Learning from Healthy Living Centres: final evaluation summary
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Key findings and lessons

This document presents the final findings from the Healthy Living Centre (HLC) programme evaluation. It is our interpretation of the full report, which is available along with the previous evaluation reports on our website at www.biglotteryfund.org.uk.

Our flagship HLC programme has achieved all that it set out to do – promoting good health, reducing health inequalities and improving the health of the worst off in society. It has done this by focusing on disadvantaged groups, local ownership of projects and strong partnerships. It is an unfortunate reality of public policy and politics that at the present time, despite these important achievements, it does not look as if there will be significant take-up of the HLC model by the statutory sector in England, Scotland and Wales. However, the picture is currently different in Northern Ireland, where many statutory Health Boards have shown greater interest in sustaining the work of HLCs, and are backing up their interest with tangible support.

Some key impacts of the HLC programme include:

► HLCs help people to become healthier, both in the short and the longer term, and safeguard the health and well-being of their regular users.
► 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.
► 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.
► HLCs successfully attract their target communities by combining health and social benefits in the activities they provide.
► 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.
► HLCs help people and organisations to learn, and help to build relationships within communities.
► HLCs develop, improve and organise local partnerships and networks, building strong trusting relationships with the voluntary, community and statutory sectors.
► Much of the ongoing impact of HLCs will be dependent on the priorities of regional and national government policies.

Some key lessons from the evaluation include:

► Projects benefit from early and ongoing support for sustainability, self-evaluation and business planning.
► Broad programme aims and funding criteria can encourage innovation in the way that projects engage with communities to tackle local problems.
► 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. Also important are flexibility, resources and a platform from which to operate.
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.

Effective partnerships require strong leadership, a clear direction and enough funding to support the initial set up.

This summary will be of interest to funders, policy makers, HLCs and their partners, other community-based projects and the statutory health sector, which may develop similar activities to those of HLCs over the next few years.
The programme

The Healthy Living Centres (HLC) programme was launched in 1999 by the Big Lottery Fund (previously the New Opportunities Fund). Over £280 million has been awarded to 352 HLCs across the UK for funding periods of up to five years. 166 HLCs will have come to the end of their Big Lottery Fund grant by December 2007.

The aims of the HLC programme were:
- to promote health in its broadest sense
- to target areas and groups that represent the most disadvantaged sectors of the population
- to reduce differences in the quality of health between individuals, and improve the health of the worst off in society.

A number of policy assumptions were identified as implicit to the success of the programme. These were that:
- improving health inequalities requires more than medical intervention
- for health promotion to be effective, communities and users must be involved
- people want to improve their health
- partnership working can enhance impact and promote sustainability.

The programme was designed to support the health inequalities agendas of the UK Government and the devolved administrations. These agendas were influenced by the Acheson report of 1998, which drew attention to the growing gap...
between the health of the better and worse off sections of British society, and the failure of conventional health promotion approaches to address this gap.

HLCs were intended to help people of all ages improve their well-being, both physical and mental, and get the most out of life. Projects were asked to focus on the wider determinants of health, addressing factors such as social exclusion, mental health, poor access to services and the social and economic aspects of deprivation.

It was intended that HLCs would design and deliver services according to the needs of their local communities, and that management arrangements should revolve around partnerships of key local players from the statutory, voluntary and community sectors. All HLCs involve their local communities in using and delivering a diverse range of activities. However, beyond this there was no standard blueprint for a healthy living centre, and the programme funded a great variety of projects. Not all HLCs are physical centres: many operate as networks of activities or focus on outreach work. Some are based within the statutory sector while others are run by charities or voluntary bodies. Some projects use tried and tested approaches while others use more innovative ideas, and all are encouraged to share good practice. Some HLCs have a simple focus or tackle a particular local need (e.g. mental health services), while others promote good health in a broader sense through health information, physical exercise and education.

The major challenge to the programme since its launch has been the huge amount of change taking place in the wider environment in which HLCs work. This has included:

- the devolution of government to the four separate UK administrations, leading to a growing divergence in overall policy. Different public health policies in the four countries have led to some interesting differences in the approaches taken to tackle key public health issues
- major changes in the institutional structures of the health services
- changes in public health policy agendas and priorities
- the emergence of a strong ‘civic engagement’ agenda across all four countries
- the growth in target setting in relation to public service provision
- the inclusion of key areas of HLCs’ work, such as partnership building and tackling health inequalities, in new government agendas.

Some of these changes have worked to HLCs’ advantage, and others have created problems. They are explored in more detail in the final HLC evaluation report and in a separate paper by Professor David Hunter of Durham University, entitled ‘Healthy Living Centres: the changing policy context’ – see Further Information.
We commissioned the Bridge Consortium (led by the Tavistock Institute) to evaluate the HLC programme in 2001. This evaluation summary is based on their final report, written in January 2007.

The Bridge Consortium were asked:
- to evaluate against the aims of the programme (see above)
- to develop and implement a health monitoring system designed to show who uses HLCs and how their health and well-being changes over time
- to evaluate the contribution of HLCs to the public health agenda and its delivery.

As the evaluation progressed, it became clear that HLCs were having an impact on community development that was just as significant as their stated aims to improve health and well-being.

The evaluation gathered rich information about the programme using a number of approaches:
- an analysis of application data from all 352 HLCs, using a database funded by the Department of Health
- a qualitative survey of 40 case study HLCs, covering all the main broad types of HLC. This involved multiple visits over the course of the evaluation, as well as final telephone interviews. 24 case studies were selected in England, six in Northern Ireland and five each in Scotland and Wales
- a Health Monitoring System (HMS) that surveyed project users and gathered data on local people to monitor the health and well-being of HLC users and their communities. All 352 HLCs were approached, and 226 (64 per cent) agreed to take part by distributing questionnaires to their users. 4,075 users returned these first questionnaires. Over 1,400 of those initial users then took part in six-month and 18-month follow-up surveys
- an online survey of all HLCs, carried out towards the end of the evaluation, to provide an overview of progress and achievements since projects initially applied for funding, and to complement case study data. 189 HLCs returned questionnaires (54 per cent)
- gathering and analysing reports produced by HLCs that undertook self-evaluation, or commissioned evaluations of themselves.

More background on the methodology can be found in the Bridge Consortium’s annual reports – see Further Information.

Other evaluations of the HLC programme
The programme has been evaluated at a number of levels, by the Big Lottery Fund as well as the Department of Health and the government departments responsible for health in Northern Ireland, Scotland and Wales, all with slightly varying aims. HLCs themselves were encouraged to self-evaluate, and the majority indicated at the start of their funding that they intended to do so. Some projects evaluated themselves, while others commissioned external organisations to do so. While many projects found evaluation to be a challenge, particularly when using it to demonstrate their impact on health, they often also viewed it as an opportunity to develop and enhance their work. Reflecting on their experiences, HLCs have identified the importance of building evaluation into project work from the early stages, of including evaluation costs in initial budgets and of training staff in evaluation techniques from the outset.
The HLC programme aimed to promote health, target disadvantage and address health inequalities. By doing this it was hoped that projects would then improve the health and well-being of individuals and communities.

The evaluation indicates that HLCs have had an impact on the lives of those who regularly take part in their activities. In addition HLCs have engaged with people who had little previous interest in healthy activities.

Improving health and well-being
The evaluation found that regular attendance at an HLC (at least once per month) is crucial in developing a positive impact on an individual’s health and well-being. Regular attendees enjoyed the following benefits in comparison with non-regular attendees, over an 18-month period:

- a protective, stabilising effect on physical and mental health
- improvements in smoking behaviour, participation in physical activity, consumption of fruit and vegetables
- a more positive perception of their health and quality of life.

HLCs were generally confident about their ability to improve well-being and their ability to have a positive influence on their target communities. They were less confident about making more specific impacts on health. 80 per cent of HLC managers felt that they had achieved a great deal of success in improving their users’ well-being, while only 40 per cent believed that their HLC had done a great deal to prevent particular health conditions.

Reaching their target populations
Attracting people to health-related activities, and encouraging them to remain involved, is central to most HLCs’ ability to influence the health and well-being of their target groups.

Users of HLCs
The Health Monitoring System (HMS) gives a flavour of the kinds of people that have used HLCs. A comparison with BIG’s monitoring data collected by all HLCs showed that HMS respondents were representative of the HLC population in terms of age and gender.

- 79 per cent of users were women.
- 57 per cent were aged 45 and over.
- 93 per cent were white.
- 47 per cent were retired.
- 32 per cent were unemployed.

The numbers of people involved in activities at HLCs vary from a handful to tens of thousands. Different activities were designed for different numbers and types of users. The frequency and regularity with which people attended an HLC was a key factor in determining whether or not their health behaviour and well-being had changed. However, the notion of HLC users (or beneficiaries) as being only those who attend activities is misleading. Many HLCs specifically target their interventions on those who can pass the benefits on to others.

The evaluation concludes that HLCs have successfully reached the more disadvantaged communities and those with the greatest health needs, although reaching these people has often been a challenge.
Most surveyed HLC managers were happy with their success in reaching their target population, and attributed this success to:

- using new or innovative methods
- tailoring services to the needs of the specific target group
- using diverse approaches
- delivering services in appropriate locations for the target group.

A holistic approach to health
Most HLCs have a large and varied range of services that approach health inequalities from several different directions. Activities among case study HLCs include: giving health advice and health care, teaching health skills, supporting self-help, providing emotional support, providing training, providing financial help and providing a social activity. A combination of social, emotional and health benefits were particularly apparent for HLC users who had potentially stigmatising health problems that had previously excluded them from ‘normal’ social activities. For example:

“J fears trying out certain activities, such as going to the pictures or going swimming, due to her epilepsy. She also has difficulty with most social situations and can become flustered when speaking to unfamiliar people. J was matched with a befriender with whom she felt comfortable. They met every week for five months, participating in many activities including going to the castle, shopping and meeting at J’s home where they completed jigsaw puzzles and had talks. They also went swimming – the first time for J in many years as she had never felt comfortable or safe going alone. J regularly expressed how happy she was now that she had a befriender.”

Example from case study interview at Wester Hailes HLC.
For more information contact Linda Arthur at Wester Hailes Health Agency, email: linda@whhealthagency.co.uk
Providing multiple activities, in a social setting

HLCs often provide social activities as a ‘hook’ to get people interested in healthy activities. In this way they tackle social isolation, which can be a particular cause of poor health among more vulnerable communities. 87 per cent of regular HLC users said that contact with people at the centre was the greatest influence on their health and well-being, and it was often perceived by HLC managers that the social benefits of an activity encouraged people to get, and stay, involved.

The integration of health-related activities in an informal, non-stigmatising social setting, rather than as part of a specialist health facility, was particularly helpful. The social aspect was key to attracting those who had been isolated – through cultural barriers, emotional difficulties or caring responsibilities. For example:

A Gujarati Hindu, who cares for her wheelchair-bound husband, commented: “I have learnt so much and made so many friends through the centre and it feels like a second home… So many local women from all our Asian communities have learnt so many things from our sessions and from each other. This is not just about exercise, but about a bit of independence, and a lot about confidence building. We talk loads about issues we all face and individual problems.”

Example from case study interview at Palfrey Healthy Living Centre, Walsall, England.

For more information, contact palfreycommunity@yahoo.co.uk

Other factors related to health inequalities

Poverty and unemployment, and poor access to health provision are closely linked to health inequalities. A number of HLCs found that people gained more confidence as a result of attending activities at a centre, and as a result felt more able to seek work after years of unemployment.

Many HLCs have provided training and volunteering opportunities, offered benefits advice and help with debt and other factors related to poverty and unemployment. HLCs have also helped people to gain access to health services that had previously seemed inaccessible. This kind of support was particularly important for those who had been experiencing discrimination and exclusion.
Community change

A key part of the HLC programme has been to engage local people experiencing deprivation, exclusion or isolation in the development of projects that lead to positive changes in their local area, thereby improving the health of their target communities.

HLCs have worked with a number of different types of community. These may be geographical communities such as a housing estate or a village, or communities of specific groups of people such as Asian women, families or people with learning difficulties. HLCs may also work with more than one type of community, for example providing services for everyone on a housing estate, with some specialist services for particular groups.

<table>
<thead>
<tr>
<th>Method used to reach community</th>
<th>Number of HLCs</th>
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<tbody>
<tr>
<td>Providing services and activities in a more accessible way for the community or particular groups</td>
<td>26</td>
</tr>
<tr>
<td>Avoiding clinical, official, formal settings for services</td>
<td>26</td>
</tr>
<tr>
<td>Being situated in the community where services are needed</td>
<td>24</td>
</tr>
<tr>
<td>Home visits, or outreach with groups already working in the community</td>
<td>21</td>
</tr>
<tr>
<td>Providing an intensive, personal, ‘hand-holding’ service</td>
<td>21</td>
</tr>
<tr>
<td>Using voluntary and community organisations with close contacts to the targeted groups to provide services or encourage use of HLC services</td>
<td>20</td>
</tr>
<tr>
<td>Using local or lay people to run activities, rather than professionals or outsiders</td>
<td>15</td>
</tr>
<tr>
<td>Providing services in the language of the community</td>
<td>14</td>
</tr>
</tbody>
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Total number of case study HLCs: 40. Most used more than one of the above methods.
Engaging with communities

HLCs have developed the knowledge, skills and relationships to engage with hard-to-reach communities, and the programme has provided an environment to test and develop different forms of community engagement. Approximately 90 per cent of HLC managers felt that their strategies to reach target groups had been ‘very successful’ or ‘successful’.

HLCs used a variety of methods to make themselves known to their potential users (see Table 1). While many used newsletters, websites or leaflets to advertise their work, most found that ‘word-of-mouth’ was by far the most effective method of gaining recognition in a local community.

Effective community engagement requires persistence, patience and flexibility, and the recognition that different approaches work for different groups. Underlying this approach to engagement has been the need to develop trust, which had sometimes been eroded during previous experiences with local agencies.

The development of trust has seen HLCs develop an informal and welcoming presence in their communities. HLCs present themselves as open to approaches from the community and as ready to respond to their needs. They do so by creating informal spaces for people to meet, or by going out to meet their community. Developing trust was particularly challenging when engaging with diverse and separate communities (see Case Study 1).

Case Study 1 – Peninsula HLC

This HLC operated in a rural area with a dispersed population, poor transport links and a stark geographical religious divide. Peninsula HLC used a community development approach to bring local groups and individuals together to work on health issues.

Local people identified transport as the main ‘health’ issue. The HLC set up a community transport scheme that enabled people from different communities to come together to work on common issues or take part in activities using premises across the area. Other activities at the HLC have included training for local people, for example as walk leaders, setting up two Afterschool Clubs, and rolling out a physical activity outreach programme to all local villages.

The HLC’s work was reported to have helped individuals to increase their health knowledge as well as supporting local groups in working together to achieve goals that they set for themselves.

For more information, contact Sheila Bailie, email: Sheila.Bailie@setrust.hscni.net
Another key to successful community engagement is being able to approach people on their own terms, by demonstrating an understanding of their particular situation. At one HLC, success in involving the community was said to be about:

‘...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.’

Another HLC stressed that they are able to gain access to local people who would not otherwise have engaged with their services because ‘we go out there and meet them in their own area’. Having a manager from the area was also an advantage: ‘I’m from the area: they know me and I know many of them.’

Building community capacity
HLCs aimed to encourage local people and users to take on new citizen roles in relation to health improvement. These roles have been created through, for example:

- the development of funding applications
- members of the community chairing the management board, advisory group or steering group
- employment of community members as staff or volunteers.

HLCs built the skills and confidence of local people to enable them to fulfil these roles, through training, mentoring or other support (see Case Study 2).

Case Study 2 – East Belfast Community Health Information Project (CHIP)
This HLC trained Lay Health Information Workers and used an ‘ambassadorial’ approach to encourage them, and the people they then worked with, to identify and inspire other vulnerable individuals to use HLC resources and activities. This work is conducted in ordinary social places such as local pubs, providing people who may normally avoid health services and activities with an opportunity to have their blood pressure taken and their weight checked.

For more information, contact Maggie Andrews, Partnership Manager at East Belfast CHIP, email: maggie@eastbelfast.com

Training included professional volunteer training or specific training such as in committee skills. Many HLCs found ways to involve community members as decision-makers, with health professionals available as advisors. Local people have also been formally employed by HLCs as staff members.

Some HLCs created independent community-led groups, forums, community action teams or reference groups, which were loosely tied to project structures (see Case Study 3). It was hoped that these would continue to exist within the community after the HLC programme ended.
Impact on communities

Most HLCs considered that the best way to bring about a sustained improvement to the health and well-being of their communities was to work towards changing the social, economic and physical environments in which they operated. Case study HLCs produced a range of new resources and networks to help communities become more resilient to the causes of ill health, or have better access to health-improving services or activities. Some of these are listed in Table 2, and are explored in more detail below.

Case Study 3 – Newham Healthy Living Network for Elders and Carers

This HLC has supported and developed a reference group of older people to become actively involved in the network’s activities. The group has developed from a modest start to the current set-up of over 20 representatives, with agreed job descriptions, roles and responsibilities.

The group has influenced policy, lobbied for change, visited hospitals and sheltered housing units, attended conferences and other key meetings, and helped to recruit core staff. They have stressed the importance of good training and support.

For more information, contact Age Concern Newham, or email: info@ageconcernnewham.org.uk or phone: 020 8503 4800
New physical and social resources
As a result of the HLC programme, many buildings have been built for community use that did not previously exist. These may be new, or revitalised versions of existing facilities. HLCs have worked with their communities to build and refurbish these spaces, and they will be a lasting legacy of the programme.

New services
HLCs have developed new services and have improved access to existing services – particularly for groups that were previously isolated or excluded. Projects such as walking programmes, green gyms, allotments and community cafés promote health through opportunities provided in ‘ordinary’ settings. Developing these new services has been dependent on changing the way in which community spaces are used.

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.

New networks
Many HLCs sought to have a positive impact by developing new networks and support groups, and strengthening existing networks. Many networks were created to inform the development of the HLCs. Some then focused on sustaining a particular activity, such as a local food forum or young people’s project, while others provided mutual aid and support. These groups connected the needs of particular groups to local health and health care development.

Table 2: The impact of case study HLCs on their local community

<table>
<thead>
<tr>
<th>Type of impact</th>
<th>Number of HLCs</th>
</tr>
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<tbody>
<tr>
<td>New services are being provided locally, that were unlikely to have been provided by other agencies</td>
<td>25</td>
</tr>
<tr>
<td>A group without previous access to health-related services is now having some of its needs met</td>
<td>24</td>
</tr>
<tr>
<td>New resources are being provided for local organisations to use and develop</td>
<td>22</td>
</tr>
<tr>
<td>Services are being provided more appropriately for the local population or target group</td>
<td>22</td>
</tr>
<tr>
<td>Local people or target groups are having a say in what services are needed</td>
<td>21</td>
</tr>
<tr>
<td>New networks have been developed to support the community</td>
<td>21</td>
</tr>
<tr>
<td>A new building can be used by the community to bring activities and services into the area</td>
<td>14</td>
</tr>
</tbody>
</table>

Total number of case study HLCs: 40. Most had more than one of the above impacts.
Further benefits of these networks or groups were seen by HLCs as: reinforcing social interaction; improving communication between communities, HLCs and public agencies; connecting local people to a broad range of local authority and health organisations; providing a sense of ownership to particular groups or local communities and developing the skills and capacities of local people.

**Building social cohesion**

42 per cent of HLC managers surveyed said that promoting social cohesion was an issue that they addressed a great deal, and 37 per cent said that they addressed it to some extent. Some projects tried to address social exclusion and provide links between certain groups (see Case Study 4).

**Challenges**

HLCs reported two main challenges to influencing change in their communities.

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. HLCs were also concerned about the impact of a loss of funding, after their Lottery award ended, on the relationships they had built.

Secondly, some HLCs were unable to persuade local people or users to take on leadership roles, whether in managing the HLC, developing community-led networks or groups, or developing community-owned services. In some cases expectations about what could be achieved within the timeframe may have been too high. In other cases, HLCs reported a persistent lack of interest in community-led development.

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**Case Study 4**

This English HLC brought people from several ethnic groups together at celebratory events or arts activities. One respondent commented that ‘It was a delight to see the Asian women with the Morris men!’

Achieving change was a delicate and painstaking process. As one worker in this HLC explained in relation to work with Asian children: ‘We had to make sure that the work got the approval of the mosque. Relationships with the elders were important. We became more successful, and potentially more sustainable, as relationships developed – between us and parents, us and the mosque, us and the school.’
HLCs have been successful in developing a range of services for their local communities, and in establishing working partnerships between local agencies. A key role for many was to address a lack of accessible, appropriate or indeed any relevant services in their communities.

HLCs aimed to improve the level and accessibility of services in their areas in the following broad ways:

**Identifying the needs of the target population, and gaps in existing services**
Most HLCs identified service needs by building relationships with local agencies and their target communities. Information about local needs and issues was also provided from HLC partnerships, which had links into existing community groups and networks. Service development at HLCs was also informed by local and national policy agendas (sometimes with linked funding).

**Addressing need through the provision of new services**
Most centres focused on services that reached out to target communities on their own terms. HLCs have provided their services in, for example, sheltered housing, GP waiting rooms, mosques, pubs or shopping centres. At least two have used a bus or van to reach remote communities, and many have set up ‘health information points’ in their area.

HLCs have often become key access points into the mainstream health system, either by providing referral pathways or bringing relevant health services directly to community members.

HLCs also worked with their partners to develop services and ensure that they met the needs of their communities. Many centres encouraged their users to suggest or set up their own services, and services sometimes evolved from one initiative into a web of service provision (see Case Study 5).

### Case Study 5 – Maesgeirchen Healthy Living Centre
The health visiting service at this HLC began with ‘Bumps to babies’ sessions run by midwives and health visitors at the HLC, providing advice, support and information to young families expecting babies. This evolved into a wide range of facilities including ‘little rascals’ sessions for families with small children, a breast feeding group and other forms of support for parents, skills training (including cookery classes) and stress relief sessions.

For more information, contact Paul Hockaday, email: paul@marchog.fslife.co.uk

### Working in partnership with local agencies to improve co-ordination between services
The HLC programme aimed to address a lack of coordination between statutory agencies, voluntary agencies and community groups, which they found in many areas of high deprivation.

Most HLCs set up a formal partnership with a number of local agencies, which often evolved over time. Many HLCs described themselves as a ‘healthy partnership’ rather than a healthy living centre. In these the HLC had a co-ordinating role, while partners might be part of a management group, engage in
strategic decision-making, and contribute resources to the HLC. At many HLCs the partners developed and delivered activities at the centre.

Some of the clear benefits of partnership working identified by HLC managers include:

- support for administration, decision-making, management, staffing and delivery
- closer joint working on community engagement or service development and provision
- user referrals
- evaluation and dissemination guidance
- new funding
- avoiding competition
- better access to target groups.

Partnerships also operated as enablers of dialogue, catalysts and sources of leadership and learning.

Partnership success was also attributed to statutory sector support, although this in turn partly depended on the level of coordination and collaboration between local agencies prior to the arrival of the HLC. HLCs have improved this co-ordination in various ways, such as:

- providing forums for local agencies to meet
- identifying areas of service overlap or gap, and notifying the appropriate agencies
- providing mechanisms, including databases, to exchange local information about health and local services

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Case Study 6 – The For All Healthy Living Centre

The Centre includes a GP practice, children’s centre facilities (a play and therapy centre, little library, and community learning and mental health services), council information point and limited library service, community hall, day centre (lunch club for older people), church, community and learning facilities, community café and offices. There is a shared reception and information service at the front of the Centre. These services and facilities are all managed by the partners of For All HLC.

The Centre also houses health visitors, school nurses, a 5–13 Family Support Service, Homestart, the local Neighbourhood Management Team and other agencies offering a variety of drop-in services.

For more information, contact Jenny Hendy at The For All Healthy Living Company, email: jenny.hendy@forallhlc.org

- providing premises in which a range of different agencies could offer their services (see Case Study 6).

The task of managing a partnership and maintaining successful networks was often challenging and resource-intensive. Over half of surveyed HLCs mentioned problems with their partnerships arising from conflicting agendas and priorities, incompatible working practices, differing monitoring procedures and varying degrees of commitment to the...
partnership. One solution to these problems was to clearly define the roles of each partner.

Partnerships were also undermined when key people moved on, weakening the enthusiasm for the partnership in their organisation. Strong leadership from the HLC was essential in overcoming this kind of disruption, as well as the investment of time in building new relationships with any restructured organisation.

There are several indicators of the success of HLCs in developing services:

- Many expanded their range of activities as their networks and partnerships developed and expanded, or in response to changing national and local agendas.
- Most of the HLCs studied had achieved a level of stability, suggesting that they had established services that met the needs of their community, and were well used.
- HLCs have gained a reputation for delivering quality services, and have been seen by other agencies as models of good practice in their approach to community engagement, delivering holistic services, facilitating or working with other agencies.
- Many have successfully attracted and worked with sections of the community that had been difficult to reach. The holistic approach, responsiveness and flexibility possible at many HLCs meant that they could offer a range of activities in support of an issue or a need (see Case Study 7).

**Case Study 7**

A smoking cessation programme at this Scottish HLC was successful because they identified various concerns that smokers associated with smoking cessation, such as weight gain. The package that the HLC put together included weight management, exercise classes, sessions that raised self-esteem and cooking sessions.
What is sustainability?
The sustainability of HLCs can be considered at three levels:
- sustainability of the HLC itself, as a whole or in a slightly different form
- continuation of some or all of the activities established by the centre
- a legacy of improved strategies, approaches or ideas initiated by the HLC.

The distinction between the first two levels of sustainability is an important one. It raises the key question of whether it is important to sustain whole HLC projects, or to sustain the individual activities that they set up.

Sources of future funding for HLCs
Case study HLCs that have secured further funding have mostly done so from a broad mixture of sources. The most frequently mentioned funding sources were grants and service level agreements from local authorities or health services, and grants from charitable trusts. Two case study HLCs have managed to mainstream their work into statutory services, and two are working towards a ‘social enterprise’ model.

HLCs hoping to derive an income might consider:
- rental for space in their building
- charging for activities and services
- small business enterprises
- service level agreements
- grants from funding organisations
- donations of in-kind services.

Funding activities or core services
Having developed a wide range of activities, many case study HLCs then tried to secure the continuation of these – whether through service level agreements, mainstreaming or through being supported by the community itself.

However, it has often been hardest to secure the future of the core administration services of the HLC, even when the delivery of most or all of the actual activities has been taken on by other organisations. Some that faced a shortfall in their core funding have tried to adjust their services accordingly, while others have needed to develop an exit strategy. These core services are key to developing and supporting new activities in the future. Without them, the target communities of HLCs are left with the services delivered to date, and little expectation of further development.

Other factors contributing to the sustainability of HLCs
While the issue of sustainability is complicated, some identifiable factors have a significant impact on it:

- **Being designed for sustainability:** it proved beneficial to incorporate sustainability in the design of the HLC from the outset. This helped HLCs to create the conditions that best enhanced their long-term prospects.

- **Buildings versus networks:** owning a building gave HLCs a useful resource to raise revenue and to provide a focus for support. Network HLCs (those without buildings) found that partners often had their own sources of support to fund activities. However, the co-ordinating role of the HLC could not always be sustained.
Approach to health inequalities: HLCs with a strong health focus were in a good position to lobby their local statutory health organisations for funds, but were vulnerable to how much support those agencies were able to provide. HLCs with a broader approach could be seen by the statutory sector as a ‘luxury’; however, they are able to seek funding from a wider range of sources.

The lead agency: HLCs led by a statutory health agency appear most likely to secure continuation funding. Such HLCs were more closely aligned to the priorities of that agency, and their activities already embedded in mainstream action. However this association could make it harder to raise additional funds.

Partnerships: While there is no consensus on an ideal type of partnership, it is clear that the existence of a partnership, and the commitment of the partners, can play a key role in the future of an HLC.

Fund-raising staff: staff with skill and experience in fund raising were essential for HLCs to become fully sustainable.

The local statutory sector: however positive the local statutory sector was about a HLC, it might not always be able to provide financial support.

Wider environment: while changes in national policies leading to a restructured statutory health sector had some detrimental effects on the future of HLCs, they also provided some opportunities. These challenges and opportunities varied according to the different health policies across the UK. Taking advantage of the opportunities required a dedicated member of staff to take account of them, and the flexibility to alter practices.

The role of the Big Lottery Fund: the Development and Support programmes implemented by BIG aimed to support HLCs in developing sustainability strategies beyond the end of their Lottery grant, and included training, networking and sharing of good practice. Projects that took part in the programmes found them to be beneficial, but would have appreciated the support earlier in the programme, when it would have had a greater effect. Some HLCs suggest it would have been helpful if BIG had required applicants to produce a bespoke sustainability strategy.

It is also worth noting the role of some national networks that have emerged from the HLC programme which are now promoting the concept of HLCs, representing them to government and working to enhance their prospects for sustainability. In England there is the Healthy Living Alliance, which emerged in 2005 out of a policy workshop run by this evaluation. Northern Ireland and Scotland both have HLC Alliances, which have also been working together to share knowledge. Furthermore, Northern Ireland has a Health and Wellbeing Advisory Panel, which has made a significant contribution to championing the HLC programme. While there is no national alliance in Wales, there is an active South Wales HLC network, which meets regularly to share experiences and information. See Further Information for more about some of these.
The legacy of the programme
Many of the benefits brought about by HLCs are likely to remain as their legacy, even if the centres themselves close down at the end of their grant from BIG. The managers at most case study HLCs were optimistic that this was the case, and talked about legacies in terms of impacts on:

- **Individuals**: HLCs have increased people's awareness of healthier lifestyles, improved their ability to access services, helped to guide them out of isolation, depression or poor physical health, to be more confident, health conscious and motivated to improve their health, and to become involved in community activity and development.

- **Local agencies**: HLCs have often influenced the approaches and strategies of other local agencies: for example by helping them to understand a social model of health, to understand the needs of a particular group of people, or to see the benefits of community-led service development.

- **Activities and services**: many HLCs have found funding for at least some of their activities, or have found other organisations to take these forward. Hence these services will remain even if the centre itself closes.

- **Partnerships**: HLCs working primarily in partnerships or networks hope to leave a legacy of improved cooperation between local agencies, and an improved understanding of each other’s work.

- **Other local improvements**: Some HLCs have helped their neighbourhoods to feel safer, to be cleaner, or to be more attractive through planting and gardening.

Nevertheless, benefits for individuals are at risk if an HLC closes down. The evaluation has shown that the health and well-being of users not regularly involved in HLC activities tends to reduce over time. Furthermore, HLCs with co-ordinating roles may see a reduction in the activities being offered by network partners. Communities may find it harder to sustain activities themselves without a paid staff member to work with them.

Particularly lacking will be the role of the HLC as a ‘platform for innovation’ in their area – identifying and responding to new needs, working to extend the reach of their activities, or developing and supporting other local groups and agencies.

The picture is not yet clear as far as sustainability is concerned, and many HLCs still have a year or more before their Lottery funding expires. A number of centres may sustain themselves intact or only slightly changed, and this will vary greatly in each of the four UK countries. Many others may ensure that some of their services and activities will continue.
The HLC programme has encouraged innovative local projects that have tackled many of the issues relating to health inequalities at a local level. The majority of HLCs have run a range of activities, tailored to the needs and interests of their target groups. They have usually addressed the broader determinants of health by combating social isolation, providing people with skills, experience and support, or helping them to access other support and services that they were entitled to. HLCs have worked in partnership with other local agencies and catalysed better co-ordination and co-operation between them. Most have involved the local community in project planning, development and management, and have built the capacity of that same community. Finally, HLCs have succeeded in providing activities that relate to current government objectives, particularly in areas such as exercise and diet.

The evaluation has found good evidence that the HLC programme across the UK has successfully worked towards and achieved all of the objectives it set out to meet, as well as some additional significant unforeseen benefits. It is an unfortunate reality of public policy and politics that at the present time, despite these important achievements, it does not look as if there will be significant take-up of the HLC model by the statutory sector in England, Scotland and Wales. However, the picture is currently different in Northern Ireland, where many statutory Health Boards have shown greater interest in sustaining the work of HLCs, and are backing up their interest with tangible support.

The Big Lottery Fund will continue to disseminate lessons from its experience of funding HLCs.
The Final Report of the Bridge Consortium
This is the final evaluation report of the HLC programme, and contains more detail on the subjects introduced in this evaluation summary. This report, and all the previous annual reports and summaries, are available from the Big Lottery Fund website: www.biglotteryfund.org.uk

Healthy Living Centres: the changing policy context
An article by Professor David Hunter of Durham University, which discusses the impact of the changing public health policy context since 1999 on the HLC programme. Available from the Big Lottery Fund website: www.biglotteryfund.org.uk

HLC Alliances
Healthy Living Alliance, England – www.healthylivingalliance.org
HLC Alliance, Scotland – contact Paul Nelis or Susan Paxton at CHEX www.chex.org.uk
The HLC Alliance, Northern Ireland – contact Danny Power at danny@frankgillencentre.com

Healthy Living Online
The Healthy Living Online website was set up as part of Big’s Development and Support programme for HLCs across the UK, and is now run by the Healthy Living Alliance. It includes a database of all HLCs, and a collection of good practice.
See: www.healthylivingonline.org.uk

The DHSSPSNI evaluation of HLCs
The Institute of Public Health in Ireland were commissioned by the DHSSPSNI to evaluate the HLC programme in Northern Ireland. More information about this evaluation can be found here: www.publichealth.ie/index.asp?docID=763&locID=573

The Scottish Executive’s evaluation of HLCs
The Research Unit in Health, Behaviour & Change at the University of Edinburgh were commissioned by the Scottish Executive to evaluate the HLC programme in Scotland. More information about this evaluation can be found here: www.chs.med.ed.ac.uk/ruhbc/evaluation/hlp_index.html

The Scotland HLC Evidence Summary paper
This paper, written by CHEX, highlights how the HLC approach impacts on health improvement priorities through partnership working, community development and service user involvement.
www.chex.org.uk/healthy-living-centres/HLC-reports/

The Welsh Assembly Government’s evaluation of HLCs
The Cardiff Institute of Society, Health and Ethics at Cardiff University were commissioned by the Welsh Assembly to evaluate the HLC programme in Wales. Their interim report can be downloaded here: www.cardiff.ac.uk/sosci/research/publications/workingpapers/paper-90.html. Further information about this evaluation can be found here: www.wales.gov.uk/cmoresearch

The Wales HLC Evidence Summary paper
This paper, written by Momenta, highlights how the approach of HLCs has impacted on health improvement priorities and regeneration outcomes.