

# Evaluation of Camden Community Action Research Programme

18<sup>th</sup> April 2023



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## Overview

The overall aim of the Community Action Research (CAR) project was to develop a partnership model between Camden Borough Partnership (CBP) and Voluntary, Community and Social Enterprise's (VCSE) by undertaking community action research to explore the health inequalities experienced in Camden using the resource and capacity that VCSE organisations, resident researchers, and residents have. This research was conducted to understand and develop a replicable operational model that could be used by organisations like Voluntary Action Camden (VAC) with VCSE organisations to find effective ways to support and enable the feedback from local communities. Voluntary Action Camden, Lifeafterhummus Community Benefit Society and Umoja Health Forum were commissioned to work in partnership for this research.

Any abbreviations and shorted names used in this report are as follows:

CAR – Community Action Research

CBP – Camden Borough Partnership

NCL ICS – North Central London Integrated Care System

VCSE – Voluntary, Community and Social Enterprises

Lifeafterhummus - Lifeafterhummus Community Benefit Society

Umoja – Umoja Health Forum

## 1. Introduction

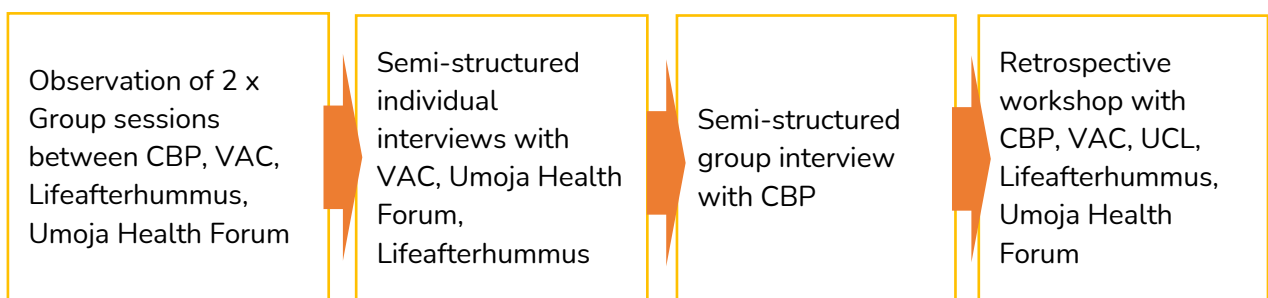
### 1.1 Aims

This evaluation aims to understand the mechanics of the partnership model and the relational aspects between the organisations involved in delivering against the priorities set by the commissioners. Using the insights from the evaluation, we aim to develop a Theory of Change model and operational model that can be replicated across the Camden Borough.

*“We [Camden Borough Council] have health and wellbeing strategy and it's highlighted quite well in there that our communities find a number of health and care services inaccessible.”*

*“We want to address, through our neighbourhood working<sup>1</sup>, ways in which we can do things differently to address the issues experienced by those that are most deprived.”*

### 1.2 Methodology



<sup>1</sup> Neighbourhood working is a collaborative approach to help deliver local services and join up support for people on a local level. This includes involvement from health (NHS), social care, voluntary organisations and charities.

The following evaluation framework (see Table 1) was used to understand the intended outcomes and impacts of the programme. It was developed from M. Reed et al.'s work on the common standard for the evaluation of public engagement with research<sup>2</sup>.

Table 1. Evaluation Framework for Community Action Research Programme

| Theme   | Indicator   | Research method                                 |
|---|---|---|
| <b>3.1 Design and mechanics</b><br>Does the design follow good practice, underpinned by sound ethics?   | i. Have you systematically identified relevant publics (and stakeholders)   | Interviews and observations                     |
|   | ii. Do you understand the expectations and specific benefits each group is likely to derive from engagement?                | Interviews, focus group, retrospective workshop |
|   | iii. Have you identified and made contingencies for any risks & assumptions   | Interviews, focus group, retrospective workshop |
|   | iv. Have you tested your activities and sought feedback from relevant publics?  | Interviews and observations                     |
| <b>3.2 Context</b><br>How well do you know the context you are working in, and have you adapted the design of your activities to this context | i. Does your proposed programme match the interests and needs of your target publics and their social and cultural context? | Interviews and observation                      |
|   | ii. Is there experience of engagement and existing trust between members of the research community and publics?             | Interviews, observation, retrospective workshop |
|   | iii. Does the project team have sufficient resources and support for engagement in this context eg. for research.           | Interviews, observation, retrospective workshop |
| <b>3.3 Outputs</b><br>What immediate outputs do you want to deliver for engagement  | i. How will you know you have delivered these outputs?  | Interviews                                      |
| <b>3.4 Impacts</b><br>What benefits or 'impacts' do you want to achieve from engagement   | i. How will you know you have achieved these impacts?   | Interviews                                      |

### 1.3 Community Action Research

This research method is based on reflection, data collection and action but determined by and involving the community. This methodology aims to research alliances within stakeholders involved and those acting within the community. The community plays a crucial

<sup>2</sup> Reed, M.S., Duncan, S., Manners, P., Pound, D., Armitage, L., Frewer, L., Thorley, C. and Frost, B. (2018) 'A common standard for the evaluation of public engagement with research'. *Research for All*, 2 (1): 143–162. DOI 10.18546/RFA.02.1.13.

part in determining the localised solutions. This pilot programme specifically aims to improve health and reduce inequities through using this research methodology.

A breakdown of this methodology is shown in figure 1.

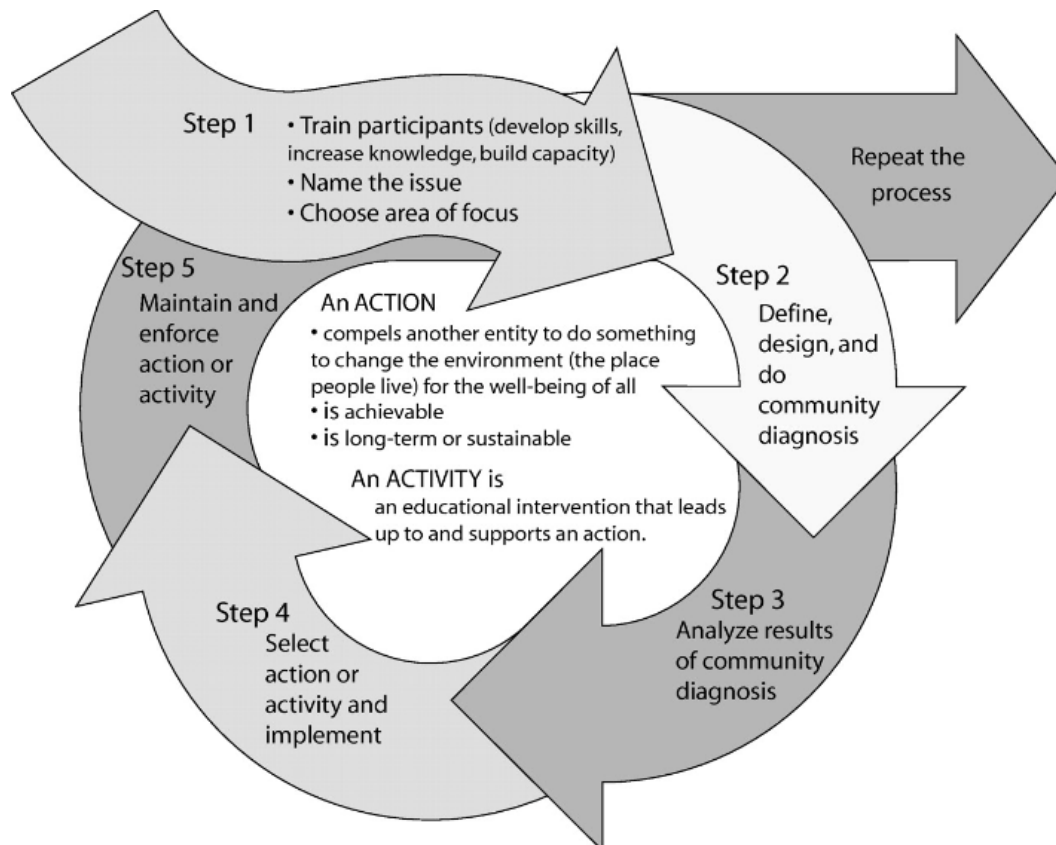


Figure 1. Community Action Research model.<sup>3</sup>(The definition of the methodology is described within the 'Community Action Research' paragraph)

In this pilot, the community action research is combined with a new partnership model between VAC, Lifeafterhummus, Umoja and CBP. The programme aimed to identify whether this is a feasible model to improve community health and reduce social isolation through building research capacity within the community organisations and for the community.

## 2. Rationale for Evaluation

The evaluation for this programme is conducted to understand whether there is a feasible operational partnership model that can be used by organisations such as VAC and other VCSEs to enable citizen-led action through building research capacity.

Understanding the key variables, drivers and barriers for this model will be key in understanding how CBP, as the commissioners, can help support the community have better access to services and reduce isolation ensure that they are serving the community of Camden galvanising the partnerships that already exist between

<sup>3</sup> Illustration taken from paper by S. Lavery et al., 2005, The community action model: a community-driven model designed to address disparities in health. DOI: 10.2105/AJPH.2004.047704

organisations such as VAC and the community organisations.

An integrated evaluation process was conducted where the evaluator was embedded within the programme. A developmental approach was taken with the evaluation to facilitate spaces for reflection, and this was designed within a retrospective workshop. The workshop also provided an opportunity for all stakeholders involved to discuss challenges that were systematic versus challenges of the programme itself in a safe and productive manner. The workshop aided conversations to co-produce actionable solutions within the context of a complex integrated healthcare service. This programme wanted to also test setting up the appropriate research capacity with the two organisations and within the community to understand whether this is feasible, its opportunities and challenges and that feedback loop from research findings back to the CBP.

### **2.1 Understanding of the context of this pilot**

The brief for this pilot programme was issued by Camden Borough Partnership and the Integrated Care Partnership whereby the purpose was to focus on areas of deprivation within the Camden borough and develop a partnership model with VAC and VCSE organisations to tackle access to healthcare and social isolation within these areas for residents. This provided an opportunity for VCSEs to develop a working relationship with decision makers within a complex healthcare system and partake in a pilot that would act as a vehicle to develop solutions that can directly impact residents.

VAC had prior working relationships with Lifeafterhummus and Umoja Health Forum. Lifeafterhummus and Umoja Health Forum had been a community partner with VAC on the 'Winter Health' programme, where the primary aim was to serve communities during the COVID-19 pandemic.

Umoja Health Forum had also previously used VAC's services for training on how to build a community organisation working within the British health system. They have reported that this has been invaluable in understanding some of the cultural and systemic differences in the health system. They have also previously conducted similar research projects such as this but the recruiting of volunteers this time is different to what they have done before.

## **3. Key Findings**

### **3.1 Design & Mechanics**

*i. Have you systematically identified relevant publics (and stakeholders)?*

Communities within postcodes NW1, NW5, NW6 were the primary focus end user groups as these areas were identified as known areas of Multiple Deprivation<sup>4</sup>. VAC responded to the commissioning brief including Lifeafterhummus and Umoja Health Forum within their proposal as they are community organisations that are already

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<sup>4</sup> Index of Multiple Deprivation (IMD) are data files from multiple sources that provide small area measures of relative deprivation across the country. This can be accessed: <https://data.cdrc.ac.uk/dataset/index-multiple-deprivation-imd>

present and serving communities within Camden.

*“Camden has the fourth highest population of people that live alone. There is a high number of people in Camden predominantly in council housing, who live alone. Social isolation and loneliness is impacting on their physical and mental health.”*

VAC had selected the two organisations based on their existing working relationship with them. The communities that they serve are also currently defined as underserved communities where it is a priority for the integrated healthcare service to ensure they are reaching and understanding their respective needs.

*a. Mechanics of building research capacity*

When setting up the two organisations to ensure that they were set up to conduct research within the community, VAC spent time supporting and encouraging both organisations in the development of their surveys. VAC encouraged both organisations to be critical of their questionnaire writing to determine whether some questions were relevant within the context of this programme. This equipped the organisations with new tools and the opportunity to critically assess why they might be asking some of the questions that they are asking and what their aims are from asking those questions.

The community organisations have previously taken on research surveys or questionnaires handed from public health bodies where the questions may be developed based on assumption rather than experience. The surveys are then usually conducted verbatim without understanding why those questions are being asked. In this programme, the organisations have taken an active role in shaping the questionnaires that they are going out to the community with. This has been reported as invaluable in shaping a more co-productive, collaborative process.

*“I feel that's what's happening here. There's a lot of pulling things apart and learning about getting the process right which is a good thing.”*

*“What do we expect from the small [community] groups to do in terms of research, what is it they can do that is light touch by doing these surveys. Surveys are quite onerous. It can feel repetitive... Is there another way?”*

*“A lot of assumption is made by people who don't have any frontline experience. And that is really damaging but it goes on all the time.”*

*b. Data collection and managing this with VCSEs*

The two organisations had different ways of collecting the data: Lifeafterhummus used google online forms and Umoja worked with VAC using Form Assembly for their electronic version. For storing data, Lifeafterhummus used Salesforce and Umoja wrote up their findings onto Excel and then it was stored on their own computers. Umoja's forms were also printed off as hard

copies when conducting research in-person. VAC had hoped that both organisations could store data centrally so that it would be possible to collate and compare between accumulated datasets.

To align on GDPR, there was a light touch discussion at the start of the programme on how data should be managed and how this is communicated to those that they engaged. However, it has been reported that there was not enough resource to do a more thorough GDPR training with the individual organisations although VAC do offer these workshops outside of the programme.

*“If you are going to collect information from people and store it, you know, it is so important to emphasise the importance of that no matter what size organisation you are.”*

It is hoped that by going through this process, the organisations will prioritise these training workshops going forward as part of their own best practice as these workshops are currently attended by bigger organisations that accumulate larger sets of data.

There were some conflicts identified between VAC and the community organisations where some data was identified as unnecessary for the purposes of this particular programme but the individual community organisation deemed it to be important to understand from a demographics data perspective. This has pulled up the question of how to ensure that the brief is understood and ringfenced around the needs of the programme itself and has highlighted the need for guidance on GDPR and data collection from the commissioners brief to ensure alignment on these aspects of the programme.

*“Sometimes it’s more important to understand the boundaries of the programme. Pointing out everything and asking questions that you won’t need, or use is quite intrusive, and it’s not good practice at all.”*

ii. Do you understand the expectations and specific benefits each group is likely to derive from engagement?

From the commissioners’ perspective, the perceived benefits of this approach is being able to galvanise the neighbourhood network for the community groups for better working solutions across the borough, not only by understanding the needs of the communities within them but by offering the opportunity to co-produce the solutions using the resident feedback. Other ways this approach benefits commissioners are being able to understand the needs of the communities that they may not usually have access to. This helps to ensure the services provided by the integrated care system is relevant and for the community.

*“It’s about getting to what’s important to the communities and working with those*



*communities to design the future neighbourhood and/ or provision of service. It's also important to understand the real-life barriers for those experiencing it, we need to capture those"*

The expectations in terms of outcomes of this approach is that there will be an equitable partnership built amongst the organisations involved. This partnership helps to better understand communities' experiences and understand how to improve local solutions, services and working. It gives opportunity to those organisations to elevate their services and skills across the borough to better serve Camden's diverse communities.

*"This programme facilitates discussions and brings together findings in a way that hasn't been done before. This is the opportunity to try and implement change in a different way. An opportunity to embed engagement and co-production."*

For the community organisations, it is about being able to engage and collaborate with local communities and harness local VCSE and communities' strength. Using the partnership and neighbourhood working, they can tap into communities that are not their immediate service users but those that could benefit from their services. When the VCSEs were using research tools to reach out to the local communities, this was an opportunity to support those communities in accessing the relevant health information and understanding their current needs in relation to the health system.

It provided an opportunity for VCSEs to understand the needs and think about how they can tailor and deliver their services considering those needs. The expectations from the community partners are to gather feedback from the communities and to be able to use this to develop community-led solutions for the borough relating to access to healthcare and social isolation and loneliness.

*"What we want is to collect rich and useful information for this project. But we would also like to see the feedback and how the results are shared and actioned."*

At the start of the project, it is reported from interviews with VAC and the community organisations, that it is unclear how the communities that are engaged may necessarily benefit from engagement outside of participation being seen as a positive benefit to improving public health. The expectation from the community organisations is that the feedback from the communities would be turned into actionable insights that could be integrated as solutions for the wider borough.

*"We should be recruiting more people from local communities, to be working in our services, to be working in the ICB, to be working for the Camden borough partnership. That's how we can really embed the voice of people."*

iii. Have you identified and made contingencies for any risks & assumptions?

Risks and assumptions are not outlined explicitly for the programme as there was an

open brief to allow for the community organisations and VAC to determine the programme deliverables and the opportunity to co-produce the partnership model. Some of the perceived risks and assumptions identified by the stakeholders having participated in the programme have been highlighted in Table 2.

There were challenges and limitations to the level of change the organisations could achieve through the programme, having to work alongside a complex system such as the wider NCL ICS and NHS services. Although the communication about the programmes' limitations on enabling change and some of the endemic challenges within the system was explicit from the start, at points it proved difficult for the community organisations to understand how they would be able to enable change on a local level without the help of senior executives from NHS. This caused some disruption in producing solutions that could be workable for the organisations involved.

*“A number of things are structural and endemic across all of NCL ICS across all of the NHS.”*

*Table 2. Main assumptions and risks highlighted from interviews with CBP, Community partners and VAC*

| <b>Assumptions</b>   | <b>Risks</b>   |
|--|--|
| Community partners think that CBP would be able to support and give them information and access on the healthcare system for research purposes   | Lack of resource and can have a knock-on effect on engagement of participants  |
| Community partners assume that the CBP/ICB want to leverage insights so that this can be implemented for action but quite often may not understand what they need to present to enable impact in this area | Reputational risk for CBP, ICB – further dissatisfaction from community partners which can cause distrust amongst the partnership.                 |
|  | There are activities that are set out in the commissioners' brief that take longer than initially expected which influences the delivery timeline. |

*iv. Have you tested your activities and sought feedback from relevant publics?*

The data collected by the community organisations and resident researchers was good and rich from both survey feedback. The key insights are being presented at the CBP Board meeting on the 20<sup>th</sup> of April 2023 and data is being stored by the community organisations. 80%+ feedback collected were from people of colour with 147 residents participating in total. Some of the wards targeted such as St Pancras, Somers Town and Regents Park are some of the most deprived wards in Camden.

Throughout the programme, the joint meetings with community organisations, VAC and CBP was used to raise any barriers and concerns for conducting research. For example, when there were barriers in reaching more residents within Camden, CBP were able to use the neighbourhood connections to connect the community organisations with more residents within the borough.

### 3.2 Context

*i. Does your proposed programme match the interests and needs of your target publics and their social and cultural context?*

For Umoja Health Forum, their service users are Black African communities and through their research they were able to find that communities experience loneliness, low-paid jobs and are hugely affected by the cost-of-living crisis. There is a language barrier with many residents reporting that this affects their ability to engage with healthcare services, e.g., limited time to express themselves at GPs, misdiagnoses; mental health problems; paranoia; and digital access barrier. This has allowed them to develop a solution that helps communities 'feel connected' by advocating for solutions that are supported by cultural advocacy with existing providers such as foodbanks and other care provision.

For Lifeafterhummus, they have been able to conduct the research on many disadvantaged groups where economic barriers limit them to only access the public health system through one pathway which has been reported as being usually through their local GP surgery. The residents they reached report challenges such as digital exclusion, lack of face-to-face appointments and mistreatment in the surgery due to racial discrimination or language barriers. The feedback has highlighted the need to find ways to amplify resident voices within the surgeries and for surgeries to consider the experiences of the residents within the GP services.

*ii. Is there experience of engagement and existing trust between members of the research community and publics?*

Engaging smaller community organisations that provide services for existing communities within the borough is a strength within this programme. It helps the CBP and ICB to reach communities and publics that they may usually not have access to. Although the trust is reported to be good between the community organisations and the residents, many report that without actionable outcomes they fear that this trust could be lost with them too.

*“We want our results to be heard and something to be done about it. We want as many people from the community, as wide as we can reach, to take part in these interviews, but I think the main thing this information should be used in the right way. So that it can improve the well-being of our community.”*

This is particularly relevant for those communities where the language barrier affects their ability to access healthcare services easily and might influence their ability to

connect with others which in turn can cause them to become isolated.

The community organisations are well placed to begin developing trust within these communities. Their ability to reach communities without an 'NHS' label also makes them more accessible for certain communities. This also presents an opportunity for these organisations to begin advocating for the specific needs of these communities and develop solutions alongside CBP.

*iii. Does the project team have sufficient resources and support for engagement in this context eg. for research?*

As the risks and assumptions were not explicit for this programme outside of basic safeguarding training and DBS checks, the resources and support needed for this type of engagement was reported as difficult to scope. Scoping the programme with community organisations or organisations that would be able to advise on contextual elements such as challenges and opportunities of a project like this may be beneficial.

Resource and capacity are always difficult within VCSEs as most organisation members are volunteers and do not have full time roles within the organisation so having to manage this within the programme was highlighted as being difficult to manage. A clear project managerial role may have helped to ensure that any risks were raised when they arose.

*“Small organisations rarely have the capacity to do things. But for this project we were expected to attend so many meetings. Some I wasn't sure why I needed to be there, and this made things overwhelming as I struggled to know who would need to attend or not attend. It wasn't very clear.”*

There was training at the start about how to work within a complex system, however, more training on stakeholder management could have helped throughout the process as understanding how to manage the relationships between the stakeholder groups has been one of the most important learnings from this programme.

### **3.3 Outputs**

The immediate outputs from this programme are:

- The research surveys delivered by the community organisations and data collected from residents.
- Key insights which each of the community organisations will be presenting to the integrated care partnership board.
- The research surveys and data collected are managed by the community organisations with advice from VAC regarding data storage.
- Evaluation report
- A retrospective workshop with all stakeholders from CBP, VAC, UCL and the community organisations.

*i. How will you know you have delivered these outputs?*

Research surveys and data have been created, collected, and stored as part of the research programme for each of the community organisations. The key insights have been drawn out and edited into the final report to be presented at the CBP Board meeting. The retrospective workshop was delivered whilst the final surveys were being disseminated. This gave the project team an opportunity to reflect on the process and what variables are needed to ensure this runs smoothly. It also gave each stakeholder group the opportunity to discuss the challenges from both an endemic perspective and those occurring from the programme delivery.

This evaluation report and CAR programme findings produced by VAC will be disseminated to ICB, community partners and to residents.

*a. Operational Framework*

The evaluation has helped to develop an operational framework that can be used to mobilise a participatory community action research programme. The framework is divided into four key areas that can help to mobilise a participatory community action research programme. These are categorised into: People & development, Processes & tools, Programme performance, Leadership & direction.

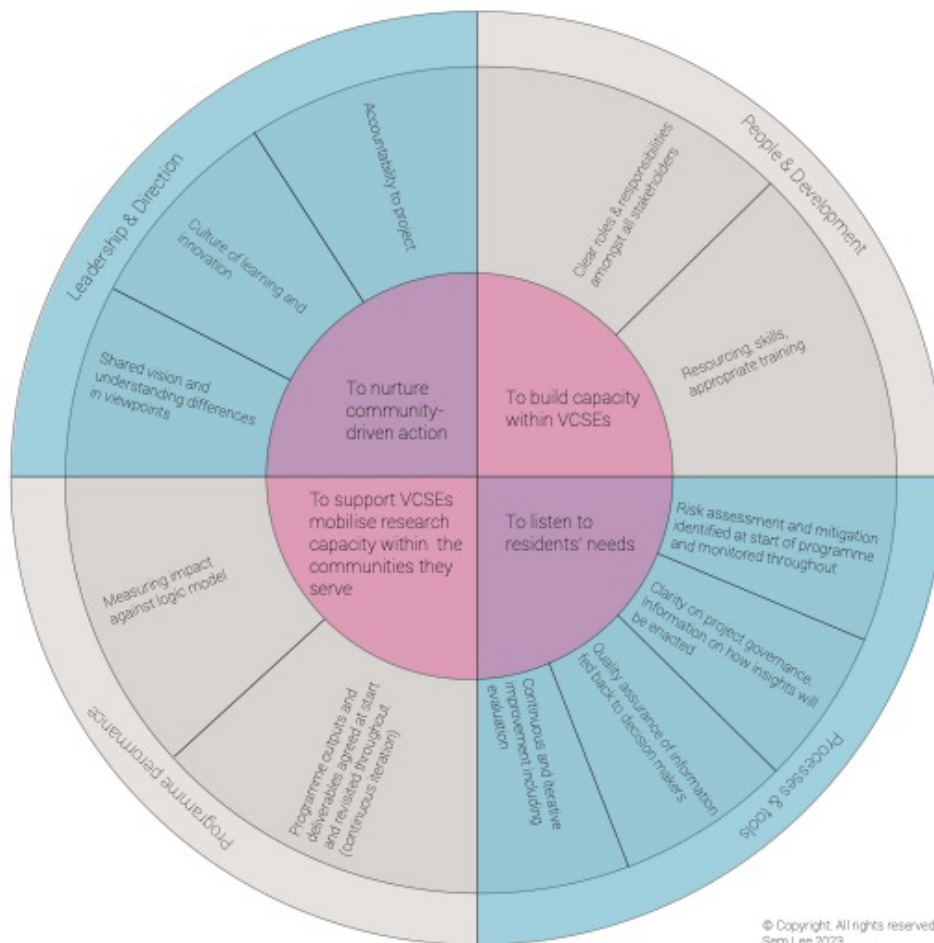


Figure 2. Operational framework for working with VCSEs on Community Action Research Programme

In the people and development segment, it identifies activities that will help to build capacity within VCSEs. It is not necessarily about hiring more people but ensuring that for those involved that there is clarity around roles and responsibilities on the programme are clear which will help project teams know what the expectation of their participation is and what the commitment will be. It also highlights the need for appropriate training and providing the team with the skills needed.

Within processes and tools, these are some of the project processes and tools that have been identified as helping to build a robust CAR programme that elevates residents' voices and enables a feedback loop between the residents, community organisations and NHS partners. A risk assessment and mitigation plan should be identified at the start of the project and carried throughout to ensure the safety of the project team and residents involved within the programme. An understanding of how the data and insights will move through the project and actions prioritised should also be identified at the start of the programme and communicated with all stakeholders. The outcomes, impacts and operations should be closely evaluated and monitored throughout the delivery of the action research.

To mobilise and improve research capacity using CAR is by implementing an iterative process and measuring performance at frequent stages. Activities that help towards this have been identified in the programme performance segment. The iterative nature of measuring performance helps to understand what works well and shift priorities if an element of the programme is not working so well. The outcomes and impacts can be identified through a logic model and revisited throughout the programme to measure impact.

Within the leadership and direction segment, it identifies values that can help to nurture community-driven action. An environment of learning and innovation should be cultivated with all stakeholders being held accountable for enabling citizen-led action. This shared vision for the programme should be made clear at the start of programme and all stakeholders trained to nurture ways of working that take on an empathetic approach. This can help to understand the differences in viewpoints and help in providing a more productive working environment.

### **3.4 Impacts**

The following are the impacts of being part of the CAR programme identified by those that were interviewed. In some cases, for example health impacts are expressed as aspirational but have been reported as potential positive impacts if the CAR programme were to be sustained longer-term. Detailed outcomes identified through the programme logic model can be viewed in Appendix 1 and 2.

#### *i. How will you know you have delivered these impacts?*

Through the stakeholder interviews, impacts have been identified and categorised within operational, economic, environmental and social impacts. The impacts that have been delivered through this iteration of the programme have been identified and

communicated but others may need to be evaluated on a longer-term basis to understand its actual impact.

*a. Operational*

Both community organisations have reported that they have had previous experience conducting research, but this was the first time they were responsible for the development of the research questions. This has allowed them to build new skills in having agency over developing own research, but it also helps them to have the tools to teach their student or resident researchers that they may recruit to conduct the questionnaires. This is a great opportunity in knowledge exchange and building capacity between the community organisations.

All stakeholder groups were able to learn from each other about each of their skills and the knowledge that they bring to the programme. This helped to streamline processes but also helped the community organisations to creatively solve problems together which built trust amongst those involved. Once the organisations began to collect data, synthesising and communicating the data to the CBP was a quick and easy process. However, more training could be helpful for the community organisations to understand or synthesise this information into a format that could be used and integrated alongside NHS workstreams so that impact of collecting data and sharing is seen from the organisations.

There is a stronger partnership between VCSEs and wider NHS organisations due to the community action research programme which could help with understanding how to mobilise future collaborative projects and/ or understand how to build research capacity within the community.

*b. Economic*

The economic impact of this programme is difficult to distinguish over the short period of time given for the evaluation. However, those interviewed highlighted the potential to improve community health. The programme helped to identify how to improve access to healthcare services for those that have a language barrier. Building knowledge within the community about the relevant community organisations can have a knock-on effect on the number of people needing acute healthcare. Residents would be empowered to either reach out to the community organisations and then be signposted to the relevant services. The benefits of the impacts in integrating this programme could be understood through using a form of cost benefit analysis which includes the potential health impacts within the economic calculations.

From the research, both community organisations highlighted the difficulties that residents face when English is not their first language. This can cause barriers in access to healthcare but also can often cause individuals to lose their confidence which further exacerbates social isolation. Residents that understand where to go for information but also who to speak to can build their confidence. The community organisations being present and accessible within the borough can help improve

overall community health and in turn, improve the economics of the borough.

#### *c. Environmental*

The programme has evidenced how the community organisations can help to build trust within the community and mend residents' relationship with the healthcare system. This can help the healthcare service to build capacity within the integrated healthcare system but also provides an opportunity to lean on the skills of the community organisations to ensure that residents are receiving the care that they need.

Ensuring that all communities across the borough have equitable access to healthcare despite language barriers can help communities feel more empowered and help with the overall health and wellbeing of the population. The solutions that come out from the programme can also have positive effects on improving residents' health literacy as residents will begin to understand where to go for any healthcare advice if they need rather than going directly to the GP and through word of mouth the information is likely to be shared with the wider community.

#### *d. Social*

One of the key benefits of this programme was to test out how to mobilise the working relationships between community partners and CBP/NHS networks. The assumption was made that this would allow for more efficient feedback loops regarding data but also offer opportunities in elevating community organisations and their purpose within the NHS ecosystem.

The data feedback gained from the research has been very positive and invaluable as the demographics targeted were those that may usually be excluded from surveys conducted by NHS services. It is important to state that both Umoja and Lifeafterhummus were able to gather feedback from those that may usually be digitally excluded but also may experience language barriers. Umoja conducted their surveys in-person which meant that they were able to work extremely closely with the residents and build a rapport.

These in-person visits by the community organisation helps to improve trust amongst residents and has potential to improve independence once residents understand there are other services that they can reach out to with regards to healthcare. This highlights the importance of a community organisation conducting this form of engagement and being able to provide the knowledge on care services within the borough.

## **4. Recommendations**

The key learnings from this programme have been on how to develop effective ways of working between the partnership organisations alongside a complex system and how to mobilise research capacity of this format given that complexity. As the initial brief had not been defined with the community organisations, there were some real-world barriers that caused delays in the mobilisation phase of this programme. The



iterative process of the programme seemed to be a new way of working for most stakeholders involved so more training or facilitation on understanding these dynamics could have helped the community organisations to understand how some of the challenges are part of the process to arrive at a solution.

As identified in the operational framework, building capacity in a way that holds people accountable throughout this process and supporting the project teams with clarity around how decisions could be enabled are just some of the ways that this programme can thrive and achieve the longer-term impacts on the project team, community and wider integrated healthcare system.

Systemic barriers that the community organisations identified through their research were relevant in understanding how these barriers manifest in real-world contexts, however, understanding the aim and objectives of the programme to be about developing solutions despite those barriers caused some confusion throughout the programme.

The leadership values identified in the operational framework such as communicating a shared vision and being able to be clear on the boundaries of the project are core to the success of the project. Being able to navigate difficult discussions with stakeholder groups that work in different parts of the healthcare ecosystem is integral to the success of a programme such as this. It is important that all participants within the programme understand that there needs to be an empathetic way of working and more training around this can help support this.

This programme evidenced how effective integrated partnership models could help improve health equity by galvanising the knowledge and resource of VCSEs. It has highlighted the opportunity to help those that are most disadvantaged and the responsibilities that community organisations have in providing integrated healthcare from both a signposting perspective but as a knowledge hub.

We recommend that for a CAR programme, it is essential to co-produce the aims, objectives, deliverables, and timeline together once the team have been assigned the project. This would allow for the project team to feel accountable and help to identify the risks and assumptions together at the start of the project. An integrated and participatory evaluation process that allows for collective reflection and an opportunity for the team to work through difficult discussions including topics on more systemic issues can help to bring alignment on the aims and objectives of the programme.

We also recommend that there is more clarity on how the information from the research collected helps create change which is shared with all stakeholders. For example, whether they will be used at a higher strategic level or as insights to implement solutions at community level as there was confusion amongst the community organisations about who had decision making power and whether this was relevant information needed for this programme.

For future programmes, it is also important that there is a centralised data store which the community organisations can feed into once the data is collected. This will help to organise, evaluate and synthesise information in a more efficient way.

## **5. Conclusion**

This programme was a good pilot in understanding how to mobilise research capacity with the community organisations playing a key part in understanding the needs of the community. The community organisations were able to take on skills to help them pro-actively shape the questionnaires but also were able to begin building trust with residents whilst disseminating the surveys. There is an opportunity for community building through this research activity and helps the community organisations become expert in understanding the communities' needs.

Developing a partnership model between the commissioners, VCSEs and other organisations to enable community-led decisions could help to build capacity within the integrated healthcare system and ensure that solutions are catered to the needs of the community. However, it is important to identify the risks and assumptions at the start of the programme collectively and to ensure that there are a co-produced set of aims and objectives which are set by all stakeholders involved.

Managing risk throughout the programme including the safe handling of data is priority throughout. This helps to ensure that the research is delivered in a safe way that continues to have a positive impact on the community.



## Appendix 2. Logic model of programme

