community were involved, it was clear that there was sometimes dissent as to what issues and services the project should/could provide. Involving and enabling became difficult at times to sustain effectively especially during times of conflict.</p>
<p>HLCs help people and organisations to learn, and help to build relationships within communities</p>	<p>During the final period of the project, several resident led projects were developed, Whole Food Co-op, Urban Evolution, Wheatgrass project, to name but a few. Support was provided by staff in terms of general business support, financial support and assistance with all the necessary financial and legal considerations and subsequent relevant documentation. General encouragement and support at a more personal level was provided also - the project successfully helped the above projects to begin and establish.</p>
<p>HLCs develop, improve and organise local partnerships and networks, building strong trusting relationships with the voluntary, community and statutory sectors</p>	<p>The project had to work continuously to establish good relationships with other organisations. Perceived historical difficulties about organisations had to be overcome and individual perspectives on what the project should be doing and the degree of involvement with other organisations had to be negotiated and agreed within the project itself. Time is needed to develop trust, by the end of the project, effective working relationships had been established, especially with the lead health organisation.</p>
<p>Much of the ongoing impact of HLCs will be dependent on the priorities of regional and national government policies.</p>	<p>The local health trust has successfully mainstreamed some of the project's activities and has developed a community and public health agenda to continue to work with the existing community groups and take forward the relationships and networks built since the Healthy Living Project's</p>

	inception.
Some key lessons from the evaluation include:	
Projects benefit from early and ongoing support for sustainability, self-evaluation and business planning.	In the early stages of this project (as with other HLC s nationally) evaluation was not considered from the outset with no support offered to do so. There was little support to establish ways of moving resident ideas forward to workable business plans or to foster the taking of risks both in individuals in financial risks.
Broad programme aims and funding criteria can encourage innovation in the way that projects engage with communities to tackle local problems.	The use of broad aims within this project, whilst encouraging innovation, also caused conflict, as broad aims and differing perceptions varied amongst those closely involved with the project and made shared aims and objectives a difficult vision to achieve.
Longer-term grants, of at least five years, are key to allowing projects to build trust with hard-to-reach groups, a process that takes two to three years.	These findings also acknowledged the shortcomings of time limited funding both in identifying long term impacts and also in fostering trust between the stakeholders involved AND hard to reach groups who were reluctant to engage and benefit from a service/activity that was ultimately expected to be withdrawn.
The sustainability of a project is improved if it has robust sustainability plans, a strong partnership, access to entrepreneurial and fund-raising staff, and the flexibility to adapt to changing local circumstances, government policies and funding opportunities.	Robust sustainability was not in place until the latter period of the project's life time. The issue of sustainability was perceived in this case as not just appertaining to financial matters but to individual capacity development also.
Effective partnerships require strong leadership, a clear direction and enough funding to support the initial set up.	The project manager appointed later in the project showed strong leadership and successfully role-modelled entrepreneurial thinking and processes for residents in taking their ideas forward. There was clear evidence that the project demonstrated flexibility as it adapted to developing resident led projects whilst encountering local organisational changes in response to national changes in the delivery of health and social care.
	The key role of the project manager has been described elsewhere in this paper - but the evaluation was able to clearly demonstrate the importance of this key role to the project.

17:2 Boscombe Project Outcomes compared to National HLC Outcomes

The Boscombe project had its own feedback system and evaluation (comments book and evaluation

forms) for various activities, they regularly highlighted the benefits participants gained from regular attendance at the exercise classes and other shorter term courses provided by the project eg., weight loss classes and cooking classes. Similar to the Big Lottery Evaluation, there were reported positive impacts on physical and mental health, an increase in physical activity, improved diet and more positive perception of health and quality of life. The greater benefits were seen in those who attended activities regularly. As has been described nationally, it was very difficult to provide clear evidence as to the project directly improving health for specific health conditions.

There was concern at times at the low numbers of attendees at activities however this has been noted from the national evaluation, whereby the numbers attending could range from a handful to hundreds. The Boscombe project also recognised that the beneficiaries of the project are not only those who attend activities, but those who attend classes and training and are thus able to pass on the benefit to others.

Unlike the national evaluation, the Boscombe project evaluation raised concern that the HLC had not reached those within the community with the greatest health needs, it is acknowledged nationally that to do this successfully is a challenge.

17:3 Comparisons in Approaches

Within the Big Lottery Final Evaluation most surveyed HLC managers were described as happy with their success in reaching their target population, the evidence from the managers within the Boscombe project also felt that they had achieved as much as they could with regards to reaching their target groups. The successes achieved in much the same way as reported by the BLF Evaluation – see table below.

Table 11 Healthy Living Centres - Comparisons in Approaches

Big Lottery Fund Evaluation - What other HLC s were doing...	Boscombe Healthy Living Project - what they were doing.....
Using new or innovative methods	Training volunteers to become qualified instructors in exercise to run the classes. Pump priming of community projects eg. Food co-ops, wheatgrass enterprise. Introducing health walks and trails for families to participate in.
Tailoring services to the needs of the specific target group	Volunteers participating in foot-care for the homeless. Creche available for mothers using activities. Adding evening yoga classes as requested.
Using diverse approaches, and partnership working	Working with a local night shelter to provide foot-care for the homeless. Outreach work. Volunteer working with a large supermarket chain to redistribute food to the homeless. Using voluntary and community organisations with close contacts to the targeted groups to provide services or encourage use of HLC services eg. Neighbourhood management, Brendoncare Students from the university on secondment to the project were involved

Delivering services in appropriate locations for the target group.	and reported feeling valued as members of the project.
Using an holistic approach to health	Exercise classes run in locations close and accessible to the local community. Addressing social and economic factors affecting health eg. Providing training, providing social activity, providing financial help and business advice, providing emotional and social support/encouragement.

Social Activities

This evaluation recorded that a success of social activities was that they “hooked” in the local community to consider engaging further in the healthy activities provided. The Boscombe project organised social gatherings to tackle social isolation in disadvantaged groups, both to provide social contact and establish meaningful contact.

Access to Health Services

The use of non medical centre/locales was appreciated by attendees, especially those who were homeless attending the podiatry and dentistry services. They reported feeling stigmatised when attending “regular” health facilities, but after experiencing the health benefits on offer, the increase in self confidence (especially improvements in dental hygiene) and self esteem provided the impetus for them to engage and benefit from in mainstream health services. Again this is a feature noted within the Big Lottery Fund Evaluation.

Employment

With regard to obtaining employment as reported in the national evaluation, the Boscombe project evaluation itself, “lost” volunteers to employment opportunities. The volunteering opportunities and training offered by the project provided further positive benefits to confidence and self esteem for attendees, as well as practical advice on job applications and processes.

Healthy Living Centre “Visibility”

A constant difficulty for the Boscombe project was their seeming difficulty in becoming recognised within the community. Similar to other HLCs, newsletters, websites and leaflets were used to advertise, however by the project end it was still felt that this was not enough, albeit nationally, “word of mouth” was also the most common method as to how projects became known to users.

Engagement

Another persistent challenge for the Boscombe project seemed to be engaging effectively with the local community, conflict was commonplace and reported within various evaluation documents. TRUST was identified several times by the Boscombe project as being crucial to its success – however at times, this continued to remain elusive. As the national evaluation suggested however, this may be due to previous historical difficult working relationships with partners. As the project staff and management changed, the need for persistence, patience and flexibility and a difference in approaches for the groups was embraced with some success. The manager and project staff organised informal gatherings and went out (outreach) to meet with the various linked projects to offer support and guidance. The Project office continued to be seen as open, welcoming and helpful.

Community Capacity

The success of the “pump primed” projects established in the final stages of the project can be traced to the approach adopted by the Board and staff of the project best summarised by a quote from the national evaluation. ‘...getting to know people, getting to know what they are interested in, getting them to support and understand what they are trying to do, and getting them to develop a sense of ownership of things that they may get involved with which also then brings other people on board.’ (Big Lottery Fund, 2007). This quote summarises the support offered, the risk taking involved, and encouragement for community members was needed for success. The successful projects then moved on to become independent and manage their own projects and volunteers.

This approach can be seen as building community capacity, which the project had attempted to do from the very beginning. Examples are employing community members as staff and volunteers, members of the community chairing the management board and steering group, and latterly the independent applications for funds. There was however a lack of training and mentoring put in place to support this from the beginning of the project, eg perhaps professional volunteer training or specific training such as in committee skills would have been beneficial.

The national evaluation notes that ...”in some cases new services are created and sustained by local people. Food co-ops and walking projects are particularly suited to community control, perhaps because people enjoy the social aspects as well as appreciating the direct health benefits” (Big Lottery Fund, 2007) This was the case within the Boscombe project, the feedback from the Physical Exercise initiatives regularly recorded these positive benefits as experienced by attendees. The food co-op came into being in the final stages of the project, and was being run independently under a Service Level Agreement by the project’s end.

Shared Challenges

Nationally, two main challenges are reported which were shared by the Boscombe project.

Firstly, developing community relationships and building trust took a significant amount of time for projects, and projects felt that these should be recognised as outcomes in themselves. Instead these activities were under-emphasised in comparison with the collection of evidence about people being involved in health-related activities. This was certainly true of the Boscombe project where the initial key evaluation parameters were deemed to be of a quantitative nature and outputs only. The results of this were a cause for anxiety with regard to sustainability issues and funding for activities after the project ended – again this concern was similar to the national evaluation and thus shared by many of the other Healthy Living Centres.

Secondly, nationally it was reported that some HLCs found difficulty in persuading local people or users to take on leadership roles, perhaps expectations about what could be achieved within the timeframe may have been too high. For the Boscombe project, there was considerable difficulty in engaging the wider community beyond those community members who remained committed, for reasons difficult to establish beyond anecdotal suggestion eg. Fear of other members of the community, fear of ridicule/failure, and lack of confidence.

Reflection back to the successful precursor the ACHIEVE project draws attention to the following recommendations.

- 1) Practitioners may need new skills to work with and listen to local residents, and these skills need developing.
- 2) Managers and practitioners need to recognise and support risk taking, both their own and residents.

These recommendations are also applicable to the current Healthy Living Project with additional proposals.

1. **Working with and listening to residents is also key for *other residents* to take on board, regardless of their level of involvement in the project.** The need to have a capacity building/development programme in place to address this is essential and needs to be available from the start of any project.
2. Key project personnel must *already* possess these skills to enable others’ development in this area.
3. Project staff with key residents and/or Board members (ie. Individuals who are involved in project

decision making) need to recognise and support risk taking, in terms of investing money or investing in people. This also means risk taking for the individuals involved in the making of those decisions and suggests the need for a supportive and encouraging environment in which to do so.

17:4 Contrasts and Comparisons with other *Local* Evaluations

Letting go...

Similar to the report from the South Wye Healthy Living Community Evaluation, the Boscombe Project Manager was able to let go of projects, support as and when required and also suggest termination when necessary. This allowed for the initiation of new, autonomous community based systems to develop also with spin off initiatives. This enabling approach was evidenced by the increased knowledge, ability, and capability of involved residents and there was an overall change in outlook expressed by those involved with the project, a more positive outlook than had previously been identified.

Long term impacts v Social Capital

The evaluation of Healthy Living Barnsley also generated a considerable amount of rich data through its evaluation processes, however, similar to findings within the Boscombe project, their conclusion suggested that it was difficult to “move beyond the rich accounts of the individual experience to a more generalisable picture of the effect of ...Healthy Living Centres ”(South Wye Healthy Living Community, 2005). The issue of measuring long term impacts was clearly a problem for HLCs generally. Having stated that however, it would appear from the literature that positive long term impacts can be suggested through the understanding of Social Capital – Healthy Living Barnsley reports “Social capital contributes to health and prosperity both at a regional and neighbourhood level” (Evaluation of Healthy Living Barnsley, 2004). The aforementioned evaluation also had difficulty in recruiting volunteers to their project.

Engagement

The St Augustine Healthy Living Evaluation highlighted the need to engage with the community right at the outset of the evaluation, for this project it is suggested that progress may have been made sooner if the evaluation had been integrated with the project from the start. The evaluation refers to “experts” involved with the evaluation needing to have listening skills and perhaps patience to allow for others’ skills development in order for them to participate meaningfully in the evaluation. The Boscombe evaluation certainly listened to others, often with some difficulty given the differing opinions and emotions expressed! – and also provided the support, training and development opportunities for resident volunteers to participate meaningfully and to good effect within the evaluation, time was certainly the key, working with the residents own time scales and time available. Resilience was an attribute described by St Augustine as essential for project members to have as there were, as indeed for this project, many obstacle, usually in terms of perceived “red tape” to overcome, as well as creativity in the use of funds, which the Boscombe project certainly had in the development of resident ideas, albeit only latterly.

Socialisation/Direct Health Benefits/Ripple Effects/Breaking Down Barriers/Efficacy

The Dundee Healthy Living Initiative (2005) reported, similar to the Boscombe project, that providing social access to the project (teas, social gatherings) opened new social networks for residents and reduced social isolation. The aforementioned project also highlighted the direct health benefits of explicit activities provided, within the Boscombe project, the exercise class feedback reported direct benefits to health for individuals as well as the importance of reducing social isolation, especially for mother with young children and the availability of the free crèche.

The “ripple effect” described within the Dundee initiative ie. Beneficial effects of service/activities on individuals influencing their friends and families, also occurred within the Boscombe project pertaining to the cooking classes, whereby feedback reported that healthy eating and cooking had benefited entire families as a result of the main carer/parent attending the classes. The cooking classes also achieved the objective of breaking down barriers by providing the sessions at a suitable locale and time, and cost NOT being an issue.

The exercise classes demonstrated the shift from self efficacy to group efficacy as described within the

Dundee initiative, as responses from the exercise classes demonstrated that individuals who felt they had benefited from the classes went on to encourage others to take part to experience the same health and social benefits. The successful breaking down of barriers for these classes by the provision of perceived “non-threatening” physical activities, providing a free crèche and not requiring expensive clothes etc. to take part.

The Boscombe project also mirrored the Dundee initiative, in its latter approach to developing team working amongst the staff and partnership working with other organisations to good effect for the project as a whole as it then opened up avenues for the resident members to become involved within the project. This involvement of residents contributed to fostering trust within the project, which previously had been lacking, perhaps partly due to (as reported within other evaluations) as a result of cancelling or stopping activities or taking residents’ ideas forward (perhaps for good reason although not perceived that way!).

Supervision, support and guidance for staff is essential for managing these relationship issues effectively for themselves and the good of the project as a whole. Supervision would also provide the opportunity to fully understand the roles others play in the project, and foster interdisciplinary working with an acceptance of differing attitudes and perspectives eg. A move from the staff roles fostering dependence in individuals and taking on a more enabling and empowering role. As Lewis (2005) suggests, this is a very difficult to overcome and, certainly for the Boscombe project provides an insight into the stresses and strains experienced by the first project manager and lead for the Trust.

Overview

The three Healthy Living initiatives described all reported the difficulties for their projects as all the service/activities were known to be funded for a short term only before the true long term benefits could be seen. The Dundee initiative suggests that for successful collaboration within the project and with other organisations there needs to be:

- a) Clear and shared objectives
- b) Consultation with all parties involved
- c) Clear role specification
- d) Commitment from all
- e) Ongoing effective communication

Through the course of the Boscombe evaluation, the above needs were also identified, with communication being the most important feature.

Validation for the evaluation methodology can be seen to come from Dundee initiative report which states that “A recent NHS Scotland guide states , where outcome measure have been developed in conjunction with the communitythen studies which address feelings, attitudes and experiences are as important as reviews of effectiveness.” (Lewis, 2005). This project shared the difficulties of other healthy living projects in finding it difficult at times to target areas and hard to engage groups as well as those with specific conditions – those with mental health conditions were frequently cited. It was mooted at various Board meetings that the solution to this would be, as the literature suggested that the project needed to go out TO those members of the community rather than wait for them to approach the project eg. Going out to local clubs and pubs etc. this however was not taken forward. The local presence of the Boscombe project as an office in the heart of the community, and having staff and residents who had an intimate knowledge of the local community, meant that the Boscombe project became responsive to locally identified needs. The working knowledge of other local organisations, both statutory and voluntary, ensured streamlining of provided activities and avoided duplication. This knowledge also could be seen to extend to individuals, whereby the suggestions as to who could fill the vacant project manager post was successfully made and supported by a Board member.

Final comment

For the evaluators, a key note from the Dundee initiative addressed the behaviours of members of the project. Lewis (2005) states “It is part of the community development approach to challenge aspects of behaviours....and to encourage group members to take ownership and raise issues with one another” (Lewis, 2005, p.56). The evaluators found it difficult at times to be successful, immersed, evaluators with negotiation skills to avoid being (or at least perceived) as put in the position of managing others’ behaviours, and it took considerable mutual reflection and support to effectively ensure that the project itself was encouraged to address undesirable behaviours in its members.

18. Outcomes and the Literature- Social Capital

18.1 Key empowerment concepts

Upon reflection it became apparent to the evaluators that, by and large, most of the evaluation outcomes addressed community development, which saw a change in focus from some of the original aims and objectives of the evaluation.

The table below highlights the links between key empowerment concepts and introduces the social capital factor for community development.

Table 12

Key Concept	HLC Link to Reduction in Health Inequalities
Social Capital: refers to the networks and trust between people, significant in combating social exclusion and providing a base for long term economic development	Social capital build links within communities that strengthen their ability to identify and realise their health potential.
Capacity Building: development work that strengthens the community’s ability to build structures, systems people and skills so they are better able to define and achieve objectives.	It develops the skills and uses the assets of marginalised communities. It helps them articulate their concerns and find practical ways of addressing health concerns.
Social Inclusion: Concerned with countering assumptions of dependency. It is rooted in an understanding of citizenship that sees people as having the right to influence and participate in decisions that affect them and to have views and experiences listened to.	Links here are expressed in terms of indicators, such as infant mortality and life expectancy - GMD2 Indicators.

(adapted from Lewis S 2005)

18:2 Social Capital

Underpinning the theme of user involvement within the Healthy Living Project itself as well as the evaluation, is the concept of Social Capital.

Morrissey at al (2002) state “that funding is not just about financing an organisation to deliver specified targets, but is also an investment in its capability. In this sense, capability is about positive relationships with the relevant community, about flexible and adaptable problem solving and long term sustainability.” (Morrissey at al 2002, p.4) The Healthy Living Project in the last 2 years invested heavily in the community

in providing financial and business support for community led projects. These projects were brought to the Board from the community having identified a need and clearly stating where the benefits and outcomes lay measured against local health improvement targets. Eg. Boscombe Wholefood Co-operative.

The staff worked with the community members in negotiating Service Level Agreements and process monitoring, as well as expected outputs and budgets. Over time a positive relationship was established between the staff, community members, and other community networks and organisations. As a result of this a further project was established, an independent “umbrella” organisation, Urban Evolution wholly managed and run by the community. The success of these projects would appear to be a result of what is termed “social glue” – the degree to which people take part in group life; the level of trust people feel when participating in such groups;” (Morrissey et al, 2002, p 5). This appeared sadly lacking in the early years of the evaluation as were “social bridges” which are described as the link or connections between groups and which give access to wider groups of players outside of their area/specific interest group” (Morrissey et al, 2002, p5)

Fig 2 The Three Components of Social Capital (adapted from Morrissey et al 2002, p.12)

The above figure highlights the 3 components of Social Capital, and using this model it can be seen where issues arose within the early years of the project. Linking capital in this case had possibly two funders, the Big Lottery Fund and the local health Trust. The Trust was involved from the start in the original bid and was the administrative organisation for finances. Perception of the funders’ role was often confused and sometimes seen as restricting movements within the project. “Bridging” saw conflict emerge from time to time as project members/participants were also involved with other local organisations perhaps with different priorities, again confusion often occurred. Towards the end of the project however, clear networks and true partnership working emerged with the other organisations. “ Bonding” became more difficult to assess and evaluate due to the inherent nature of the process, as the community became more capable and independent, contact was reduced and limited with the project staff and members of the Evaluation Team. It would seem reasonable however, to assume that a degree of bonding must have taken place to achieve the successful independent project outcomes. As stated previously however, the issue of trust, remained a challenge for the project albeit to a lesser degree by the project’s end.

In summary, it could be argued that the project community members and staff enabled bonding, bridging, and linking by for example, empowering, providing infrastructure, being and allowing accessibility, promoting connectedness and engagement, being innovative, and using resources and influences usefully (Morrissey at al, 2002). The project as well as the community members developed willingness over time to try new ideas and new ways of working. The evidence for this can be found within the evaluation processes and the set monitoring tasks. Eg. The numbers of attendees at training courses and personal development workshops increased with appropriate certificates awarded (Food Hygiene). The feedback from the questionnaires highlighted the personal benefits from the exercise classes as well as the establishing of new social networks, plus clearly demonstrating the improved relationships within the project itself amongst community members, staff and other organisations.

The documentary analysis provided evidence for the addressing and tackling issues eg. Behaviour and communication within the project (Communications Policy and evaluation of the same) and the Board papers track the evidence for ideas proposed, developed and often ultimately realised including relevant

correspondence from other organisations wishing to work with the project.

The concept of Social Capital can be seen as another theme for evaluation beyond the scope of a monetary or health/emotional cost and benefit analysis akin to an unexpected added value for the project.

19. Evaluation Participation - Challenges

Effective engagement and participation within the project took time – this again was a feature of the ACHIEVE project. It took approximately 6 months to establish working relationships within the project, with staff, the Board, residents and wider community. It was complicated by perceptions of what the evaluation was. As expected, there was the perception that it was an outside “monitoring” body, set out to highlight failures generally and failure to meet targets, rather than a means to achieve the targets. This perception was articulated at meetings and through formal and informal meetings with the project and the evaluation staff.

Platt et al (2005) articulate within their evaluation of HLCs in Scotland that existing plans for HLC evaluation and monitoring processes were not well constructed, and the outcomes of their activities were difficult to conceptualise, identify and measure by staff (Platt et al, 2005, p3). As was found within this project there was a focus on measuring and reporting activities and intermediate outcomes which were estimated as indicating impacts on health. These differing perceptions as to monitoring and evaluation were addressed as the relationships between the project and the evaluation were being established.

The time necessary to build effective relationships, establish collaborative working groups, and recruit resident volunteers took considerably more time than expected. The budget did not have this built in to the set agreed timeframe, and the researcher(s) from the University had to increase their hours to meet the set evaluation targets. This time was spent in formal and informal meetings with all those involved with the project, gaining an understanding of the varied perspectives both of the project itself and the evaluation. Resident involvement for the evaluation was a difficult challenge. The ACHIEVE project highlighted that it “took time for residents to feel that they were involved.” (Hemingway et al, 2004). The initial issues expressed from residents concerned experience and ability to be involved in the evaluation followed by financial aspects, impact on benefits (for those on low or no wages) and childcare issues. The Evaluation Team addressed these issues by identifying and negotiating with residents a suitable time and place for all meetings with children welcome. The evaluation staff tried to be as available and approachable (with contact details) for residents to discuss any queries/worries residents may have had. The staff discussed individual strengths as well as training and development opportunities for residents to foster confidence and a sense of ability. Payment for involvement in the evaluation was made as flexible as possible and included options such as cash, food vouchers, book tokens and child care payments.

An unexpected issue for residents becoming involved in the evaluation concerned perceptions that other residents who were not involved may develop in relation to them. Involvement in the evaluation for residents was felt to be, by some, as perhaps having an impact on their working and personal life should other residents view their involvement in the evaluation with misunderstanding possibly even giving rise to conflict. A few interested residents withdrew from the evaluation citing this as a reason. The staff of the Evaluation Team were aware of this issue and made it clear that support and guidance would be available – however, it would not be possible to eradicate, or control conflict between residents should it occur. **This is a key finding not only for the evaluation for community working in general. It builds into the concepts of linking, bridging, and bonding and community cohesion, which for this project, the evaluation could promote but cannot, and should not, control.**

An unexpected, but key, expectation from the project was that the evaluation had the power to change the project. The first round of questionnaires raised evidence that the evaluation process was seen by some as a means to provide leverage for changes, and perhaps a means to shift responsibility for those changes from within the project to without ie. To the Evaluation Team. Whilst it is reasonable to suppose and make use of evaluation findings in this way, the driver seemed at that time, as expressed in the questionnaires, was that the Evaluation Team look for and direct findings to effect prescribed changes that individual

project members felt were necessary. It was a challenge for the University members of the Evaluation Team to both participate and immerse themselves as necessary to fully take part in a participatory evaluation but to be able to disseminate findings *without* a prescription for action back to the project as it was essential in the early stages of the evaluation that the HLC board members developed the skills to respond to the evaluation findings themselves. The Evaluation Team struggled at times with the conveyed sense of disappointment from the project that no action was being dictated, despite the fact that findings were regularly being fed back to the project for **their** decisions on action to be taken. Despite this approach however, some suggestions and skills were offered, eg. A follow-up “Away-Day” for the project to focus on communication, and processes/strategies for developing community ideas for projects. This was not taken up.

19.2 Evaluation Participation – What the evaluators learnt

For the staff evaluators, the Healthy Living Project provided many challenges and subsequently lessons learnt.

First of all the staff evaluators had to be clear, and make it clear to others within the project as to what their role was. Reflection and supervision from others, in this case senior staff within the University, were the key to this. The reflection process addressed role merging and highlighted potential “problem solving” or “rescue” behaviours from the staff evaluators. This strengthened focus and the need for setting, maintaining, and reinforcing boundaries.

The need for effective communication became clear as was the need for clear, open and transparent working. This was to ensure that there was understanding, and also to make clear that there was the same expectations from others within the project.

Within a wider context, it became apparent through the literature search, that the Big Lottery Fund did not consider support for evaluation of the Healthy Living Centre initiative was necessary and this was, for many projects, a much needed afterthought as they were later asked to provide evidence of their impacts on individuals and communities. This added pressure to projects as evaluation was seen as able to influence further funding. As Platt et al (2005) report “Lack of expertise and knowledge of evaluation among the HLCs, combined with the lack of ring-fenced funds available for evaluation, compounded these difficulties.” (Platt et al, 2005, p3)

The table below is adapted from the UK Evaluation Society Good Practice Guidelines (2006) and provides a useful framework for identifying lessons learnt for the evaluators.

Table 13 What the Evaluators Learned

Building Relationships within the Project	Cultural Information is necessary	How the evaluators are perceived by others	Unexpected skills/attributes required for evaluators
There is a need to establish effective trusting relationships with the project – beyond the expected traditional expectations	There is a need to truly understand an embrace a community project’s “uniqueness” and where/how perspectives and goals are developed and developing.	There is a need to be aware of how others may view not just the evaluation itself, but the evaluators. May be perceived as an insider, or confidante, someone who may	The evaluators need to be approachable, friendly and contactable. The ability to see opportunities to obtain further additional data either quantitative or qualitative – ad hoc at times. The ability to remain

of working relationships .	There is value in socialising and being open to what may appear only gossip and rumour.	breach confidentiality, someone to act as sounding board, or as a colleague.	external despite the pressures of being immersed in the project (supervision being the key tool required).
Use formal and informal chats, emails, impromptu meetings.	There is a need to be aware that others may feel threatened by the process of evaluation and the evaluators, or indeed that it is a waste of time.	May be perceived as in a therapeutic role!	The ability to remain independent of the project despite immersion.
There is a need to respond genuinely and appropriately to individuals and groups in context.	We needed to be aware of those people who have emotive reasons for becoming involved in the evaluation (and can therefore react emotionally to proposals and decisions) and manage what emotive discourse arises - often personal in nature.	May be perceived as an arbiter of disputes, or as an advocate, or advisor.	There is a need to constantly review and update the literature searches - otherwise the original literature review may be very out of date! Also necessary for writing up the final paper.
	We had to remain focussed on addressing core concerns should challenges and issues arise, and not become embroiled in a myriad of irresolvable issues to the detriment of focussing on the evaluation.	Evaluators may be perceived with suspicion and mistrust - the evaluation seen as a test that must be passed.	There is a need to record and document information at all times - this allows for clarity, avoids conflict and can track changes in the project over time.
	We found it difficult at times to understand the politics and dynamics of the project!		Effective filing of ALL information is vital for retrieval purposes and to ensure confidentiality ie. Confidential documents are locked away.
	The project lead was a senior		Mutual trust and support was essential between the evaluators.
			The money, time, and evaluation methods, must fit into the budget. There difficulty in recruiting volunteers for the evaluation which Influenced the above - there difficulty conveying this information at times to the project.
			We found it very difficult to always fulfil the role of negotiator - especially with regard to Sharkey's (2006) suggestion the role of the negotiator/evaluator should "set and maintain a positive climate in which concessions can be made and, eventually

	<p>academic which was crucial to the perceived credibility of the University Staff on the Evaluation Team.</p> <p>"Time" often meant different things to those involved in the evaluation and project: we had to communicate and how and why time was necessary for evaluation processes and be explicit about the actual time needed for tasks. We also found we didn't understand time eg. that "will get back to you" "will send it to you" may have an open ended time frame whereas we had attached a non expressed/negotiated time span in our heads!</p>		<p>a settlement can be achieved".</p> <p>We had to be sensitive to situations, in meetings for example (effective reading of verbal and non verbal clues), where attitudes such as defensiveness were conveyed by stakeholders, by recognising that this could be due to feelings of threat or feeling "out of their depth" - and respond by reframing perspectives and information. This also included not highlighting work not completed for the evaluation by individuals. It was very difficult however to remain detached and focussed and not become involved in project group dynamic issues.</p> <p>Mediation skills were necessary at times!</p> <p>Be genuine at all times.</p> <p>A sense of humour is absolutely essential! - and often used in mediation, discussion and negotiation.</p>
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(adapted from Platt et al, and Wainwright 2002)

The evaluators also learned that it was very difficult to communicate to others both within the project and externally that identifying a causal relationship between a particular activity and a particular outcome is often difficult or impossible especially with regard to long term impact – indeed any changes may even only be apparent after the project has ended (Wainwright 2002). It was also difficult to convey that whilst the original set aims and objectives both for the evaluation and the project itself should remain in focus, there needs to be flexibility in order to capture unexpected outcomes and avoid wasting valuable time and effort on redundant or unachievable objectives.

Time

The time involved in working on this type of evaluation was considerably more than had been envisaged and reflected in the original plan. The evaluation lead was considerably more involved in supervision, liaison, facilitation/negotiation and general management of the project than had originally been projected.

The use of the following second table identified further lessons learnt for the evaluators.

Table 14 Comparing UKES Guidelines with the Evaluators Lessons Learnt

UK Evaluation Society Good Practice Guidelines : recommend for Evaluators	What We learned as Evaluators
To be explicit about the purpose, methods, intended outputs and outcomes of the evaluation; be mindful of unanticipated effects and be responsive to shifts in purpose.	There is a difference between being explicit and thinking we are understood! - thus, there is a need to communicate clearly. It can be difficult for stakeholders, funders and community projects to be able to respond to shifts in purpose as a result of the evaluation.
Alert commissioners to possible adjustments to the evaluation approach and practice; be open to dialogue throughout the process informing them of progress and developments.	We aimed to be as open and transparent as possible maintaining open dialogue - but external organisational changes nationally and locally often meant re-establishing relationships and made responsive changes within the evaluation a source of dissatisfaction.
Consider whether it is helpful to build into the contract forms of external support or arbitration (should the need arise).	Whilst arbitration was not necessary - supervision and support was essential from an external source and also from each other.
Have preliminary discussion/s with commissioners prior to agreeing a contract.	Although this took place, over time the agreed objectives etc. became open to interpretation and their ambiguous nature contributed to some degree of conflict within and without the project.
Adhere to the terms agreed in the contract and consult with commissioners if there are significant changes required to the design or delivery of the evaluation.	There were no significant changes that needed to be made, however agreement over minor adjustments were difficult to achieve at times.
Demonstrate the quality of the evaluation to other parties through progress reports e.g. on development and financial accountability and adhere to quality assurance procedures as agreed in the contract.	We did this through regular reporting to the Board and did our best to ensure findings/reports were made available in the public domain - this was often difficult to achieve however as there was a perceived fear that the reports reflected unfavourably on the project.
Be aware of and make every attempt to minimise any potential harmful effects	We learned from residents and our volunteers on the

<p>of the evaluation prejudicing the status, position or careers of participants</p>	<p>evaluation that their participation on the evaluation caused conflict for them within the community - this needs to be addressed at the outset with support, guidance, information and supervision provided on an ongoing basis to interested/participating residents and to be always available if needed.</p>
<p>Demonstrate that the evaluation design and conduct are transparent and fit for purpose.</p>	<p>We involved residents and staff in the design of the tools although consensus was often hard to reach as to the most appropriate tools - often as a result of differing agendas as to what should be evaluated.</p>
<p>Demonstrate comprehensive and appropriate use of all the evidence and that evaluation conclusions can be traced to this evidence.</p>	<p>All information, drafts, paperwork etc. is available for audit if required. All the literature used for the reviews and searches are available also.</p>
<p>Work within the Data Protection Act and have procedures which ensure the secure storage of data.</p>	<p>We made use of locked filing cabinets and used passwords to protect data on computers. Any transfer of material via email was through organisational secure networks.</p>
<p>Acknowledge intellectual property and the work of others.</p>	<p>Clear indication (within formal documents presented to the Board and others) was made to as the contributions made by staff and our Resident Volunteers - made either verbally or in written communication/data collected. We were unsure as to whether our material was being used for other purposes.</p>
<p>Have contractual agreement over copyright of evaluation methodology, findings, documents and publication.</p>	<p>Agreed at the outset.</p>
<p>Write and communicate evaluation findings in accessible language.</p>	<p>We aimed to communicate clearly and effectively and work in a clear and transparent manner - however, we struggled to prepare written documentation and papers in plain English. Aware of this we attempted to recruit residents to assist - but were not successful</p>
<p>Agree with commissioners from the outset about the nature of dissemination in order to maximise the</p>	<p>Agreed at the outset. Presentation was made at a conference in April 2008.</p>

utility of the evaluation.	
Demonstrate a commitment to the integrity of the process of evaluation and its purpose to increase learning in the public domain.	We continued to remain focussed on effective evaluation within the time, people, and financial constraints present to ensure robust findings - this was often difficult to communicate to others who did not always understand the limits that were imposed. We also had to check and ensure findings were released into the public domain.
Be realistic about what is feasible to achieve and their capacity to deliver within the time-scale and budget agreed.	We achieved this and beyond - 6 months was available for write up of the evaluation however funders asked that it be made available within 3 months.
Know when to refuse or terminate an evaluation contract because it is undoable, self-serving, or threatens to undermine the integrity of the process.	At times of intense conflict within the project and the evaluation we did consider withdrawing as we did not feel able to evaluate effectively as our roles had become confused and blurred. Effective supervision however clarified focus and re-set boundaries which enabled us to continue and move forward.
Be prepared to argue the case for the public right to know in evaluation in specified contexts.	As described several times in the above paragraphs!
Treat all parties equally in the process of the evaluation and the dissemination of findings.	We feel that we did so - evidenced by our working in an open and transparent manner - the second round of questionnaires asked open questions about the evaluation/evaluators - this issue did not appear in any of the responses.

<http://www.chs.med.ed.ac.uk/ruhbc/>

19.2 Evaluation Participation – Lessons Learnt for Commissioner/Trust

Rankin et al (2006) also suggest guidelines for commissioners within their paper.

To ensure good practice in evaluation, it would be helpful if Commissioners:

- 1) Acknowledge the benefits of external, independent evaluation.
- 2) Operate fair tendering situations in which competitors ideas are not exploited or intellectual property misused as a result of commissioning.
- 3) Hold preliminary consultations with all parties to the evaluation to support a relevant, realistic and viable specification.
- 4) Specify the purpose and audience(s) for the evaluation with appropriate background material to

encourage relevant tenders.

- 5) Operate a tendering procedure that is open and fair ensuring that appropriately qualified assessors are involved, making explicit criteria upon which a tender decision will be made.
- 6) Clarify the constraints that commissioners operate under, e.g. timescales, budgets, deadlines, and accountability.
- 7) Adhere to the terms agreed in the contract and consult with evaluators and other interest groups if significant changes are required to the design or delivery of the evaluation.
- 8) Specify the legal terms and responsibilities of the evaluation in the contract.
- 9) Match the aims and potential outcome of the evaluation to the knowledge and expertise of the potential evaluator(s).
- 10) Provide access to documentation and data required for evaluation purposes.
- 11) Establish clear principles for the reporting and dissemination of evaluation reports funded by public monies, consistent with acknowledged procedures which ensure quality evaluation and reporting.
- 12) Have realistic expectations on what an evaluation might provide including sufficient time for evaluators to respond to an initial invitation to tender and produce a proposal.
- 13) Include experienced evaluators (who are not potential applicants for funding) in initial drafts of evaluation specifications, including feasible budget and realistic timescales.
- 14) Have trust in evaluators and mutual respect between participants, commissioners and evaluator(s).
- 15) Take advice of evaluators on research methodologies for collecting and analysing data.
- 16) Communicate openly and have respect for people involved in the evaluation and keep the Evaluation Team informed of changes in circumstances affecting the evaluation.
- 17) Recognise where evaluators need to keep their sources of information anonymous.
- 18) Preserve the integrity of the findings, e.g. by not quoting or publicising such findings out of context.

PART 7

20:4 The key points of learning from the evaluation focused on the following areas:

- 1) Effective communication within the project, with the local community, and partner organisations needs to be viewed as a key process and outcome of community projects.**
- 2) The skills that key staff need to bring with them to the project when they are appointed.**
- 3) The skills that community members need to be facilitated to develop in order to be involved effectively.**
- 4) Effective management and support including policy and process development to support the projects smooth functioning and audit of activities and achievements.**
- 5) Skills of the lead organisation in establishing well supported key staff posts, and managing community involvement, skills development and effective communication.**
- 6) A focus on effective processes to enable measurable outcomes needs to underpin the design of projects from the point of bidding for funding and agreeing project aims through to the evaluation and planning for sustainability of community projects.**

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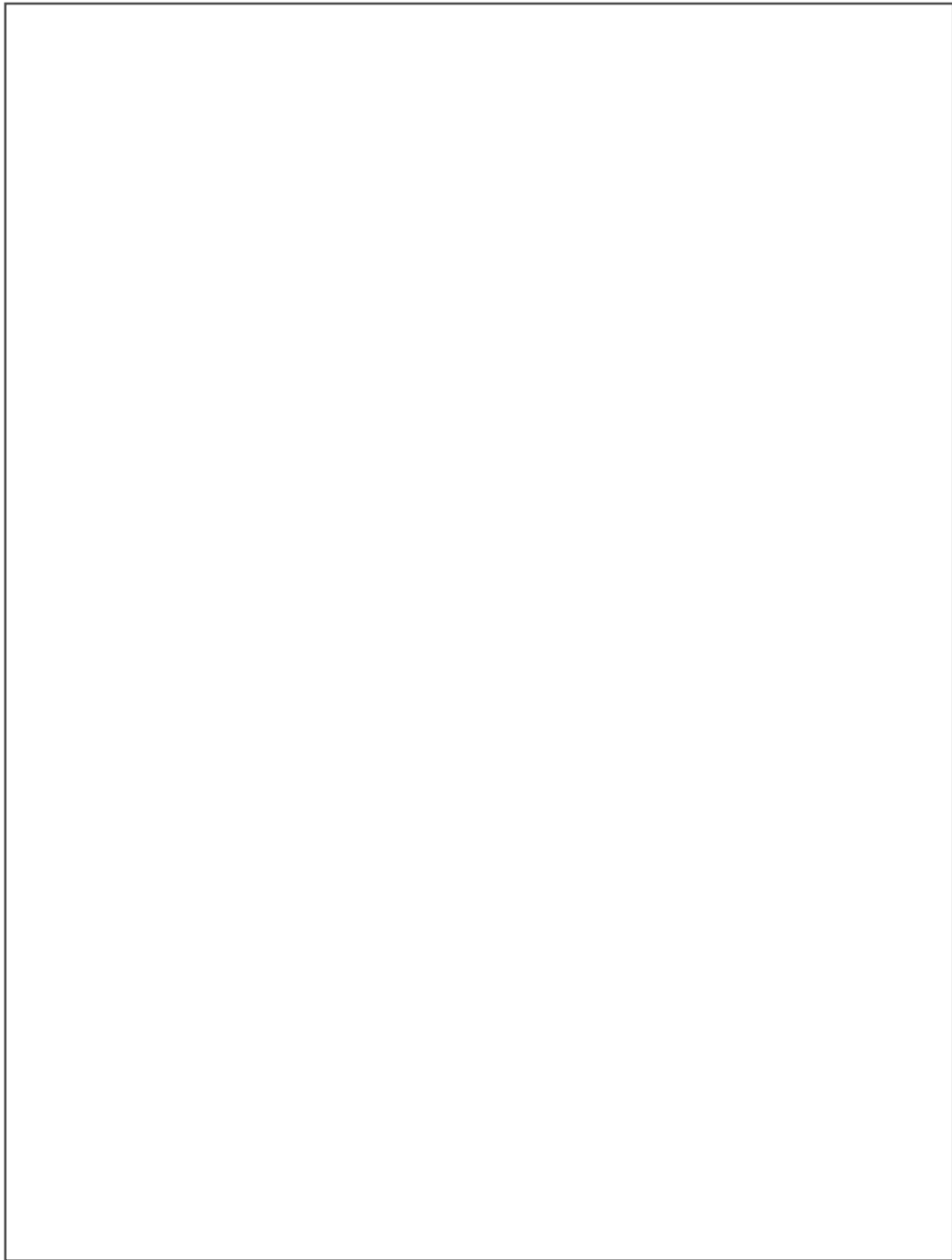
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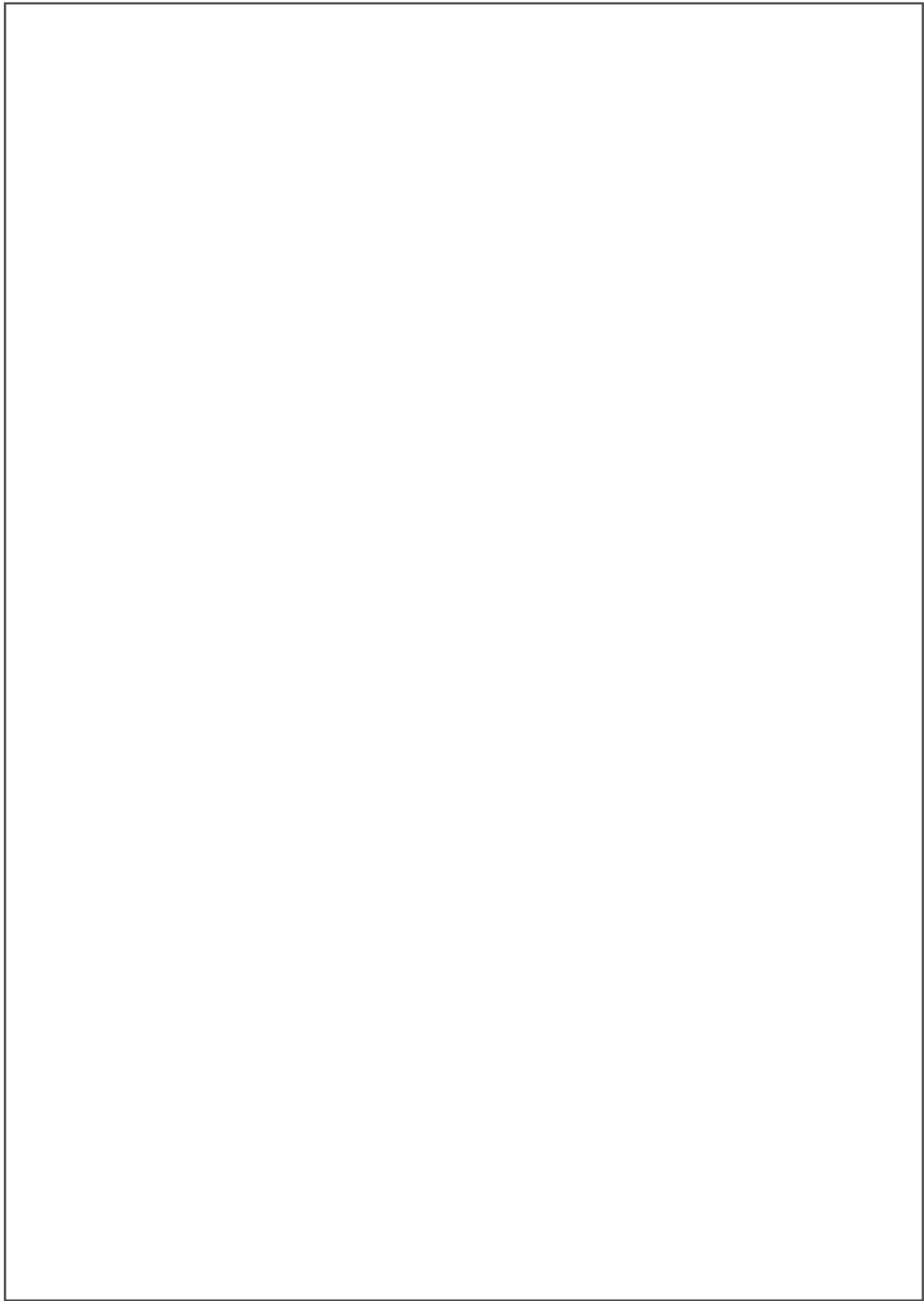
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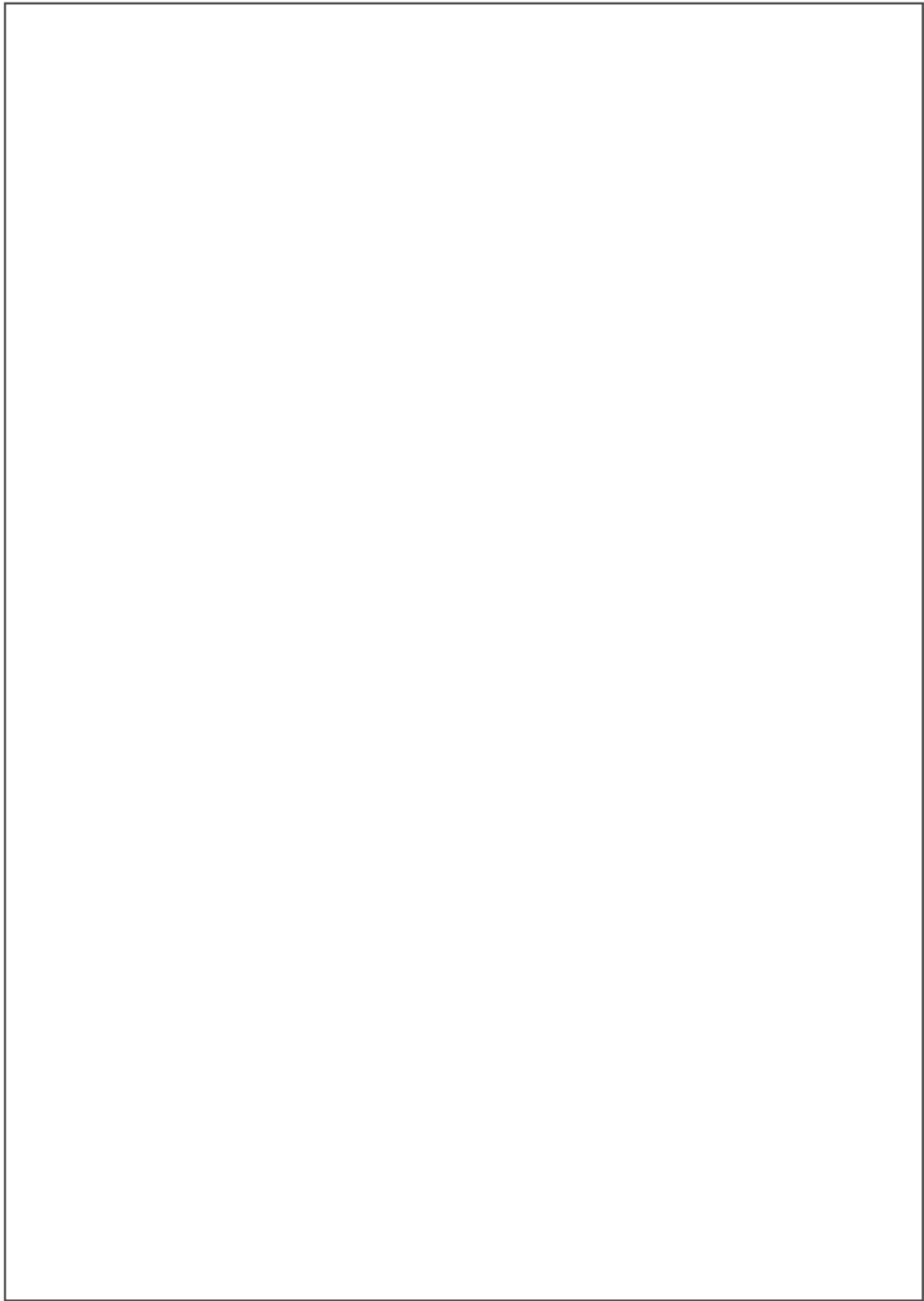
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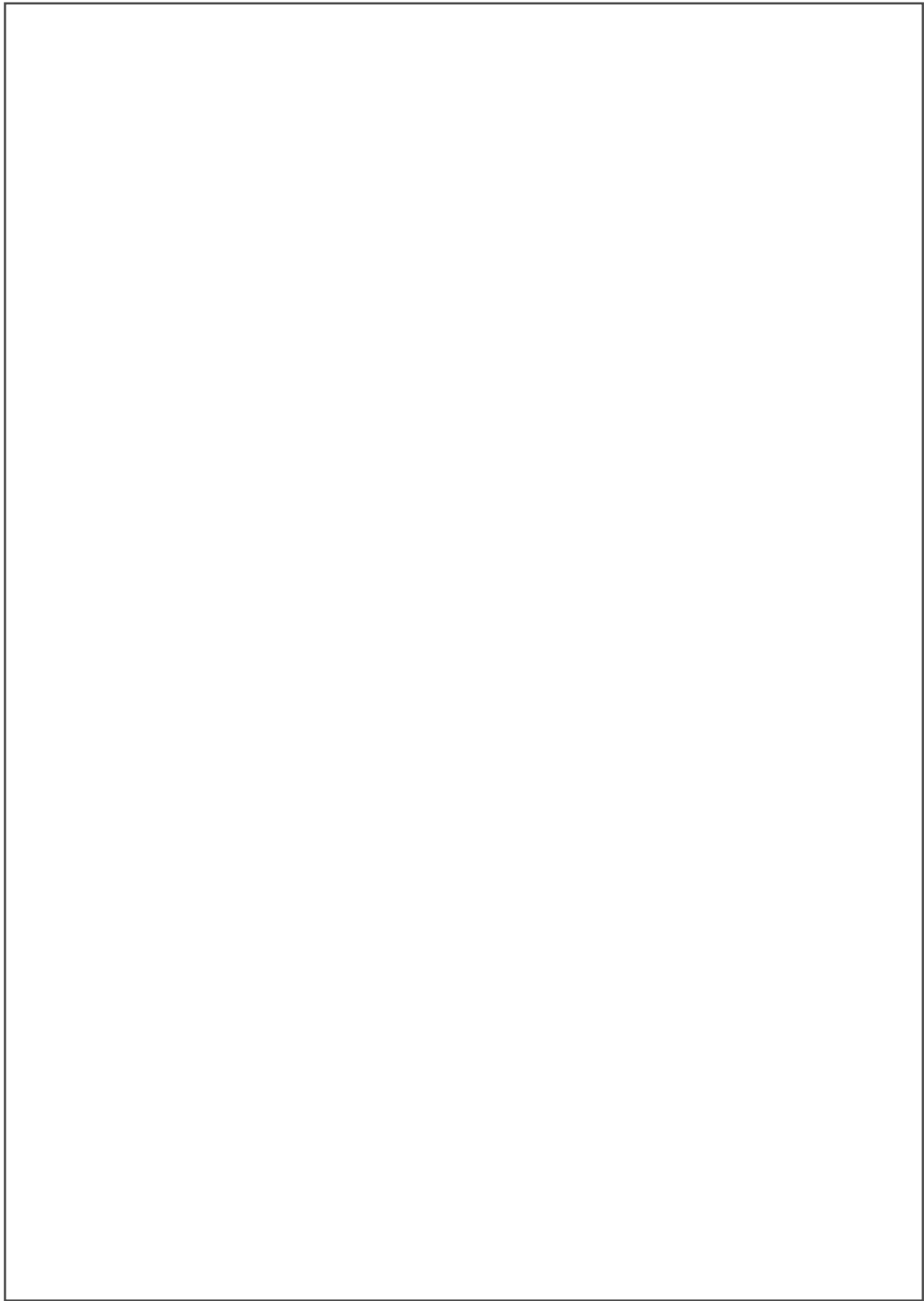
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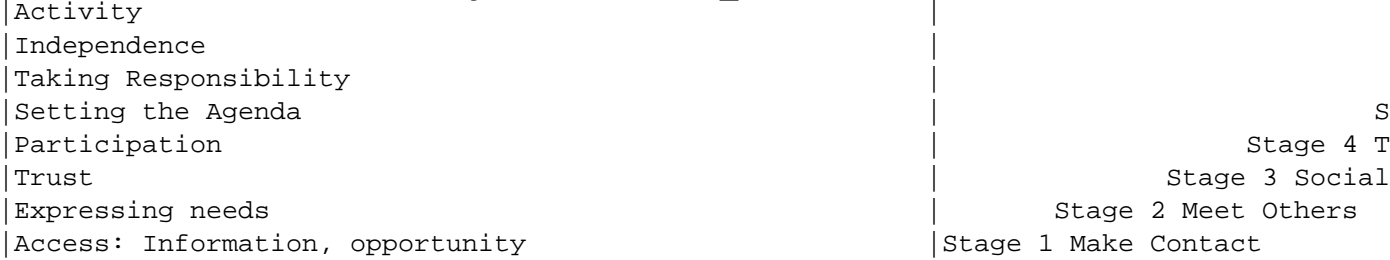








Community Development Model



Adapted from Huskins J (1995) Youth Work UK

Evaluation of the Boscombe West & Springbourne
Healthy Living Centre in Bournemouth

Sept 2005-Oct 2008

Final Report Draft

Appendix A

Linking Capital
Transaction with Funder

Bridging Capital
Connecting with others

Bonding Capital
Engaging with one's own community

Health Outcomes



Follow up
Momentum
Support/Advice
Project termination

Project Birth
Pulling it together
Administration
Governance