DOCTOR OF PHILOSOPHY

A Realist Evaluation of Geographically Distinct Community (Health) Development Projects: What works in Wales, for Whom, How, Why, and in What circumstances?

Rogers, Andrew

Award date:
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Thesis submitted for the degree of Doctor of Philosophy

December 2022 (Final Amendments November 2023)

DECLARATION

‘Yr wife drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw’r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o’r blaen ar gyfer unrhyw radd, ac nid yw’n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.’

Rwy’n cadarnhau fy mod yn cyflwyno’r gwaith gyda chytundeb fy Ngrichwyliwr (Goruchwylwyr)’

‘I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.’

I confirm that I am submitting the work with the agreement of my supervisor(s)’

Signed:

Andrew Rogers

Date: 14 December 2022 (Final Amendments 15 November 2023)

ABSTRACT

Background: Community development as an idea and practice for building health and wellbeing has been around a very long time and is a heavily researched area. Despite this there remains a lack of consensus about how it works best. A vast pool of theory suggests what should work, but little consensus exists of exactly how it works and for whom it works best in specific contexts.

The **aims** of this research are to utilise realist lenses to unpack the black box of what works in community health development, for whom it works and in which specific circumstances to improve health and wellbeing. A **methods** combination of realist synthesis and realist evaluation methods were employed and flexibility with the application of methods became crucial.

The Coronavirus Pandemic cut across the research at an early stage and made this work and findings even more poignant. The impact upon communities was universal. All communities were affected, but with variable consequences, as some communities were enabled to find new ways of operating and building wellbeing, whilst others were debilitated.

With minor methodological adjustments this research (whilst somewhat challenged) continued apace, bringing exciting new dimensions and depth, to the understanding of how community development works to bring about wellbeing outcomes in North Wales communities.

Four community development projects were studied from across North Wales to find what works, for whom, how and in what circumstances.

The research **finding** was a set of four consistent programme theories and an overarching meta programme theory within which programme theories work synergistically within projects. These findings led to the **conclusion** that these programme theories may be used to harness and build on both a

particularly Welsh sense of ‘Cynefin’, and an understanding of salutogenesis within projects, to enable the communities they work with to develop greater health and wellbeing.

The findings are crucial for the research partner Betsi Cadwalladr University Health Board as they increasingly seek more effective, sustainable ways to involve communities in building their own wellbeing, co-produce effective prevention methods and reduce the need for care services.

Keywords: Community Development, health, wellbeing, Cynefin, salutogenesis, realist evaluation, context, mechanism, outcomes.

"*Like when you fail to make the connection, you know vital it is*
Oh when something slips through your fingers you know precious it is
And you reach the point when you know
It's only your second skin".

The Chameleons *(*1983*) Second Skin,* Script of the Bridge

Almost a lifetime of searching for the connections

ACKNOWLEDGEMENTS

This thesis is dedicated to Cariad and Cynefin.

First and foremost, to my faithful and supportive wife Jillian who has provided sustenance and motivation even when her own well ran dry during a momentous time in our lives with changing life circumstances in both of our families.

Secondly to the land and communities that continue to inspire me in North Wales.

I have felt connected to this part the world since my own childhood and the happiest moments of my childhood in Llanbedrog, introducing my own children to Pen Llyn in the 1990s, throughout the ten years I happily lived in Nefyn between 2010 and 2020.

Nefyn is where I established my business consultancy and began the research leading to this programme theory after observing communities at work trying to take ownership of their own wellbeing and resources.

Latterly to our home in Llanddaniel Fab on the quite unique Isle of Ynys Mon.

This thesis also could not have been completed without the support of European funds through KESS 2 and the motivational support of Penny Dowdney locally in Bangor University and her team.

Similarly, it could not have been conducted, or sustained through the pandemic, without the active engagement of all the participants and in particular the lead stakeholders in each Community Health Development Project – Karen Sankey, Cher Lewney, Scott Jenkinson and Lyndsey Campbell – Williams.

Heartfelt thanks to Paul Brocklehurst and all the supervision team, particularly Sion Williams for picking up the reigns when six became one,

and Glynne Roberts for providing the vital links with the Health Board and case studies as well as securing funding. Gail Findlay provided such a valuable touchstone for all things health promotion and community development, and whilst only along for part of the journey Lynne Williams and Jo Charles both provided necessary guidance and support in the initial stages. And, to Professors Carolyn Wallace and Angela Harden, who between them provided robust challenge as external examiners that was much valued, plus Jaci Huws as Chair of the Viva process and an invaluable mentor.

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In the same way I experienced great support from my Manchester University long term colleagues, particularly my co-pilot in teaching Angela Spencer.

And finally, to my own children Chris, Alice, George and Kat, I hope your lifelong learning opportunities are embraced and you keep building on the great foundations you have already made.

I realise a miracle is due.

I dedicate this melody to you.

But is this the stuff dreams are made of?

(The Chameleons, 1983)

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LEXICON – SEMANTIC CONSIDERATIONS

Rather than a “glossary” which tends to suggest a fixed set of meanings, this section of the Thesis is more accurately described as one which covers the “semantics” in and around community health development. As such it is more like a lexicon, or dictionary of terms, used within this field. This is an essential element of the thesis because many of the words are common ones used beyond the field but are used in extremely specific ways within it.

“Community” and “Wellbeing” are particularly important to anchor as core definitions to work from as they are both words that are commonly used in the arena of social policy, but that usage, understanding and application varies remarkably widely.

Every aspect of the concept’s “community”, “health” and even “development” are essentially contested (Gallie, 1964) and the arguments underpinning them are important to understand as they are reflective of the many different positions taken across theory and practice. Positions which are underpinned by professional ideologies, philosophies of life and living, and political beliefs.

Community is the cornerstone concept in the thesis. At its most basic it means people coming together with other people to share their gifts. Gifts in this sense can be anything from tangible help and support to the exchanging of ideas, learning, empathy or merely recognition and acknowledgement. What is most important is the coming together in a dynamic interaction to do this. In that act are the core elements of people relating to each other and not merely interacting but giving and receiving.

However, that is a far from universal definition of community as it is a word that is used commonly across many different contexts to refer to a wide variety of things. It most often denotes the people in a shared place, a people with a shared connection or interest, or simply people who have a similar demographic. What seems to be central to most definitions however is the

centrality of the people in that community defining it themselves, rather than outside observers, and so most often it denotes people with a shared understanding, challenge, values, behaviours or resources upon which they rely.

As MacQueen et al., (2001, p. 6) assert.

> "*Community collaboration in public health programs and research presents many challenges, in part because community has been defined in ambiguous and contradictory ways. Despite important differences in the experience of community, our study suggests that people largely agree about what community* is."

This suggests that despite ambiguity there are certain core features around which most observers or users of the term coalesce.

For example, traditionally definitions of communities have had hard geographical and tangible boundaries associated with them, and are dominated by notions of place, but with the rapidly evolving impact of social and digital media communities can morph with online versions of themselves and bleed through and across any geographical local boundaries. Common themes about 'community' however remain in the social and digital media uses of the term such as social ties, sharing common perspectives, and engaging in joint actions.

Communities may be small, large, and they also be nested inside one another but irrespective of such a wide variety of definitions the use and application of the word is always deeply contextual and specific people within it.

In common usage the notion of communities most often has a rosy tinged glow to it, however this overwhelming positivity also masks more negative elements and applications. Whilst positively it is associated with collectivism, mutuality, social capital building and strengths-based approaches it also extensively used to describe people who are considered problems in a collective sense, 'social challenges' or a 'problematic population'.

Symbolic boundaries separate people into groups and generate feelings of similarity and group membership (Epstein 1992, p. 232) however that also places those without such similarities beyond the boundaries. It is always therefore important to acknowledge that as much as community is about forming a boundary to describe an “us” that very boundary also determines a ‘them’ and this may then give rise to multiple interpretations and a gamut of applications of the concept.

To ensure that the concept of community on its own is not rendered almost worthless due to its sheer breadth of interpretation, and even paradoxical application in practice, it requires caveats and explanations alongside it to guide its use in any particular set of circumstances.

This can be a lengthy and complicated endeavour being so contextual to any given place and collection of people, yet this thesis does need to start somewhere, therefore a core definition has been selected that has a both a strong recognition and heritage within community wellbeing and public health in Wales.

This touchstone for further deliberation and scrutiny comes from the ‘Strategic Framework for Community Development’ produced by the UK wide Standing Conference for Community Development (SCCD, 2001a) which is a membership organisation bringing together those involved in community development practice, policy, and research. SCCD has members in the community, voluntary, public, and private sectors plus is partly funded by the Home Office and supported by the Local Government Association.

They define community as

> *“the web of personal relationships, groups, networks, traditions and patterns of behaviour that exist amongst those who share physical neighbourhoods, socio-economic conditions or common understandings and interests”*
>
> (p. 4)

Community development is then further described as

> *"...about building active and sustainable communities based on social justice and mutual respect. It is about changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives."*
>
> (p. 5)

In other words, it is primarily about building and strengthening communities by enhancing the webs of personal relationships and then helping them deal with shared challenges.

The SCCD also assert that community Development is strongly supported by a set of values and commitments. Indeed, without the attendant values and commitments being considered alongside the definition it is merely a shell devoid of any real meaning.

Health

This is potentially even harder to pin down conceptually and linguistically as community.

In his seminal book "Health is for People" (Wilson, 1975) Michael Wilson claims that health, like truth, is a concept that cannot be defined as to do so kills it. In other words, like community there is a richness in its varied interpretations and contested ness that somehow gives it a life force.

He makes no attempt at a definition himself but instead lists over a hundred important characteristics that may constitute health. His rationale for not defining it is that he suggests in modern usage it denotes a value judgement. Different people attach various values to the term, and the same people have values that vary over time which results in great complexity and confusion.

Consequently, concepts of health across most societies become closely linked to the fear of pain, dying and death; entangled with our concepts of

dirt, hygiene, and cleanliness; and even to how we view order in society (Acton,1984, cited in Acton & Chambers, 2018).

From a historical point of view, prior to the 19th Century, Acton accounts that health was a value to people that was intricately entwined with their struggle to exist. It was a goal and explanation of life itself. The rich had physicians whose focus was on keeping them healthy not on curing ills. The poor in contrast had little access to physicians and maintained their health through self-care and lay healers. For them health was a process not an outcome and its relationship to daily and community activities was well understood and embedded.

People were regarded as a unified whole, illness and disease understood as the imbalance between an individual and the world around them. Life was viewed predominantly in cosmological terms and the spiritual dimension had a central place in the concern for health.

It is interesting to reflect that the well-worn classic modern definition of 'health' that comes from the World Health Organisation "*health is a complete state of physical, mental, and social well-being, and not merely the absence of disease or infirmity and is a fundamental human right*" (WHO, 1978) sits more easily with the way health was understood then than it does in the 21st Century.

Whilst the Alma Ata definition is still often cited it also done so against the concept of illness, using illness it as its reference point and it usually needs much more explanation in comparison and contrast to health care or medical/nursing models.

Which is itself a curious departure from its original usage and reflects the way that the rise of healthcare has reshaped its understanding rather than the fact that the basic understanding of health as holistic and about balance in living goes back beyond the 19th century to primitive times. Its development as a basic concept remained largely unchanged through the Centuries (certainly through Medieval times and beyond) with only modifications for different culture and times.

The holistic sense of health still exists in some cultures today and similar expressions may be found in aboriginal cultures, such as Ba in Japan and amongst the Navajo Native Americans. Yet the dominant ideas of health, even in the face of the WHO definition, across most cultures remains one that is essentially about avoiding or managing illness (Kennedy, 1980)

> *"'Health, if it is to have any useful meaning, must refer to more than the mere absence of illness. It must have a positive quality. It must refer to all those factors which combine to represent man's aspirations and expectations. But, if expressed in this way, again you see at once that here is no term of nice exactitude. It is, in short, an evaluative term, redolent with moral, spiritual, political and social overtones, and by no means limited to bodily functioning*".

Quotes like this are against the orthodoxy, largely due to the continued dominance of the medical model which not only uses symptoms as the basis for determining health (or not) it also steals the responsibility for health from people themselves and their communities. Definition and diagnosis are conducted by experts who prescribe or recommend ways of dealing with problems and the actions required to prevent further occurrences.

When considering health in community development programmes the comparison between the medical and social models of health is frequently returned to as it is from this dynamic that almost all approaches to improving wellbeing in communities flow in one direction or another.

The medical model and its focuses on disease and disease prevention (described by a set of symptoms resulting from, genetic pre-disposition, pathology and individual lifestyle factors) essentially looks at what is 'wrong' with the person and what makes them ill, not what makes and keeps the person well and healthy.

There is obviously an appropriate time and place for such an approach but its dominance in practice overpowers alternative understanding and methods of promoting health and wellbeing.

At its worst it can lead to dependency on specialists and services to take control over individuals and communities health and it can foster a fatalism whereby people lose sight of their own potential to create wellbeing and accept disease.

In contrast the social model is founded upon the belief that the health of an individual and a population is also the result of the way society is organised.

The Community Development and Health Network (CDHN, 2019) contrast both these models with the other important models of biopsychosocial, ecosystem health and salutogenesis (a conceptual model that explores the origins of health rather than illness) noting that.

- The Social Model of Health was developed as a reaction to the traditional medical model, and it examines all the factors which contribute to health such as social, cultural, political and the environment.
- The Medical Model of Health, developed during the age of Enlightenment in the 18th Century, reduces health to merely an attribute you can measure simply by determining if a disease is present or not. The strong emphasis on the absence of disease as an indicator of good health, and the overdependence on the influence of medical science in health, ignores the power of other important influences.
- The Biopsychosocial Model of Health (Engel, 1977) recognises that many factors affect health including biological factors which affect health, such as age, illness, gender etc. The psychological factors: individual beliefs & perceptions. The social: the community, the presence or absence of relationships
- The Salutogenic Model of Health is a much more recent development and explores how and why we stay well, changing the focus from

looking for the cause of disease and illness to looking for the origins of health and wellbeing.

- The Ecosystem Model of Health considers people as part of, and one among many, in an environment that is being changed as result of human activity: land use, climate change, population growth, resource depletion, pollution, urbanization, loss of biodiversity, and other local and global processes disrupt the natural self-regulation of the biosphere. Health and wellbeing development in this model is about rebuilding the balance between people

The common theme that emerges when considering all these wellbeing definitions in the round is that there is a common thread of ‘feeling good and functioning well’.

This encompasses an individual’s own experience of their life and has two dimensions covering both objective and subjective wellbeing.

Wellbeing

In shifting the dialogue away from health as illness, towards more rounded and positive understandings of health, “wellbeing’ often appears conjoined with it or added as a qualifier.

Wellbeing is no easier to pin down as a concept than health.

Wellbeing denotes positive aspects of health, but also positive outcomes for people across lots of the areas of their life that affect them. Its core is that it tells us when people perceive their lives are going ‘well’ and they are achieving or making progress with their own goals. However, it also most take account of the living conditions supporting them and resources they can access to reach those goals.

Wellbeing therefore has elements within it pertaining to

- Self-perceived experience of health
- Self-perceived experience of happiness
- Mental and emotional satisfaction

- Social connectedness
- Feeling productive and growing or learning
- Comfortable in each person's unique environment
  (CDC, 2021)

It is therefore both personal and subjective but at the same time universally relevant as it encompasses all the environmental and social determinants of health in addition to the experiences, we have of them.

There is an active debate about wellbeing within the health field and, just as here, many texts on wellbeing begin by setting out their specific definitions. This is mainly because values, personal desires and goals are so very varied and equally so are wellbeing contexts. This makes any attempt at measurement of wellbeing complex as it needs to navigate objective realities of contexts and subjective perceptions of experience.

> "Neither wellbeing nor happiness are definable, nor can they be understood even as 'concepts'. There is no single 'thing' to be measured or promoted. Rather, wellbeing and happiness are vague reminders of the importance of thinking and talking about what people value – how they hope to live well and enjoy their lives".
>
> (Future Learn, 2022, p.1)

One of the main though leaders in in wellbeing (concepts and measurement) in the United Kingdom is the What Works Wellbeing Collective, their definition of wellbeing is solid and reliable as it has been built from both an extensive concept analysis and upon the work conducted by the Office for National Statistics (ONS) who have built a live dashboard of wellbeing indicators informed by the leading academics in the field globally and through conducting a national debate.

> " Wellbeing, put simply, is about 'how we are doing' as individuals, communities and as a nation and how sustainable this is for the future.

> We define wellbeing as having 10 broad dimensions which have been shown to matter most to people in the UK as identified through a national debate. The dimensions are: the natural environment, personal well-being, our relationships, health, what we do, where we live, personal finance, the economy, education and skills and governance.
>
> Personal wellbeing is a particularly important dimension which we define as how satisfied we are with our lives, our sense that what we do in life is worthwhile, our day-to-day emotional experiences (happiness and anxiety) and our wider mental wellbeing."
>
> (What Works Wellbeing, 2021, p. 1)

Whilst these definitions of health, community, community development and wellbeing all remain rather lengthy and high level, they do provide at least some foundational anchor points from which to begin the research and this thesis exploring what works, for whom, how, why and in which circumstances.

FOREWORD

This exploration around and within community (health) development using a 'Realist' lens is difficult to untangle from a personal journey and on-going dialogue with health promotion and public health that has been central to my life since the very early 1980s. In short it has been my whole career. Hence it is important for me to engage in and include from the very start an element of reflexivity to allow me the space to step out and observe my own engagement with the research with an element of objectivity and with the aim of achieving more creditable findings and a deeper understanding of the subject. (Dodgson, 2019). My interest in the subject of this Thesis can be traced back to the very early days of my career as a newly graduated Human Ecologist who joined the field of health education within public health at the very time it was going through a paradigm shift to health promotion.

It is important to consider the relationship of the selected realist methodology for this research to the inherent perspective that drove my early career.

Human ecologists are trained to be "Rational Optimists" with a talent for being able to use a wide focus lens to examine an issue and all its complex linkages to fully understand why things are as they are, but with an optimism that things are always dynamic and that there are many ways to alter the dynamics so positive changes can result.

The simple 'laws' at the heart of human ecology if nothing else seemed immutable to me and they gave me a cornerstone to build everything else around:

1. We can never merely do one thing – the interconnectedness in nature means there is always a ripple effect, only some of which we are usually conscious of

2. There is no away to throw to, everything must go somewhere – and conversely there is no such thing as a free lunch, everything comes from somewhere

3. All systems strive for balance

4. Ultimately, nature knows best

Based upon this set of principles the human ecologist uses a specific lens to examine the world through which considers people in dynamic interrelationships with their environments. Irrespective of whether the issue being studied is an environmental or a human one the relationship between parts Is always considered, specifically the complex interrelationships between all connected entities is considered, and there is some attention paid to the concept of balance or at least the striving of all systems towards stability.

At the time such concepts became a fundamental theoretical debate reshaping public health itself, in practice it was still largely constrained by a professional led top-down approach essentially attempting to mould people's behaviour in relation to lifestyle factors and with the aim of preventing disease. However, the most vibrant thought leadership in this period came from the World Health Organisation and through its Health for All movement. (Mahler, 2016)

Health for All at its core was about understanding people and their health in context, using an ecological lens to recognise complex determinants that are unique to each person, community and population. It also set out broad spheres of action to improve health that were more than simply teaching people to take more responsibility for their health. The enduring themes of the movement became gradually eroded but are now re-emerging in contemporary public health (and potentially boosted even further following the coronavirus pandemic):

- Health is socially constructed

- The prime importance of tackling inequalities in health (it is not possible to be healthy in a sick society)
- People need to be actively involved in any efforts to improve their wellbeing
- No single profession or sector provides enough answers to health improvements therefore partnerships are always required, and health needs to be integrated horizontally across all policy areas
- The key to health education is not in providing people with information but in building their health literacy which brings skills and meaning to that information
- People themselves need to be engaged in the decisions about their heath

See, for example, the Health Foundation's Briefing: A Whole Government Approach to Health (Merryfield and Nightingale, 2021).

Throughout my career I strove for balance between the strong theoretical and principles-based underpinnings to practice and interventions, and, to always implement evidence-based practice myself.

For this reason, I was always drawn to the more ecological and radical examples of practice (health promotion at its core being both things).

Today the paradigms of health (human) and health (planetary) are finally aligning and a central theme in both is the awakening and empowering of people and collectivism and a call into community action for wellbeing.

Formally within Wales, we now have the Wellbeing of Future Generations Act (Wellbeing of Future Generations Act, 2015), to frame and enact the UN Sustainability Goals. Alongside this also is the flourishing of movements like Extinction Rebellion and young people following in the footstep of Greta Thunberg in protesting on plastics reduction and lowering the carbon footprint.

No longer being treated as isolated agendas these have maintained their prominence, even through the Brexit debate, and more recently the

pandemic. Now a richer discussion has begun to emerge connecting inequalities, governance and devolution, wellbeing, and sustainability.

The sudden arrival of Covid 19 to a global stage did initially halt these connected discussions as the shock of the impact and readjustment required was being taken in. Yet following the shock of readjustment an agenda about setting ‘a new normal’ promises to be the final setting within which some of the long running rhetoric and reality debates of human personal versus community versus planetary can now finally be played out.

The pandemic has shown that the pathogenic, or bio-medical approach, to disease prevention is fatally flawed and the inadequate use of a too narrow health education approach has failed. The impact upon communities has been devastating and once again it is to local community health development approaches that attention is once again beginning to focus on a bid to build up resilience of communities in the face of public sector service reductions/changing delivery models. (Grey, Homolova et al., 2022).

This time the difference is that the agendas are being integrated and the connections are being made between health inequalities, black lives matter, environmental protection, social justice etc. In the midst of the rhetoric of the clarion call for a new normal is the sense of a breakthrough in thinking. This thinking retains the sense of wellbeing people started to find again during lockdown, the potential for local supply chains, food poverty being a societal responsibility not a personal failing, and global interdependence.

Therefore, the main section at the end of this Thesis on reflexivity is extremely important as it accounts for the research processes and findings as they relate to both my career practical experience and the ecological lens that was so central to it.

It is making sense of this double helix and the constant drive to achieve authentic practice that has been my own personal driver to undertake this PhD.

Why is Reflexivity so Important to Set Out So Explicitly and So Early in this Thesis?

By examining my own beliefs, values, perspectives and practical approaches throughout this research process and openly questioning both how they are affected by the research, and how my experience and learning to date in turn inform it, may bring greater transparency to my own positionality and biases.

All of this is important as it demonstrates openness to explore the researcher's own assumptions and bias, accepting that the researcher themselves is very much a part of the research not merely an external conductor managing a process to completion (Finlay, 1998).

Reflexivity is also a Vital Component in Community Health Development?

It is particularly important to take a reflexive approach in this research as community health development itself encourages practitioners to constantly review the values underpinning their work, to question the HOW and WHY of their actions and to fully understand processes by which change happens. (Dodgson, 2019)

Central to this is encouragement to practitioners to develop a rounded awareness of who they are and how their power and position (such things as gender, class, education, status, etc.) impacts projects and the other people involved in projects as participants, partners, funders, or stakeholders. As suggested by Dailly and Barr (2008) only community development practitioners and organisations that can demonstrate openness, be democratic and reflect upon the needs of excluded individuals and groups will make a difference in their programmes. If they lack these self-awareness characteristics their actions may contradict the end outcomes that are sought.

Therefore, my starting point in this research is to acknowledge and then place close attention to the bias I bring into this unpacking of community health development to find how it works. To acknowledge the Human

ecologist perspective that is innate in the way I examine the world, to recognise what knowledge and experience I bring from over 35 years teaching and practical delivery in the field, but also to not be blinkered by that experience, but be open to trying different lenses to examine familiar practice and issues.

This albeit lengthy foreword serves to provide the back story to how at some visceral level the realist approach (Pawson and Tilley, 1997) selected as a lens in this research to explore community health development chimes with me and the socio–ecological philosophy that has driven my work within public health.

The realist proposition that understanding the relationship between context and mechanisms is crucial to determining outcomes just makes sense to a human ecologist! It is at the heart of the human ecology definition “the study of the dynamic interrelationships between people and their environments” (Marten, 2001). In other words, people in their contexts, acting and reacting to the resources around them.

Realists propound that context matters, it influences ‘reasoning’ and mechanisms can only work if the circumstances are right. The human ecologist as a rational optimist sees in this enormous possibility and an opportunity to explore all the potential dynamics operating in a complex community development project, all aspects of the context and the relationship between the various mechanisms operating at that point in time within a shared context offer a myriad of interesting possibilities to be studied and appraised. Eschewing discipline-based limits to this study can mean this process is lengthy and at times chaotic.

Indeed, the frustrations of human ecology are that because it demands such a wide lens and fluid approach to capture all possible dynamics it can fall into the trap of opening a pandoras box but then never actually brings all the questions raised together into any acceptable conclusions or answers. Realist approaches at the very least promise some rigour to the investigation and may anchor these tendencies in a rigorous process through the

formulation, testing and revision of context – mechanism – outcome propositions.

This research is therefore not only an exercise in academic rigour to tame the wider excesses of my favoured holistic viewpoint it is also somewhat cathartic as it looks back along a career of a jobbing human ecologist asking an important question:

‘Might employing a realist frame earlier in my working life have made me more effective as a health promoter?’

CHAPTER 1:

INTRODUCTION

This opening Introductory chapter sets the background to this research into community development for health and wellbeing in North Wales.

It reviews the nature of health and wellbeing and assesses the challenges for Welsh communities prior to considering community development's potential contribution to health and wellbeing and exploring its contested and complex nature.

It then provides a brief overview of the issues surrounding evaluation and considers ways to understand what works in community health development. It then finally sets out a map of the thesis and the structure of the chapters to follow.

As noted in the lexicon that prefaces this thesis, being precise in key definitions throughout is important and accepting that different stakeholders vary in their understanding of key terms attention will focus on ensuring clarity of terms used and how they are interpreted. The Standing Conference on Community Development (SCCD) offers clear definitions to start from.

1.1 The Study in Context

> *"At its heart, community development is rooted in the belief that all people should have access to health, wellbeing, wealth, justice and opportunity. It recognises that some people, some groups and some communities are excluded and oppressed by the way society and structures are organised. Community development seeks to challenge this and ensure fairness for all citizens".*

Community is

> ***"...*** *the web of personal relationships, groups, networks, traditions and patterns of behaviour that exist amongst those who share physical neighbourhoods, socio-economic conditions or common understandings and interests".*

Community development is then a process of

> *"..building active and sustainable communities based on social justice and mutual respect. It is about changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives."*
>
> (Standing Conference on Community Development, 2001b, p. 5)

The purpose of this introductory chapter is to set the scene for this thesis by exploring the health and wellbeing challenges in Wales; the potential contribution of community health development in meeting those challenges; its status and fit within policy and practice; and it begins to unpack the essentially contested and confused elements of the field which make usual methods of evaluation difficult and of limited value.

Throughout this chapter, and throughout the thesis, the very concepts of 'health' and 'community' are defined, revised and revisited at various points. This is because the variance in the way they are understood across theory and practice reveals a lot about the nature of programme delivery and stakeholder expectations.

The lexicon included at the start of the thesis laid a foundation of the researcher's preferred definitions, and specifically the definition from SCCD provides a touchstone to return to, but how variance in understanding impacts practice needs to be unpacked further here.

This study fundamentally acknowledges and takes a broad view of health and wellbeing in Wales, encompassing a more holistic notion without ignoring the popular (mis)conception of health as merely the opposite of disease and illness (Illich and Illich, 1977)

In contrast to that reductionist notion, this perspective includes a more salutogenic viewpoint (Antonovsky, 1979; Mittelmark and Bull, 2013; Burns, 2014) as it is this wider wellbeing notion that is more often embedded in contemporary community health development theories and practice.

This wider concept of health as wellbeing at community level is explored from several angles, echoing the complexity of its definition, assessing its changing nature in communities, and it considers the contemporary challenge to improving health and wellbeing in Welsh communities as they face a perfect storm of an ageing population that is getting sicker younger.

The chapter also explores the ways in which community health development is proposed as a potential solution to that perfect storm, interrogating a range of expressions and approaches that have become popular within public health. Approaches that are often viewed as theoretically strong, ideologically driven and accompanied by strongly expressed values and principles statements, but yet also lacking clarity of how exactly they work to produce health and wellbeing outcomes.

A very thorough review of community level interventions for health improvement was undertaken by the Tavistock Institute and the Health Development Agency (Hills, 2004). They found that, within the health field, there is an ongoing tension between the demand for evidence-based practice and the growing acknowledgement of the complexity of health at community level that community health development programmes aim to address.

This lack of clarity in how community health development works may be due to the wide-ranging expectations upon community development to produce a vast array of wellbeing outcomes but could also be, quite simply, because it is itself complex.

Ben Yosef Shay suggests that there is a fundamental complexity when the core concepts themselves are mercurial and difficult to pin down, explaining that ‘community’ is at the same time considered a “playing field’ for

interventions, a “resource” to be harnessed, and a “goal”, further that this is all inevitably played out in complex contexts in communities. (Shay, 2022)

The rationale for using a broad lens to attempt to understand community development and its contribution to health and wellbeing is exemplified in the dilemma outlined by Brian Fisher, a general practitioner, in his call to primary care

> *“Community development improves health. Community development is effective as community-driven services change. Community development can be of real benefit to general practices, clinical commissioning groups and local authorities. The NHS needs to harness it now, particularly in the current economic climate, which threatens community cohesion”.*
>
> (Fisher, 2014, p. 1)

He makes bold statements, however, isn’t so bold when attempting to define what community development is. Like many other authors, he acknowledges that community development is delivered in different ways; that community development helps to organise people to identify shared needs and aspirations; improve their lives through undertaking joint actions; address imbalances in power; and bring about changes to their lives based on social justice, equality and inclusion. He also suggests that community development aims to influence the agencies whose decisions affect their lives.

This is a wide- ranging set of expectations for community development but is typical of many descriptions in that it is seldom pinned down to specific actions and parameters, more often relying upon bold ambitions and underpinning values and principles (see, for example, the national occupational standards state that the community development process is underpinned by five fundamental values on which all practice is based. (Birmingham Voluntary Service Council, 2021).

Community Development approaches are common across most policy domains and are commonly invested in and deployed with the aim of improving diverse areas of public policy including housing, crime, environment, and economic growth, but they are claimed to have a particular contribution to health and wellbeing.

It appears that community development for health and wellbeing is back in fashion across Wales. Renewed interest in governance at the community level, building local resilience and empowering people to make the most of their wellbeing assets is influencing a wide range of projects as well as policy drivers. The Well-Being of Future Generations (Wales) Act (2015) provides a further impetus to this through requiring all public bodies to work together to make an impact upon sustainable development by driving them, through better collaboration and joint action, to build wellbeing within communities. However, this is just one of the many Welsh Policy drivers implicitly relying upon strengthening communities.

This regard for strengthening the role of communities is not at all unusual or unique to Wales as it is in step with a global trend championing communities and community action (Gilchrist, 2005; Adams and Hess, 2001) and whether for health, environmental, or other reasons, community projects are now increasingly identified as providing the solutions to the most challenging of societal problems (Gilchrist, 2009; Adams & Hess, 2001).

Whilst having wide appeal across all public policy domains, it is particularly strong in public health policy and has become a central element of population-based health promotion strategies that purport to involve community groups in determining the form and purpose of resources secured for advancing their health and wellbeing. Yet this is a contentious field and remains one of the ‘essentially contested concepts’ even today after decades of it being evident in practice (Carlon, 2021).

Working out what works, for whom, and in which circumstances is challenging, fundamentally because it is not easy to articulate what it is that we are focussed upon. Just as with the variance in the way that health is

understood, community development for health is also affected by the range of stakeholder understandings and expectations of what it is and what it might achieve.

When its popularity rose rapidly in the 1970s it had distinctly political overtones and was easy to label as left wing and anti-establishment, particularly in relation to its role in promoting health, as its focus was often on changing societal structures and constructs, or on, pollical consciousness raising and activism (Foster,1996).

In subsequent decades, its nature and reputation altered, through the 1980s it became more associated with self-help, volunteering and what communities could do themselves rather than fighting against what was deemed unfair in the system.

By the late 1990s a dominant concern of many societies was rebalancing state delivery of services and building local involvement and ownership of assets. In the United Kingdom, the Blair Government's neighbourhood renewal programme re-emphasised the development of community engagement alongside democratic leadership and more inclusive partnership building.

Since the millennium community development has increasingly become a close ally to newly dominant concepts of social value, place-based working and 'strengths-based' working across health and social care. Briefly, the Coalition Government championed the "Big Society" and its stated aim was to take away power from the politicians and give it to the people, and with it was promised a programme of devolution, volunteerism, support for co-operatives, and encouragement for social enterprises (Ashton, 2010).

However, since 2010 the Big Society gradually declined as an instrument of central UK Government policy (the concept only applied as domestic Policy in England) in the devolved countries, and at many local levels in England aspects of community development continued to be developed alongside sustainable development, asset-based working and working across

partnerships to deliver wider social value and wellbeing including, most notably, the Wellbeing of Future Generations (Wales) Act (Shaw, Armstrong, et al., 2016).

Elements of each of these phases remaining across Wales and the wider United Kingdom resulting in a vivid spectrum of understanding what community health development is, and what it does, to unpack before getting down to testing how it may work and in which circumstances.

1.2. Health and Wellbeing

> *“By health I mean the power to live a full, adult, living, breathing life in close contact with what I love — the earth and the wonders thereof — the sea — the sun. All that we mean when we speak of the external world.*
>
> *I want to enter into it, to be part of it, to live in it, to learn from it, to lose all that is superficial and acquired in me and to become a conscious direct human being. I want, by understanding myself, to understand others. I want to be all that I am capable of becoming so that I may be (and here I have stopped and waited and waited and it’s no good — there’s only one phrase that will do) a child of the sun.*
>
> *About helping others, about carrying a light and so on, it seems false to say a single word. Let it be at that. A child of the sun.”*
>
> Mansfield,1922 (cited in Waldron,1974 p. 11 -18)

This quote from the poet Katherine Mansfield is a crucial opening to this section as it stands in contrast to more widely recognised and accepted notions of health in the Western world as merely something to do with avoiding illness and living long lives.

It represents a very different (even a competing) ideology within which health is viewed more holistically, integrating a panoply of ideas on what factors enable and improve wellbeing, irrespective of any existence of disease. This more subjective expression of the widely acclaimed World Health Organisation definition of health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO, 1978), shares the same sense of health being multi-faceted and not only about a personal state, but a sense of connection with others and the world around us.

In his seminal book “Health is For People” Michael Wilson carefully unpacked modern notions of health and warned that whilst the basic concept

does needs to be questioned to illuminate understanding, the mere exploration of it may turn into a Pandora's box that can take over and suffocate any serious piece of research,

"Health is a concept like truth which cannot be defined, to define it is to kill it. Nor can it be possessed. It can only be shared. There is no health for me without my brother. There is no health for Britain without Bangladesh."

(Wilson,1975, p. 117)

Within this short quotation are encompassed the many dilemmas that make health and its improvement so fascinating. Wilson contends that central to health is an experience of wholeness, but he also warns that it is a territory that cannot be fully understood from external observation, only an inside experience of what it means to be healthy. Further, he suggests that for the most part it is an unconscious state for when we reflect, recognise, and think that we are healthy the chances are that purely by the fact we are worrying about that state means that we are not.

> *"Health does not exist as a present contentment but in our restlessness. We do not ask a child why he is dancing. We dance too. And we live to dance another day faster and more furiously.*
>
> *For what are we healthy? Just for the fun of it!"*

(Wilson,1975, p. 118)

Both Mansfield and Wilson propose ideas about health that many people would find unrecognisable at first given the grip of medicalised ideas about health and illness that remain so prevalent across Western nations, and which stubbornly still frame health as merely not being ill.

As Wilson reflects, our dominant understanding of health is based on what is known about illness. He recounts that in George Orwell's novel, Nineteen Eighty-Four, he wrote about a ministry of Peace that was about war, a Ministry of Plenty dealing with scarce resources, a Ministry of Truth which

planned brain washing (Orwell, 2021) but he stopped short of suggesting a Ministry of Health that deals with illness because that is exactly what we already have in place across the National Health Service and Primary Care.

Whilst it may be difficult to think about health without straying into notions of disease there are efforts to reshape and broaden this thinking.

Challenges to the orthodoxy of medicalised notions of Health and wellbeing and pronouncements that health is more than the mere avoidance of illness or disability were increasing throughout the 1970s and this culminated in the WHO's iconic Alma Ata Declaration in 1978. Consequently, it is increasingly unusual to encounter any study of health and wellbeing that does not spend time and attention in exploring the meaning of health it rests upon and determining terms and fundamental assumptions clearly.

Such questioning was exacerbated with the more nuanced recognition of inequalities in health that developed rapidly during the 1970s and 1980s, kickstarted by the Lalonde Report in 1974 and cemented within the public health consciousness with Dahlgren and Whiteheads Determinants of Health (Rainbow) model in 1991 (Dahlgren & Whitehead, 2021).

The implication of the inequalities thread of thinking in public health is that just because communities are living longer and healthier lives it does not mean that is sufficient, it is arguably much more important to know that everyone in that community is leading longer and healthier lives and there is no gap between that wellbeing experience when comparing the health of the rich and the poor.

The 'health as wellbeing' proposition (as opposed to health as the antithesis of illness) thus suggests health is a resource for living not the object of life itself, emphasising that when we set goals for health in terms of longer life, we rather miss the point, health is not only a resource but fundamentally about the journey and experience of living rather than check points on a movement towards arbitrary goals as life expectancy or health longevity.

Katherine Mansfield came at this from the perspective of being a poet and writer. When she talked of *“I want to be all that I am capable of becoming*” (Waldron, 1974) she took the health definition way beyond avoiding illness. In fact, almost into a different conceptual place altogether, for whilst health and wellbeing are aften conjoined in the same sentence, in practice they may often be poles apart and have their own unique actions, evidence base, theories and supporters.

Both ideologies of health are crucial for this research as one drives or underpins community health programmes and the other binds the health care system (the spine of the National Health Service) plus ultimately both have a valid contribution to improving health at individual and population levels.

Whilst this initial exposition on the semantics of health, wellbeing and illness may seem merely esoteric it has a very fundamental and practical purpose within this research, in fact it is foundational.

The salutogenic notion of health as wellbeing is the driver underpinning much of contemporary theory and practice of community health development, whilst many of the efforts to evaluate its worth have in the past come from the pathogenic orientation (Hills, 2004). This is somewhat like judging the quality of an apple based on criteria taken from evaluating the quality of oranges.

Most important for this research is that salutogenesis is the theory driving the ‘What Matters Approach’ that has become very popular as an approach throughout health and social care in Wales (Social Care Wales, 2022) and more generally underpins the asset-based approaches to community development (Rippon and Hopkins, 2015).

The term salutogenesis is a reaction to and mirror of the term pathogenesis which underpins biomedicine – the way that both health and care services have still largely continued to operate despite many challenges to the model (Engel, 1977).

Whereas pathogenesis is associated with risk factors involved in disease generation, their treatment, and prevention, salutogenesis looks for the factors which cause wellbeing, literally asking the question “what are the origins of health?” (Antonovsky, 1979).

Reframing is the anchor point of using this approach in the very question of “what are the origins of health?” is an act of reframing against the orthodoxy of delivering health services and care. Reframing is therefore an essential element of what Antonovsky was trying to achieve with his model as its fullest sense goes much further than simply exploring available health assets.

Antonovsky’s core message was that reframing and focussing upon what is strong and what creates health helps people to realise that their life experiences help shape one’s sense of coherence and balance in their world, which means that their life is understood as more or less comprehensible, meaningful, and manageable.

This has been eagerly embraced by people frustrated by a biomedical model that leaves people feeling powerless in the face of health challenges (Aujoulat et al., 2007).

Across both ideologies however, the difference between struggling and thriving, winning, or losing, in health varies depending on to what extent the person can control events (or mitigate external factors) that are impacting upon them and their own responses to those factors.

> *“Wellbeing encompasses the environmental factors that affect us, and the experiences we have throughout our lives. These can fall into traditional policy areas of economy, health, education and so on but wellbeing also crucially recognises the aspects of our lives that we determine ourselves: through our own capabilities as individuals; how we feel about ourselves; the quality of the relationships that we have with other people; and our sense of purpose….*

> *These psychological needs are an important part of what makes us human, along with our ability to feel positive and negative emotions. It matters how often, and for how long, we experience positive emotions – such as pleasure and a sense of purpose – or potentially negative emotions, like anxiety."*
>
> (What Works Wellbeing, 2021, p. 2)

This is far removed from merely assessing what we need to do to live longer and as set out here, it demonstrates a common-sense element to the wellbeing concept that is an attractive alternative to pathogenic notions for health that demand verification of someone else ('experts' and clinicians usually) to diagnose or confirm whether we are healthy.

This raises the important question of who actually owns a person's or a community's health, who conveys that state and if it is an actual state or merely a judgement irrespective of how it is felt by the person concerned. People intuitively have a grasp on their happiness and wellbeing and if they feel balanced and in control of their lives. The downside of this is that tying it to so many different contexts and perspectives (to reflect the variance in individuals) then makes it so difficult to develop a common understanding and recognition of what exactly wellbeing is.

Relying on expert pronouncements upon whether someone is healthy or not narrows down the field somewhat and makes this amorphous, even woolly, wellbeing notion easier to pin down by making it a simple judgement against some standard metrics, but it also strips out some of the most important meaning to people themselves.

There is a difficulty in trying to understand two often seemingly connected concepts of health and wellbeing (for that is how they are usually portrayed) whilst at the same time acknowledging their very different embedded ideologies take the study of them along pathways in very different directions. Health as 'absence of illness' being reductionist in nature and relying on metrics governed by professional elites, and wellbeing being holistic and

nebulous yet, at the same time, easier to identify with on a personal experience basis.

Wellbeing is expressed by our emotions; positive emotions such as happiness, pleasure and a sense of direction or purpose; but also, negative emotions like anxiety and loneliness or isolation (What Works Wellbeing, 2021). Our day-to-day experience of wellbeing being somewhat of a trade off or balance between the positive and negative. The basic premise works universally but there is so much variance in people and difference in their circumstances that developing a common language to express it across contexts and perspectives is almost impossible (Diene, Scollon, et al., 2009).

Wellbeing for an ex-farmer now in a care home on Anglesey will mean something very different from that of a young teenager growing up in urban Wrexham, or a parent juggling work and managing a family home, or indeed a refugee that is homeless and seeking shelter. There may be some core common factors important to wellbeing that are consistent across these and wider groups of people but, at the same time, there is so much variability in personal attributes and attitudes as well as contexts that comparison between people or set definitions or criteria for wellbeing is of limited value.

In trying to unpick the exact nature of wellbeing for people the UK Office for National Statistics (ONS, 2022a) avoided a narrow criterion and instead produced a dashboard of people's own assessments of their quality of life and feelings of personal wellbeing and experiences based upon their responses to being asked what matters to them most.

They based their framework for wellbeing around 10 dimensions experienced by individuals:

- Their natural environment
- Personal feelings of wellbeing
- Strength and quality of relationships
- Health experience
- Personal activities (what they do)

- Where they live
- Personal finance
- Position in the economy
- Education and skills
- Governance (democracy and trust in institutions)

They also brought together indicator sets at national and local levels to build an understanding of wellbeing at individual community and population levels. These follow similar dimensions as below in figure 1.1 (ONS, 2022b).

Figure1.1: Dimensions of Wellbeing

This begins to illustrate just how complex health is when the analysis moves beyond merely accounting for a lack of illness or disease, it isn't just adding a few more considerations, there are complex dynamics and interdependencies across these dimensions plus subjective as well as objective assessments made.

The next section exploring the state of health across Wales still centres upon the impact of illness and disease, but it also includes some attempts at analysis of these wider wellbeing elements and the forces that determines them.

Irrespective of the ways in which health and wellbeing are defined and understood (holistic or reductionist) at personal, family, community, and society wide levels in Wales there is now a real and increasing challenge.

1.3. Health and Wellbeing in Wales

The health challenge in Wales is both significant and complex. Whilst it is true that across the population as a whole life expectancy has been gradually rising over recent decades, it has now plateaued and in some areas is once again on the decline (Wise, 2022). Whilst this is the measure that so often grabs headlines, it is the experience of health throughout life that remains a bigger challenge than how long we live for.

Moreover, life expectancy increases alone are a very poor measure of a nation's health and (respecting the wellbeing definition) it is now considered that 'healthy life expectancy' is a much more accurate indicator of the health of populations.

Unfortunately, however, healthy life expectancy too is getting worse and there is a rapidly growing gap between life expectancy and healthy life expectancy across the whole of Wales (Health Foundation, 2022).

In summary, across most of Wales people are living longer but getting sicker younger and that is just one of many indicators of worsening health overall as within that picture there is also wide variance in health experience across populations and groups that further indicates an unhealthy inequity.

To understand this fully demands a critique of exactly who has health and who gets sick, exploring the relationship between the span of healthy life and life expectancy and the difference between these states on an individual level but also at whole community and population levels.

In 2016 Public Health Wales summarised the health challenges for its population, starting with a stark recognition that, (just as with the rest of the United Kingdom) a perfect storm is approaching.

At the whole population level, the situation echoes the experience of individuals with people are living longer than ever before but they are experiencing poorer health and illness for many of those years, with a consequent impact upon their wellbeing at much younger ages. When this is combined with the demographic change across communities which sees a growth in the proportion of the elderly in society and a shrinking of the younger age population groups, it results in a large and relentlessly increasing proportion of the population who live longer but with a host of predictable and preventable illness and conditions which affect their independence (in the sense of needing long term treatment and care support).

The key health statistics for the North Wales population that constitute this worrying pattern are:

- Life expectancy for both men and women were increasing steadily until 2010 and since then have flattened, alongside the rest of the UK rates.
- About 20 years of life are now lived with poor health, with impairments or requiring high levels of drugs, treatment, therapy or care support for daily living.
- It is highly plausible that this levelling off of life expectancy is due to worsening of the core determinants of health and, in particular, the impact of the austerity measures of 2010/11 which have been implicated by Professor Sir Michael Marmot and others.
- Just three health conditions account for half of these impaired health years - cancers (19%), cardiovascular disease (18%), musculoskeletal disorders (11%).

- Key behaviours are the main contributors to these conditions at a population level – smoking, high blood pressure, obesity, alcohol use, high cholesterol.
- In terms of current lifestyles of people in North Wales, all these risk factors remain high, however smoking and alcohol consumption rates are showing some improvements whilst dietary factors and lack of physical activity are moving in the wrong direction and obesity is rising steeply.
- The gap in mortality rates between deprivation quintiles is still widening, in the most-disadvantaged ten percent of Wales, men have a life expectancy of 73.3. In the least-disadvantaged ten percent of areas of Wales, male life expectancy is 82.3 – a gap of nine years in the lengths of their lives.
- For women this gap is a smaller gap but is still significant at seven and a half years.
- Healthy life expectancy for both men and women is poorer than in England v Scotland. For women in the most disadvantaged parts of Wales, they can expect to live 50.2 years in good health. For women in the least disadvantaged areas, this is 68.4 years – a gap of 18.2 years. This equates to an expected 28 years in poor health versus 17.3, which is a stark difference.
- For Welsh men, the picture is similar. Those born in the most disadvantaged areas of Wales can expect to live 51.8 years in good health, compared with 68.6 in the least disadvantaged areas. Again, a gap of almost 17 years. This represents 21.5 years in poor health for men in the most disadvantaged parts of Wales – which contrasts with just 13.7 years in poor health for men in the least disadvantaged areas.

(PHW, 2020a)

At an individual level it must be acknowledged that living with a health condition or impairment does not necessarily result in an overall reduction in wellbeing as some people do manage conditions very well and may holistically gain wellbeing despite one aspect of their health being challenged. However, at a community or population level the cumulative impact of this growing health gap is now being acutely felt and services provision is health and social care is growing ever more stretched. All this data maps closely to material deprivation and the major health determinants have profound effects upon not only the length of lives but also the experience of wellbeing for people during these years. This is particularly pertinent in the later years of people lives. (Peoples HealthTrust, 2022).

This provides a very stark picture for Wales as a whole, suggesting that for most people, they must anticipate that towards the later part of their lives they can expect to be living with some level of impairment and experiencing poor health for up to 20 years.

The specific health conditions that will contribute to these increased years of health challenge are wide ranging, but the three leading conditions of cancers, cardiovascular diseases and musculoskeletal disorders are all conditions that are preventable. The evidence for prevention is well known and includes the behavioural and lifestyle factors amenable for change and the environmental/socio economic conditions that are also antecedents to those lifestyles.

Across all three types of conditions there is a steep health inequalities gradient, meaning that those people that live in the most deprived areas are likely to have even longer years spent with these conditions (not because they live longer but that they get sicker younger).

As the NHS confederation pointed out in their briefing to Welsh Assembly Members,

> *"Wales has made great strides in improving the health and well-being of its population. We are living longer, fewer of us are dying from*

infections and we have better health and care services. However, we still face a significant number of public health challenges.

While the negative impacts of obesity, drinking above the guidelines, smoking and low levels of physical activity have been well documented, there are other factors that impact on health and well-being, resulting in an ever-increasing demand being placed on the health and care service…".

(Welsh NHS Confederation, 2015, p. 1)

They cited that by 2036 the population of Wales itself will have increased by almost 9% with the largest increase in the 65 to 84 and 85 plus age groups, meaning one quarter of the population will be aged over 65.

This is the main reason why so much of Wales's health policy now swings strongly towards the prevention of illness and promotion of health as an imperative, and wellbeing and preventive health is one of NHS Wales six key principles (Welsh Government, 2018). However, it isn't merely the right thing to do to enable health and wellbeing at an individual level, at wider population level it is a societal and economic imperative enshrined within the Wellbeing of Future Generations Act (Wellbeing of Future Generations, 2015).

The costs of ill health are rising sharply at the same time that the proportion of the population contributing to the funding of health and social care through taxation is shrinking (as the older population grows the working age population is shrinking proportionally). This has grave implications for the sustainability of the current system for provision of health and care, particularly for those least able to afford it -as few can afford to pay for private care provision.

Whilst there is now a strong evidence base on effective interventions for reducing health inequalities at a whole population level from the WHO, Professor Sir Michael Marmot (Marmot 2010), Local Government Association

(LGA, 2022) etc., it is suggested by the Bevan Foundation that the evidence base doesn't yet effectively reflect the realities of people who actually live in material deprivation.

Many of the recognised public interventions focus on changing "lifestyle choices" and this is unhelpful as it locates the cause and solution within individuals rather than understanding that these are social practices which cluster within certain populations due to shared social conditions/contexts. As such behaviour or 'lifestyles merely reflect deeper structural problems and people become victimised and blamed for their own poor wellbeing, as attention is drawn away from the need for more radical intervention in those conditions (Bevan Foundation 2018).

The Public Health Outcomes Framework for Wales (PHW, 2022) is just one of the many national and local strategies and frameworks that expands upon this growing disease burden and the impact it has on the wellbeing of all communities across Wales, and it brings together the indicators and tools to measure its impact and the trends showing if it is getting worse or better over time.

It is the vehicle by which the various national strategies for health and wellbeing are collectively monitored for their impact and progress. Its core purpose is to measure the progress towards the seven goals of the Wellbeing of Future Generations Act, the most pertinent of which is "*a prosperous, resilient, more equal and healthier Wales, through improving the social, economic, environmental and cultural well-being of Wales, both now and in the future*". It also strongly relates to the Social Services and Wellbeing (Wales) Act 2014.

A raft of policies from the Welsh Assembly Government collectively aim to create social conditions that will enable people to make health choices and empower them to take control of their own wellbeing, the anchor for these being the Wellbeing of Future Generations (Wales) Act (2014) which continues to be a world leading piece of legislation encapsulating human, ecosystem, and planetary health concerns in the same framework.

The outcomes and indicators collated into the framework (figure 1.2) attempt to cover the widest sense of both health and wellbeing, and they capture a picture of the living conditions and environmental contexts and determinants that affect health; the ways of living and personal actions that may improve or harm health; and focus across different phases of the life course in a recognition that as people age different things become more salient to their health and wellbeing.

Merely reading across the range of indicators used illustrates the complexity of understanding health and wellbeing as the indicators stretch across physical, mental, social, and environmental domains, plus include absolute measures of disease states, and perceptions of health and assessments of personal satisfaction with life experiences. Hence, the indicator set is a very useful blend to show both how Wales is doing in relation to ‘health as avoiding illness’ and ‘health as wellbeing’.

Outcome		Indicator
Overarching outcomes		
Years of life and years of health	1	Life expectancy at birth
	2	Healthy life expectancy at birth
Mental well-being	3a	*Mental well-being among children and young people (NI)*
	3b	*Mental well-being among adults (NI)*
A fair chance for health	4	The gap in life expectancy at birth between the most and least deprived
	5	*The gap in healthy life expectancy at birth between the most and least deprived (NI)*
	6a	The gap in mental well-being between the most and least deprived among children and young people
	6b	The gap in mental well-being between the most and least deprived among adults
A. Living conditions that support and contribute to health now and for the future		
Children have the best opportunity for a healthy start	7	*Children living in poverty (NI)*
	8	*Young children developing the right skills (NI)*
Families and individuals have the resources to live fulfilled, healthy lives	9	*School leavers with skills and qualifications (level 2) (NI)*
	10	School leavers with essential literacy and numeracy skills
	11	*People able to afford everyday goods and activities (NI)*
	12	*People not in education, employment or training (NI)*
	13	Gap in employment rate for those with a long term health condition
Resilient, empowered communities	14	*A sense of community (NI)*
	15	*People who volunteer (NI)*
	16	*People feeling lonely (NI)*
Natural and built environment that supports health and well-being	17	*Quality of housing (NI)*
	18	Quality of the air we breathe
B. Ways of living that improve health		
Healthy actions	19	Physical activity in adolescents
	20	Adolescents who smoke
	21	Adolescents using alcohol
	22	Adolescents drinking sugary drinks once a day or more
	23	Adults eating five fruit or vegetables portions a day
	24	Adults meeting physical activity guidelines
	25	Adults who smoke
	26	Adults drinking above guidelines
Healthy starts	27	Teenage pregnancies
	28	Smoking in pregnancy
	29	Breastfeeding at 10 days
	30	Vaccination rates at age 4
C. Health throughout the life-course		
Health in the early years and childhood	31	*Low birth weight (NI)*
	32	Children age 5 of a healthy weight
	33	Adolescents of healthy weight
	34	Tooth decay among 5 year olds
Good health in working age	35a	Working age adults in good health
	36a	Working age adults free from limiting long term illness
	37a	Life satisfaction among working age adults
	38a	Working age adults of healthy weight
Healthy ageing	35b	Older people in good health
	36b	Older people free from limiting long term illness
	37b	Life satisfaction among older people
	38b	Older people of healthy weight
	39	Hip fractures among older people
Minimising avoidable ill health	40	Premature deaths from key non communicable diseases
	41	Deaths from injuries
	42	Deaths from road traffic injuries
	43	Suicides

Figure 1.2: Outcomes and Indicators from the Public Health Outcomes Framework for Wales (Public Health Wales, 2017)

The grand hypothesis sitting behind this outcome indicator set is that if they get better as a whole it means that people feel their lives are getting better, they are experiencing greater health and wellbeing as they will be living a longer proportion of the years they live in a positive state, they will feel in control of their lives, experience a good balance between the physical, mental, and social aspects of their life, and retain an independence from

requiring care and support in all these areas. The local socio-economic environment around them is healthier too, sustaining any health choices that they make.

Alongside this core aspect, they may also of course live longer too, but that longevity is not the central focus for this set of health indicators but is a biproduct.

Drilling down further to understand the conditions and social determinants across North Wales communities, the North Wales Population Assessment (2017) Recorded that:

- North Wales has a resident population in the region of 690,000 people living across an area of around 2,500 square miles and population density varies considerable between 49 people per square kilometre in Gwynedd in the Northwest whereas Flintshire towards the East is more heavily populated with 350 people per square kilometre.
- That population is estimated to increase by 30,000 by 2039 to a population of 720,000.
- With respect to the growing elderly population all local areas will see moderate percentage increase in population overall (with a few exceptions like Anglesey which will see a small shrinkage) but the over 75 populations across all with rapidly increase.
- 12% of the population live in the most deprived communities in Wales (compared to 19% across Wales as a whole)
- Within these there also considerable pockets where there are the highest levels of deprivation in Wales as a whole. Rhyl West 2 (Denbighshire) and Queensway 1 (Wrexham) are the second and third most deprived areas in Wales. Three further areas in Rhyl (Rhyl West 1, Rhyl West 3 and Rhyl South), are in the top twenty most deprived areas in Wales (Welsh Government, 2014).

- Across North Wales registered patients (with GP services) 13% live in the bottom fifth most deprived areas (89109 patients), and 31% in the bottom two fifths (215019 patients).

This suggests that the recognised health gap within communities as they live longer years but experience ill health sooner is not set to decrease in the short term, certainly not without a significant public health programme and a change in the common social conditions in which people develop shared social practices (lifestyles and health attitudes).

1.4. Relevant Policy Drivers for Health and Wellbeing in Wales

The importance of **the Wellbeing of Future Generations Act** cannot be ignored as the integrative force bringing health and wellbeing to a new focus for debate across sectors and with the public. It is also a significant enabler for community health development approaches in Wales. It is the anchor public policy that provides the legal obligation for all the public bodies (NHS, local authorities, and the Welsh Assembly Government itself) to "*work more closely with communities through engagement and empowerment to improve their health and reduce health inequalities*" (PHW, 2020b).

A Wales of `Cohesive Communities' is one of the seven goals. This wellbeing of communities' goal is defined as place-based communities that are 'attractive, safe, viable, and well-connected.' The theory supporting this suggests that,

> *"When communities are cohesive, they're well- connected (including digitally), can adapt to change, and are focused around the well-being of the people who live there with good access to key well-being services such as education, health, housing, retail and transport and that people can do the things that matter to them.*
>
> *Cohesive and connected communities are an important part of people's individual well-being. The World Health Organisation identified that lack of agency, trust, belonging and insecure neighbourhoods explain 19% of the gap in poor health between the*

top and bottom average incomes for men & women in Europe."
(Wellbeing of Future Generations Commissioner,2022)

It also frames the actions that need to be taken at community level to bring about wellbeing:

- Create viable communities where people can do the things that matter to them.
- Support communities to be well connected.
- Support access to well-being services
- Value the role of key organisations in building community cohesion.
- Understand the role and contribution of housing to cohesive communities.
- Create communities where people feel safe.
- Enable communities to be digitally connected.

This may not be specifically an approach to community health development, and it certainly isn't marketed in that manner, however it does suggest some of the central strands that community health development may include.

The Future Generations' Commissioner also suggests that there are other key actions or conditions (enablers and disablers) that are important in developing wellbeing in communities.

The main enablers are the conditions that local organisations (mainly public sector bodies such as health services and councils) can create to support communities to build their own wellbeing:

- Create supportive environments to encourage communities to focus on what matters to them.
- This approach to asking and responding to "what matters" to people in their communities is an embedded part of how services are run.

- Support the development of community anchor organisations (accessible places where people can access support and have a voice on their wellbeing and what affects it).
- Local activists, leaders, volunteers, and entrepreneurs are actively supported.

There are also things that the Commissioner says are stopping wellness creation in communities, mainly when public bodies:

- Work in silos, meaning that organisations relate to community issues from separate professionally led viewpoints – reducing what are connected and complex issues in communities to either an education issue, a social issue, or a health issue – essentially a disconnected and reductionist approach.
- Focus on deficits, what is wrong with communities, and don't acknowledge the potential for change.
- Fund local activities in unsustainable and fragmented ways.
- Talk about coproduction and engaging with communities but only pay lip service to it in practice.

These important enablers and blockers of community cohesion were also identified as the key factors required for empowering communities in a paper by WCVA in 2018, aiming to influence voluntary sector thinking and Welsh Government Policy following the closure of the phasing out of the Communities First Programme in 2017, as it promised to replace the programme with a new approach to building empowered and resilient communities (WCVA, 2018).

In addition to the enablers proposed by the Future Generations Commissioner, WCVA called for greater clarity in the use of terminology around community and wellbeing, develop understanding about the distinctiveness and importance of local 'place' in community development, and build a better understanding of what social value means.

Communities First was a community-focused tackling poverty Programme supporting the Welsh Government's Tackling Poverty Action Plan and was initially launched in 2001. The Programme had three community elements:

1. Creating Prosperous Communities
2. Healthier Communities
3. Learning Communities.

Concentrating on the most deprived communities in Wales, its original scope was narrowed following initial evaluations to concentrate on tackling poverty in 52 Communities First Clusters, each covering a population of, on average, 10-15,000 people. These were the 10% most deprived in Wales according to the Welsh Index of Multiple Deprivation (WIMD) 2014.

Each Cluster had a Community Involvement Plan to ensure that local people and community organisations played a full part in the programme and were kept fully informed of its activities and a new Communities First Outcomes Framework was developed to provide a much clearer picture of what was being achieved by each Cluster and by the programme overall.

It became regarded as a valuable Programme by most stakeholders and beneficiary communities.

While Communities First retained its ethos of encouraging community involvement in the design, delivery, and monitoring of the Programme, genuine community participation is not always being achieved or is not being facilitated in a way that is of benefit to the implementation of the Programme. Welsh Government note the importance of also retaining community engagement workers in order to meet all three of the Programme's key principles, good governance, improved outcomes, but also strong community involvement.

Such a large-scale programme, even if only across the most deprived areas, is important to note as it was driven strongly from Government policy and did inspire many schemes and programmes to flourish within and outside the

programme itself. With so much attention and resource put in, it is no surprise that it was subject to a host of evaluations. These included evaluations focused on identifying better practice around project management and determining the extent to which the Communities First programme has delivered value for money. Whether the programme was effective in promoting community involvement and empowering residents as an essential component of the regeneration process has shown that it has been relatively successful in empowering residents to affect change in their communities (Adamson and Bromiley, 2008).

However, they also found the statutory sector has failed to seize on an increased capacity for community involvement in implementing and delivering wider regeneration interventions around housing, physical regeneration, and economic development (Hincks and Robson, 2010).

The Social Service and Wellbeing Act 2014 places a statutory responsibility on public services and partners to develop services that promote individuals' wellbeing and ability to live independently in their own communities. It requires public services and partners to build upon communities' strengths and coproduce services and activities that will reduce and prevent individuals from the need to access targeted services.

Throughout the Act there is an implicit shift towards communities being more involved in health creation through coproduction, strengthening the role of voluntary and community sector organisations, and there is explicit direction to Local Authorities in Section 16 of the Act to develop community organisations (social enterprises, cooperatives, user -led organisations and the third sector) roles in health and social care and preventive health.

1.4.1. Public Health Wales Strategic Plans

Underpinning most of Public Health Wales strategic documents, the Government's aims of increasing the role of communities in wellbeing and elevating the role of prevention are given more definition. The Long-Term Strategy 2018 – 2030 highlights that the idea of community is so important to health that it is one of the key markers of Wales heritage – tightly bound up

in what it means to be Welsh. Within one of its supporting evidence-based reviews "*Making a Difference: Investing in Sustainable Health and Wellbeing for the People of Wales*" (Public Health Wales, 2017), a key theme is moving the principle of involvement of people in communities through coproduction into practice.

> *"… ensure communities and people in Wales are given a voice, involved in decisions about their health and wellbeing and listened to through knowledge forums to facilitate engagement of the public, professionals, policy makers and academic experts*."
>
> (PHW 2017, p. 12)

In summary, policy for improving health and wellbeing in Wales has clear expectations for an increased focus on communities and their health and an implied increase in their own actions and involvement in health creation, however there is great variation in how that is expressed, and no specific definitions or models have been presented beyond general propositions that communities are good, and their activation is an important contributor to improving the health of the nation.

1.5. Community Development's Position and Contribution to Public Health in Wales

It is at the community level where the social determinants of health are largely experienced; social norms influencing health and wellbeing are established; the impact of these levels of illness and disability are felt; plus, conversely, it is at the community level where the foundations to support resilience must be built.

To understand the central importance of community in the creation of health and wellbeing, it is important at this point to return to the Alma Ata declaration (and the subsequent growth of health promotion that it influenced).

Beyond the classic definition of health that it created, Alma Ata was also explicit about the levels of responsibility required for health creation from the individual through communities, to society itself and the Governments that guide them.

- Governments have a responsibility for the health of their people.
- It is the right and duty of people individually and *collectively to participate in* the development of their health.
- It is the duty of governments and health professionals to provide the public with information on health matters so that *they can assume a greater responsibility for their own health.*
- There should be individual, *community* and national *self-determination* and self-reliance in health matters.

(WHO cited in Catford, 1982)

The implication of these connected statements is that health is primarily about politics, not in the popular sense of class or group struggles, but as in the exercise of power and control of resources, politics as issues based, and requiring the mediation of personal versus societal responsibilities and accountabilities. These issues often then impact on people in the environment that is closest to them - through their local or meaningful communities.

The importance of Alma Ata in public health and health promotion cannot be understated or the subsequent ideas that it influenced. The most important of these was the Ottawa Charter for Health Promotion (WHO, 1986). Figure 1.3 illustrates how this built on the idea of health as an essentially political endeavour and defined health promotion as

> *"… the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for*

everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being".

Figure 1.3: Ottawa Charter (WHO 1986)

As the nearest conditions that people are able to control are in their communities, it is no surprise that the Charter also included within its five principles for action both the creation of supportive environments for health and strengthening community action. This Charter then placed power and control at the centre of health promotion and highlighted the prime importance of communities and their development as key to building health and wellbeing.

It has been variously claimed within health promotion that community development works by empowering communities and groups, that it leads to increased commitment by a wider range of stakeholders to change at community levels, it strengthens values and a community focussed

sensibility, increases accountability for the use of resources and that it is the crucial element in redressing inequalities as it mediates the prevailing determinants of health.

However, whilst well recognised within public health as a significant element, this has also led to multiple and sometimes conflicting discourses of how it works to protect or improve health and wellbeing, whether it is essentially about empowerment or regulation (Petersen,1994) and there is as yet no definitive explanation of what works and how it works.

From the initial brief review so far on Wales health challenges, the implicit focus on community's role in improving health within Policy and, recognising the complexity of understanding concepts of health and wellbeing, it is clearly important to dig deep to anchor some understanding of what community health development is and how it is expected to play a role expected by so much of Welsh health and social care policy, and further to test community health development as it is practiced in Wales to find how it works, for whom does it work, and under which circumstances.

Policy at national level doesn't necessarily mean that local community projects will be shaped as a reflection of it, but one line of this research investigation should be to explore that thread from national policy to local activity. It would be sensible to assume that a strong affirmation of community development in improving health and wellbeing within Policy would shape local actions through encouraging a sympathetic mindset and provision of resources, but it does not necessarily happen that way so, the research methodology should incorporate that investigation within its scope.

Whilst a clear and definitive model of community health development across Welsh Policy is not evident, there is a definition with popular recognition which was set out by the Community Health Development Network for Cardiff Advisory Group in 2002.

> "*Community Health Development is founded on the principles and practice of the `long-established community development approach and is undertaken with a specific concern for improving community*

health and well-being. Health is interpreted broadly and holistically. Therefore, health is seen to include all aspects such as mental, spiritual, sexual, social, emotional, as well as physical health. Within communities, health is recognised as being linked to a range of environmental and sociological factors such as poverty, education or jobs. All of these factors impact upon people's wellbeing and quality of life.

Community Health Development is about using an empowering "bottom up" rather than an imposed "top down" approach. A lay understanding of community health issues and needs being positively listened to and prioritised over the "professional" perspective. It is essentially working with people not doing something to them. As such it is a longer-term approach which allows for the personal development of the people involved, through providing support in gaining new skills and knowledge, increasing self-confidence and enabling them to take an increasingly active part in community activities.

Thus, Community Health Development encourages and supports people to participate in addressing issues that impact upon their community's health and wellbeing. It is particularly effective in engaging with the most disadvantaged and difficult to reach communities. It enables groups that are experiencing inequalities in health and who generally have the poorest health, to express their views, participate in activities and make positive changes to improve local health and wellbeing within their communities. "

(Goosey, 2010, p1)

They were clear upon their core foundations upon which a Welsh community health development approach should be built upon:

- That it is based upon firm values, principles, and practice.
- Concerned with improving both health and wellbeing.

- Empowering community led approaches are at its core.
- Lay perspectives on health (a community's own ideas) mostly prioritised over professional views.
- Working and developing the people in a community is an imperative and not doing things to them.

However, these foundational elements do not in themselves suggest what the exact approach is that turns the foundational elements into actions, nor whether that approach works in improving health and wellbeing outcomes.

As suggested throughout this introductory chapter, the whole area of community engagement and development has continued to be a contested concept as far back as its roots in the 19th century, pre-the welfare state. Community efforts around wellbeing were independent of state mechanisms at this time and voluntary support for each other, collective efforts through unionisation, and resource distribution through charities provided the glue to bind communities together.

In the twentieth century, alongside building the welfare state, governments became more directly concerned with community development, but the relationship between state and community development has never reached a point of being entirely comfortable nor consistent.

Hence it cannot be assumed that Policy statements in themselves show committed and sustained support to community led or focussed programmes.

This challenge may also be made to the wider field of public and population health itself, within which community health development is intricately entwined, as it too shares a political permissiveness that has bedevilled its history. (Bekker, et al., 2018).

Within Wales, this political critique is particularly important as the UK Government and Welsh Assembly Government do not necessarily share the same perspective, and both levels of government have a significant impact at

community level. If they both recognise community health development has an important role to play in improving health and wellbeing, it deserves further scrutiny as the dominant political ideologies In London and Cardiff are very different and, if there is general agreement on support for community health development, it is likely that they do not both perceive community health development in the same way. The same words are used, but to shroud very different understandings and ideologies.

It has already been suggested that community development waxed and waned globally from the first half of the 20th Century and its growth was sporadic in housing, social work, and local government planning. Even its more recent profile within sustainable development, asset-based working and working across partnerships to deliver wider social value and wellbeing (most notably through its profile in the Wellbeing of Future Generations Act in Wales) is variable.

Hanlon et al. (2011) have used the metaphor of waves to describe distinct phases of public health post industrialisation that reflected the dominant ideas of each time about the nature of society and how society impacts health. This is an obvious hotbed for political ideas as socialist, capitalists, democrats, and liberalists all have very different ideas about the actual and ideal nature of society. Hence each wave is a strong articulation of the political debates and key ideas of each time.

In short, they proposed that public health developed in different ways across these ‘waves’:

- **Wave 1** – Sanitary and social structures such as the great public works (for example the Public Health Act, 1848) which established local Boards of Health and the original Medical Officers of Health with powers to make sanitary improvements locally. This First wave of sanitary reform was as part of the great programme of nineteenth century public works implemented by Victorian movers and shakers: the recognition that clean water, and a healthy environment, lead to good health in the population at large, led to the creation of publicly

funded water and sewage facilities, and also to advances in the concept of population health itself. This work was conducted by thinkers who saw themselves as guardians of not just the public good, but also civil order and stability.

- **Wave 2** – Biomedical and the emergence of medicine as science. Scientific rationalism spanned the first half of the twentieth century and major advances were made in the identification and characterisation of diseases, medicines, and medical equipment were developed and started to be mass produced.

- **Wave 3** – Redesign of social institutions into a Welfare State (Social Security, the National Health Service, universal education, and house building programmes). This wave was typified as the 'state as machine'; it was in this wave that pathogenesis became more fully formed as health became viewed as something built and then fixed by professionals.
- **Wave 4** – Social and behavioural, which was dominated by efforts to combat disease risk factors and the emergence of systems thinking. From roughly 1960 to the present, this wave has three main characteristics: health interventions to prolong life and improve quality of life; lifestyle, and risk analysis as base criteria in thinking about public health; and the recognition that economic inequalities are reflected in population health.

A full critique of the history of public health, community health development and how the two intertwined or developed separately or together throughout these waves is beyond the scope of this thesis.

To do so would require a complex investigation of the nature of societies (the interaction between individuals, families, communities, and wider society is both complicated and contentious) and unpicking that requires investigating the political, sociological, and economic ideas that came into prominence along that timeline with reference to health and wellbeing. What is clear is that community health development was a core component in public health in

each wave and the exact nature of it mirrored the wave it was in, hence it varied alongside the waves. It was trying to do different things at different times and, whilst it may have used similar methods of working, how these methods were applied varied considerably.

Here both public health and community development will have been profoundly impacted by the dominant socio-political ideas in each of these waves and, more importantly, community health development within public health may have become more or less prominent as an idea and a strategy within each of those waves precisely because of those dominating ideas.

What is most significant is that within the 5th Wave suggested by Hanlon and subsequent authors, community health development is one of the most central ideas. They believe that the 'logic' (sic) of modern ways of living means that the effectiveness of the four waves of public health built to date are now nullified, and they argue that the fifth wave that is now required is not simply an addition building upon these prior waves, but is a complete paradigm shift, a totally different type of wave.

They argue that the biggest health challenge for the fifth wave is complexity, and it needs a new narrative that existing scientific paradigms find hard to address, but it can still be shaped based upon the socio ecological model of health.

Lang and Rayner (2012) presented a similar analysis to Hanlon on their review of the dominant public health models through the ages, coming to the same conclusion that modern public health needs to think and act ecologically if it is to reshape the conditions that enable good health to flourish.

Both Hanlon et al., and Lang and Rayner, suggest that the future shape of public health must be based upon the creation of a 'health promoting context', environments and a culture where healthy behaviours are the norm and institutional, social, and physical environments are created to support healthy behaviours.

The Public Health Network in North-West England have been working on presenting the practical application of this 5th Wave and have referenced it as the "New Public Health" or “N2PH”. (NWPHN, 2019).

Drawing inspiration from the various social determinants reports, particularly the strategic review of health inequalities in England (Marmot, 2010) conclusions on health inequalities and the need to tackle the causes of the cause of health inequalities (Dahlgren and Whitehead, 1991) and also the three horizons model for longer term change designed by the International Futures Forum (International Futures Forum, 2022).

Each of these proposes that a new paradigm of public health thinking is urgently required. A purposeful shift in understanding towards ‘health as wellness’ rather than ‘health or illness”, focus on the importance of building resilience in individuals and communities, and the need to address social conditions around people.

This makes a definitive statement about the shift into Hanlon’s 5th wave and an endorsement of ‘salutogenesis’ (health as wellbeing) as a legitimate alternative to pathogenesis (health as opposite to illness). They also placed great emphasis on the need for ‘asset-based’ community development and to shift health and social care service delivery from treating people as passive recipients for services to active consumers or co-producers of their own health.

These ideas of a ‘community’ solution are not new, the current call is for asset-based community development but there have been many other variants presented in and alongside the waves of public health. Whatever each shiny new version would have us believe, as can be seen from the briefest look at history above, it has been a response to social problems and crises of various kinds for over two centuries. (Gilchrist, 2005)

Community development at different times has been many very different things, however it is futile to try to judge its success or failure at each point in hindsight. It is always contextual and contingent and therefore it is not useful to try to understand it in the abstract. There may be general features and

approaches that can be learnt from, but then only by recognising that it has taken different forms and fulfilled different policy functions in different places.

It is arguably more important to understand what is possible in community health development in the here and now, and what the contemporary socio-political context brings in terms of opportunities and threats for community development as a way of building wellbeing, and if the policy drivers are responding to this.

The new context is all about communities facing a series of familiar challenges around poverty, isolation, lack of cohesiveness, failing amenity and lack of opportunity. But it is also a time when austerity remains the dominant political narrative along with the implications of Brexit, Covid 19, and climate change which, even though at the time of writing are still largely unknown, their anticipation already has had a great impact throughout communities. This has been labelled by Public Health Wales 'The Triple Threat' (PHW, 2021). The impact of war in Ukraine since that report and its consequential impact upon the food and fuel markets merely provides greater amplification to those threats.

This health impact assessment and report recognises that.

> "*Local communities strongly perceive the impacts of Brexit, COVID-19 and climate change and some communities will be affected to a greater extent than oth*ers" and recommends that "*Public bodies, local teams and the population will need to work collaboratively to address this. Building resilience at a population level is a key mitigator*".
>
> (PHW 2021, p. 17)

Given that the possibilities afforded by community health development and strengthened resilience in communities is a theme that has been running through the Welsh Policy agenda at national level for a decade, this much more recent push to focus on aspects of community health development (citizen involvement, citizen-centred responses, prevention and early intervention and co- production) is merely a signal that it isn't yet happening.

Despite the new context and policy support, in general terms there isn't an obvious community health development in practice evident to immediately explore in Wales. Whilst there was for several years a dominant model through the Communities First Programme (2001 to 2018), when it was phased out local authorities were only 'guided' to how they should allocate the legacy funds for the project. As result legacy monies were only allocated to a limited number of organisations and projects, and then the activity was targeted towards reducing poverty, not improving wellbeing per se. (Welsh Government Social Research, 2015).

Whilst the Communities First programme had both longevity and a general political consensus across its operation, it is simplistic to consider it a single and uniform programme as it had great local variation and local distinctiveness, particularly as it was noted for being continually subtly tweaked and altered. In reality, a programme ultimately of not only putting community first, but also of Community Firsts, as in innovating a range of different ways of tackling wellbeing in and around specific communities (Bevan Foundation, 2016).

Whilst community health development in Communities First waxed and waned (as it has elsewhere) there did not emerge one dominant form of practice or a high-profile model that could be identified, even in the wake of Communities First and the definition provided by the Cardiff Advisory Group.

On the contrary, there are a plethora of models and theories to draw from globally, a plethora from the Communities First experience, plus variable ways that they may be implemented across North Wales communities.

1.6. Unpacking the Contested and Confused Nature of Community (Health) Development

Community development's history is complex, mainly because community development exists within and draws from so many different disciplines. In the UK at least its modern roots go back beyond the 1950s and its concepts can be found, and are being applied in, housing, social care, education, criminal justice, as well as across many aspects of improving health and

wellbeing. However, its development has been uncomfortable, whilst in Wales it now has recognition and currency, across the UK as a whole it has not always received political or popular favour and has tended to drift in and out of fashion.

Across the political spectrum from right to left, from radical to liberal, there are proponents of community development. They don't however all think about community development in the same way or expect it to work towards the same goals. Some feel it should be a tool to allow the social state and nationally delivered services to be reduced, and others that it is a necessity precisely because those services are already disappearing, and communities need to be strengthened so they can be resilient to these changes. In practice this means that the bottom-up core foundations of community development are often compromised or contradicted by top-down methods of delivery, funding, and dominant systems.

Whether for health, environmental, or other reasons, community projects are increasingly looked towards to provide the answers to the most challenging societal problems and the whole area of community engagement and development is not just experiencing these tensions now, it has been a contested concept even as far back as the 19th century, pre-the welfare state, when community efforts around wellbeing were independent of state mechanisms. Voluntary support for each other, collective efforts through unionisation, and resource distribution through charities together provided the glue to bind communities together, but it wasn't to remain that way. Later in the twentieth century, alongside building the welfare state, government became more directly concerned with community development utilising it as an instrument of many aspects of government and service delivery at the very local level.

The extent that this state intervention at local community level has waxed, waned (and waxed again) in health, education, social care, crime prevention, economic regeneration and, more recently, even the prevention of terrorism sectors has been studied extensively already. Mae Shaw, (Shaw, Armstrong et al., 2016) cover this well in their consideration of the tension between

‘community development as policy’ and ‘community development as politics’. They suggest its intrinsic ambivalence leads to paradoxical application of control and empowerment within even the same programmes. Depending upon the terms under how community development is deployed and who holds or distributes power, affects how community development plays out.

This unresolved ambivalence leads to many uneasy and unresolved tensions in community development programmes, but the easiest tension to recognise is that between the top down (professionally or state led programmes) and those from the bottom up led by community members themselves. Other tensions also exist, such as the way issues are framed; whether programmes are primarily dealing with deficits in the community or if their concern is building on strengths and, furthermore, whether the purpose of community development is to simply strengthen that community for its own sake or whether that strengthening is being undertaken to fill a gap in state provision (or in preparation for a withdrawal of resource and service provision).

So, despite its constant presence in policy at some level of attention for over two centuries, the relationship between state and community development has never been entirely comfortable nor consistent. As Shaw et al. (2016) point out, it is always contextual and contingent, but as a mechanism for improving social welfare it has been variably supported by UK governments throughout the whole of the 20th and 21st Centuries.

The short lexicon at the start of this thesis introduced the dilemmas in a definition and concluded that the anchor point for a well substantiated definition comes from the Standing Conference for Community Development (SCCD, 2001b). This was also recognised by the Cardiff Advisory Group as the core of their definition.

> “*Community development is about building active and sustainable communities based on social justice and mutual respect. It is about changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives*”.

The most often associated concepts across the range of similar definitions of community health development suggest its main features are:

- Empowerment.
- Enabling.
- The primacy of people's own experience.
- Working with not on or doing for people (coproduction).
- Coproduction of outcomes.
- Collective action.
- Sustainable long-term change rather than short term fixes.

and in particular the sense that it is rooted in a 'bottom up' process and aims to capture and hone a community's knowledge and experience and, through stimulating collective action, enable self-defined goals to be met. (Labonté, 1999)

The Cardiff Framework went further to suggest that the approach is mostly targeted and applied to groups of people who are, in some way or another, initially disadvantaged or difficult to engage by service providers and, hence, it is a major tool in tackling health inequalities. This is primarily achieved by empowerment and collectivism.

This Welsh definition then makes a firm position statement with regards to how it is framed, it is on the bottom-up side of the dynamic; concerned primarily with empowerment, although it doesn't make a firm distinction on whether it should be mainly concerned with deficits or strength-based approaches.

The definition forms a promise; however, the question remains to be answered if that has been followed through into Welsh community health development practice?

1.7. Issues in the Evaluation of Community Health Development

Closely related to a concern of being clear on concepts is the related consideration that if it is difficult for interested parties to agree exactly what

community health development is, then the defining of expected outcomes it may produce will also be highly contentious. This isn't just a conceptual conundrum as there are also some attendant technical and methodological conflicts when trying to rationalise those outcomes across partnerships, with each sector and partner having its own ways of framing and measuring outcomes which, in practical terms, leaves much space for disagreement and misalignment.

If, as suggested, there is no one concrete model to look for and test community health development, is there at least a number of optional models to look at or at least a lens to look through to illuminate understanding?

A number of systematic attempts have been made to understand the field and present understandable meta narratives of the breadth, and various facets of, community health development.

Brunton et al. (2017) approached this by concentrating on community engagement as a main process within interventions. They selected 39 process evaluations and theoretical papers that focused on community engagement in order to develop a conceptual framework, and incorporated learning from 319 intervention studies of community engagement to give further texture on the key concepts and patterns of engagement.

The new heuristic model they presented for understanding the dimensions of community engagement (figure 1.4) is intended to help to disentangle the relative effectiveness of different models of community engagement but, despite its usefulness in teasing out the complexities within community engagement, it should be noted that engagement is only one aspect of community health development; a crucial element maybe, but still only just one strand.

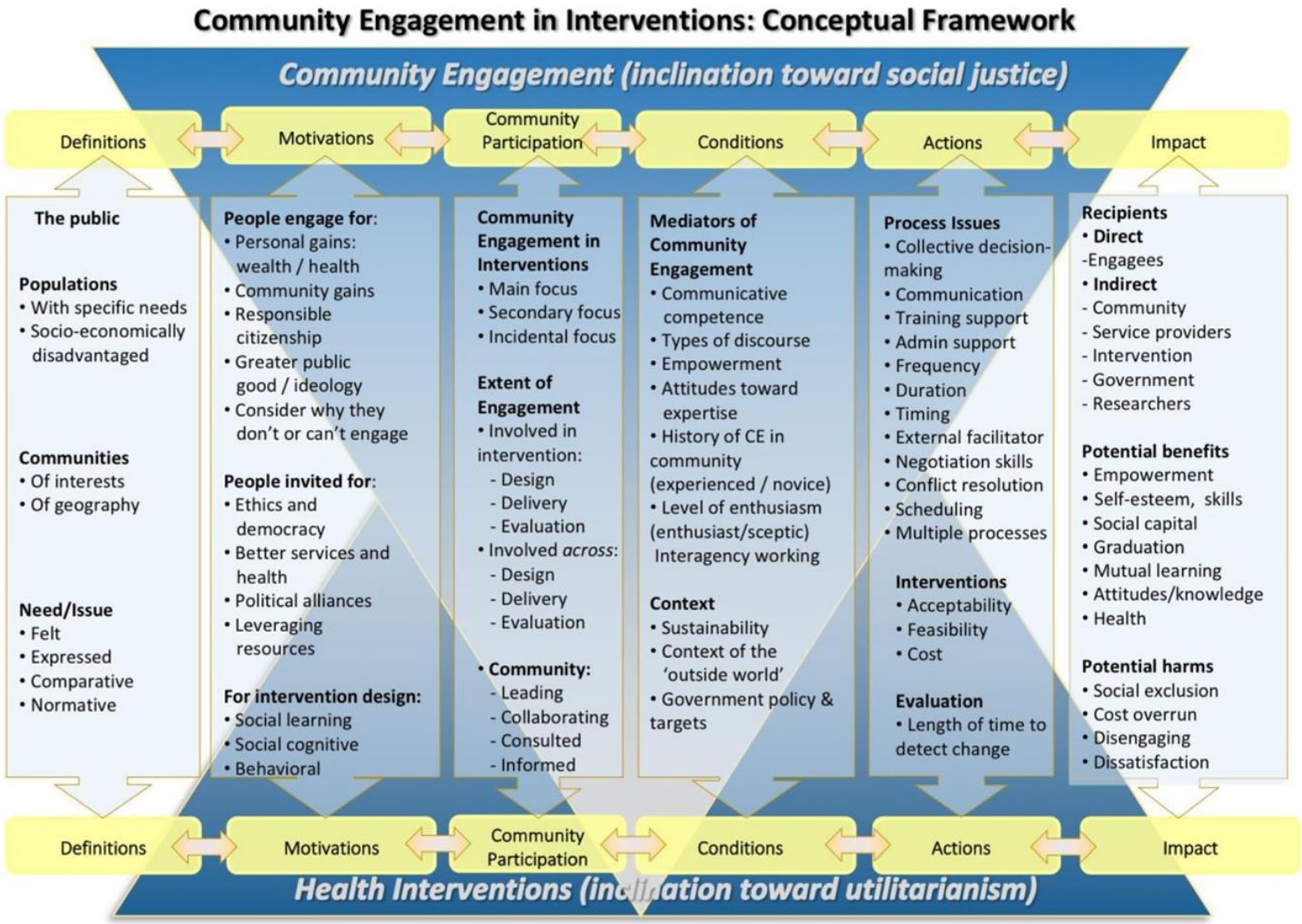


Figure 1.4: Community Engagement in Interventions Conceptual Framework (Brunton et al., 2017)

In an earlier piece of work published in 2015 by Public Health England and NHS England (South 2015), Professor Jane South preferred to cover similar ground but chose a different lens of ‘community centred approaches’ rather than community engagement or community development (Illustrated in figure 1.5). Within this she acknowledged that there exists a diverse range of community interventions, models and methods that may be used to improve health and wellbeing or address the social determinants of health. She chose to describe the many interconnections and relationships between the different approaches as a “family of community centred approaches”.

Within the breadth of this family, she suggests, are some common options, and she identifies a series of the mechanisms of change based on the core concepts of increasing equity in communities, increasing control in communities, and building social connectedness.

In her resulting typology, community development is regarded as just one approach to strengthening communities and illustrated alongside approaches to partnership development, community engagement, and peer development.

Simply comparing and contrasting these two prominent typologies illustrates the complexity of the field, and the variance in the ways that community health development may be currently considered.

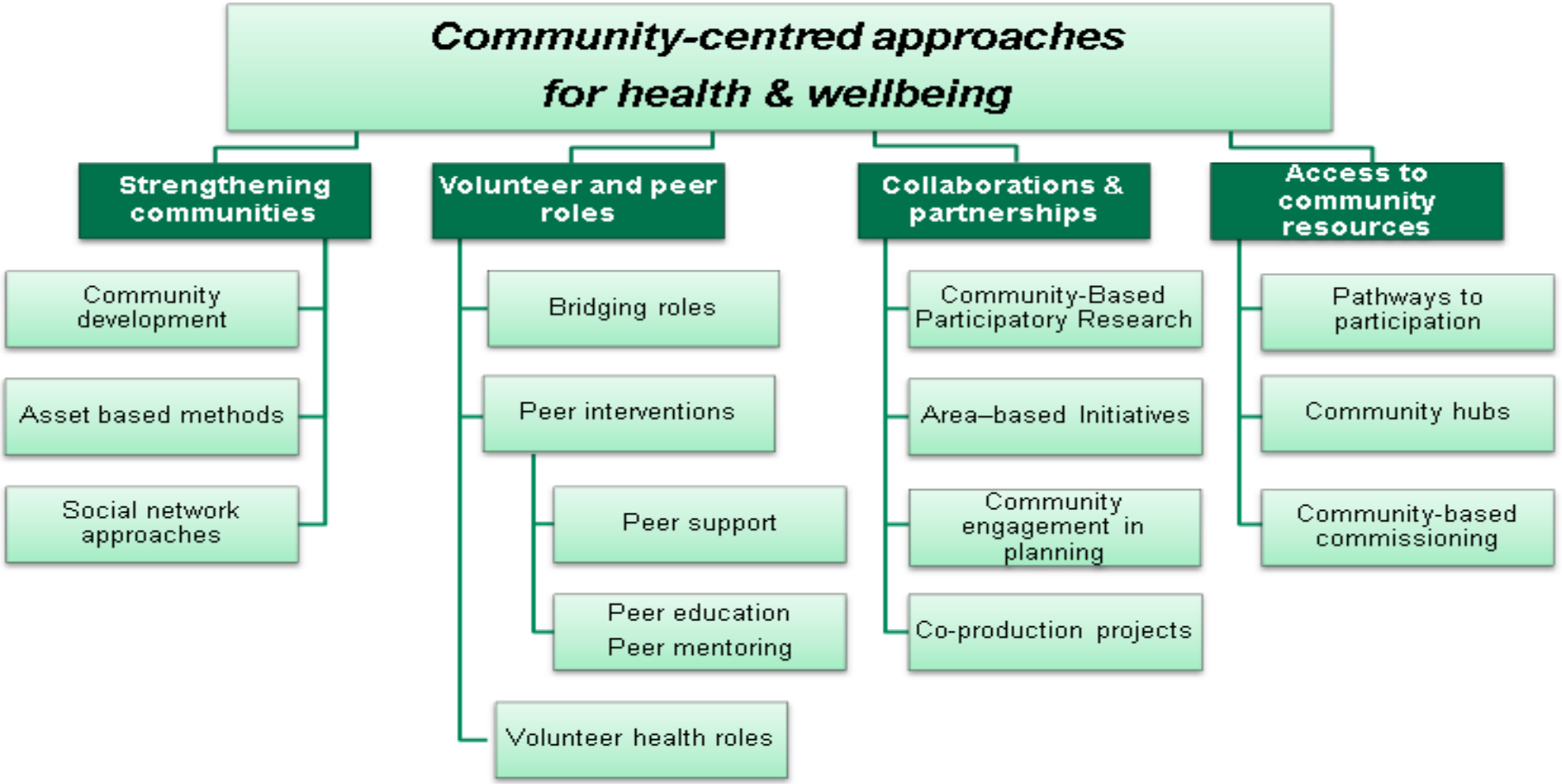


Figure 1.5: The Family of Community Centred Approaches, (South, 2015)

Rather than get into semantic and conceptual debate about the modelling around this, it is sufficient at this stage to simply acknowledge that this whole area remains broad, complex, contested, and imprecise.

One of the most important observations is that running through every element of both typologies remains a tension between the “top down” and “bottom up” approaches and variance in the purpose and extent of ”buy in” from stakeholders and decision makers to approaches in practice. Popple and Quinney (2002) explore these forces as legacies that have been embedded in UK societies from the top-down paternalism and benevolent attitudes of the Victorians, and a community up and out force that came in the wake of neighbourhood action programmes. There is a very significant difference in here that is central to this research.

The Victorians top-down approach was born out of a dominant Christian and moral imperative, emblematic of that time, to respond to working class unrest and to target the improvement of social health. No longer the sole rhetoric of philanthropists, church, and academics this rhetoric over time became a cornerstone of central government thinking and as a result many community-based projects at their heart have an ideology towards integrating individuals and groups into mainstream society and in tailoring services and resources more sensitive to their communities’ needs, usually involving communities themselves in running, ‘owning’, and organizing projects.

In comparison, the bottom-up approach has a less focussed heritage coming from multiple single issue, locally focused attempts by groups to achieve change in their own social conditions by changing policy, and available resources. Most collective community action has been typified by relatively focussed and minor-scale local attempts to negotiate with powerful stakeholders and structures in this manner (Jacobs,1976).

Whilst it is important to try to gain some concrete reference point to begin an exploration of what works and for whom and in which contexts, the anchor point for the exploration, the definition from Cardiff already cited, can provide this.

There is however a major caveat in that the definition itself does not then indicate the resulting approach it fosters and delivers. The definition suggests a preference for changing power structures and empowering a bottom-up approach but, in the wake of the experience of Communities First as a programme, and with the Policy environment profiling such strong expectations of improving social health in communities with the active involvement of public bodies, how this is actually translated into practice must be investigated with a lens wide enough and open enough to capture learning of both top-down and bottom-up approaches.

Brunton and South between them clearly illustrate the range of variants and traditions within community health development that should be considered within the research.

These two are just the more prominent meta narratives to date presented to aid understanding, but part of the complexity of community (health) development is that, despite the global recognition of the advantages of the approach and attempts to build typologies, there is still no single universally accepted definition and process to deliver these outcomes.

For the purposes of this research, therefore, a more simplified lens will be used which is inspired by these taxonomies and other relevant models of community health development, such as Alan Beatie's Taxonomy of Health Promotion (Beattie, 2002).

This lens consists of six common traditions that can be identified across theories, models, and taxonomies – traditions as they are sustained elements over time that seem to persist in rhetoric and reality as separate entities, but none consistently proves itself to be the main abiding concept or disproves the other elements.

These traditions (authors own illustration in figure 1.6) are recurrent ideas that arise in most attempts to define community health development. Each of which may operates in isolation at a theoretical level, but they more often blend into a mix of approaches when applied in practice.

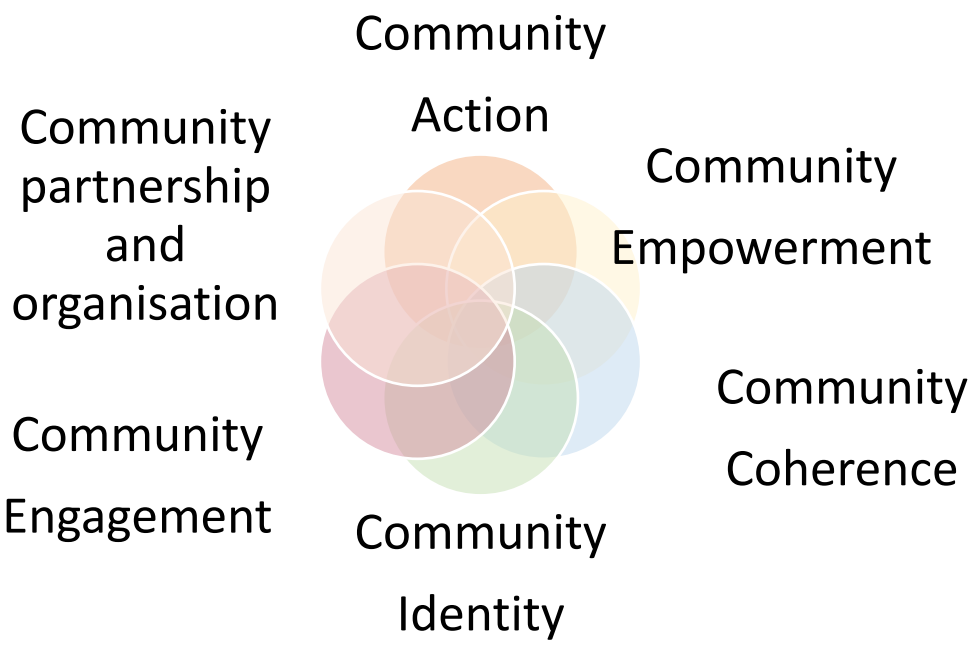


Figure 1.6: Six Tradition of Community Development Evident in Health and Wellbeing

The contested nature of community development theory, combined with the binary construct of forces up and down through ideas and actions, can be dealt with in four ways (Connolly, 2007).

- Ignore it (accept merely that it is a broad church encompassing conflicting and ideas and supporters within it).
- Acknowledge it and keep searching for a resolution (possibly adding to the range of models and taxonomies in the process).
- Fully explore it and align with a preferred approach.
- Accept its diversity and contested-ness when hypothesising its practice and be open minded about the range of possibilities the contested-ness brings.

This final approach is informed by Gallie's notion of the "moderate" user (Gallie, 1964, p. 188) who accepts there are a range of ways of interpreting essentially contested concepts. Frameworks such as Brunton et al. and South et al. are therefore considered for the purpose of description and

interpretation rather than prescription of a particular way that the research should be informed or conducted (Carlon, 2016).

Whilst it is interesting to deconstruct the nature and purpose of each iteration of community development, it is more important in this research to focus on whether community health development approaches work and, if so, how it is that they work, for whom, and what is the relationship between how they work and the context in which they operate?

Rather than begin an investigation by artificially pulling them apart and following the specific ideologies or practices in each approach, a methodology will be designed which is open to capturing insight across all the broadly drawn traditions above. The research question being ‘what works and for whom in what circumstances’, mean that it is not so crucially important to establish what the thought processes are behind what is being implemented, but what actually happens and if it is being effective.

It is highly likely that a blend of those traditions will coalesce into a local programme and multiple stakeholders will be more closely aligned to different traditions, but it is the sum impact of them all on how the programme of activity is undertaken that is important to this research.

What works, and where to start answering that question, also depends upon who wants to know what the answer. It is first worth considering whether the evaluation’s purpose is formative (providing lessons for improvement within a programme) or summative (lessons on the overall success or failure of a programme to achieve its intentions).

Scriven cites a useful analogy to clarify the difference; “When the cook tastes the soup, that's formative evaluation; when the guest tastes it, that's summative evaluation.” (Scriven, 1991, p. 19). The needs of the different audiences for evaluation are therefore very different, these audiences are wide ranging and diverse, but the key ones are:

- Programme deliverers and participants to improve its performance (Development).
- Other programme designers elsewhere to gain inspiration and delivery/impact lessons (Knowledge).
- Programme commissioners to understand the return on the resource provided (accountability and development).
- Wider stakeholders to gain a deeper understanding of some specific area or policy (Knowledge).
- Subjects of the programmes to validate their own involvement and commitment (accountability).

Chelimsky & Shadish (1997)

Bill Jenkins in "What is effective community development and how do you know it when you see it" (Jenkins, 2019, p. 2), suggests the different expectations stakeholders might have for outcomes from a community development project:

> "*On the one hand, we need to work with people in communities to help them solve their own problems (community development). On the other, service deliverers need to greatly improve their ability to plan, manage and deliver relevant services that are valued by their clients. In the fullness of time, we may even reach a stage where both components of society, citizens and the institutions that serve them, will be able to work constructively together for the benefit of communities. But at present in the UK all possible approaches are thrown together as one, with no clear method or theory to guide them, and community development and regeneration proceed as a chaotic, ineffective and resource-intensive field*".

This undermines the challenge of exploring the effectiveness of community development as it depends on what the stakeholders asking for evidence think community development does in the first place. If you believe that its

main purpose is to empower people to meet their own goals you will be looking for very different outcomes or evidence of success than if you believe that its purpose is to meet a specific policy goal around health, crime, environmental, or other specific societal expectation.

Many research studies and evaluations conducted within the public health field have had inbuilt expectations of health (or to be more specific illness) outcomes in the short term (and related to specific disease risk factors) whilst the communities and the workers involved are more likely to have been working to long term change in a less focused manner, aiming for empowerment and general control for community members around general wellbeing aspects of health. This crucial difference in perspective is a thread that runs through many evaluations of community development, and it is not always acknowledged or accounted for within the methodology.

There is an enduring and vociferous debate in the public health field about how evaluation of community development contrasts with other health interventions (Hills, 2004). For example, 'randomised control trials' are often cited to be inappropriate as they come from a very different scientific paradigm to community development itself. On the other hand, studies deemed appropriate and acceptable by the participants of projects themselves are often criticised by commissioners and decision makers for their over reliance on evidence derived from anecdotal or narrative based sources.

This has led to a stand-off between researchers and practitioners even within public health (O'Mara-Eves, Brunton et al., 2013) however, it is possible to form a bridge between the two. The Well Communities project has undertaken a broad sweep of evaluation methods within its work, and this includes a randomised controlled trial within a broad suite of approaches used. They have complemented this with other more qualitative methods of research running in parallel, plus have built all activities around a robust theory of change (Findlay & Tobi, 2016).

A good consideration of the issues in evaluating community health programmes comes from the WHO publication “Evaluation in Health Promotion: Principle and Practice” (Rootman, 2001).

The authors point out that as community programmes are inevitably complex, involving stakeholders and participants from widely varying backgrounds and diverse interests, this complexity affects the evaluation components to the extent that there is often as much debate about the evaluation of projects as there is about the projects themselves. The debate typically centres upon the futility of implementing evaluation methods that have been recognised and valued in more controlled contexts such as clinical research within complex social programmes.

This is a debate that continues to rage on and is unlikely to be resolved each time community development comes back into fashion unless a research methodology is universally agreed upon that is able to satisfy all potential stakeholders.

> *“…given the poor record of controlled experiments for evaluating community programmes, the use of alternative methodologies should be encouraged. The result of such studies should then be used to elaborate models that deepen the understanding of the mechanisms of effective community programmes*”.
>
> (Rootman, 2001, p. 232)

The Medical Research Council, who provide evidence-based guidance on the development, evaluation, and implementation of complex interventions to improve health, suggest two key questions when evaluating complex interventions:

- What is its practical effectiveness? Does it work in everyday practice not just under test conditions?
- How does it work? What are the active ingredients of the intervention and how do they exert their influence/make an impact?

> "*… only by addressing this kind of question can we build a cumulative understanding of causal mechanisms, design more effective interventions and apply them appropriately across group and setting*".
>
> (Craig, et al., 2011, p. 7)

In order to bring together existing knowledge about different approaches to the evaluation of community-based programmes, the Health Development Agency commissioned a systematic literature review of the evaluation of community interventions (Hills, 2004). It recognised that, following a rise in the commissioning of larger scale community development programmes throughout the early 1990s, there was a demand to respond to a perceived increased demand for accountability and produce more robust evaluation and outcome measurements with which to build a firmer evidence base.

The report criticised existing approaches from two directions. Firstly, they pointed to pluralistic and participatory methods of evaluations which were acknowledged to be useful for strengthening the development of programmes themselves but less useful as a means for providing generalizable results that might inform other interventions. In contrast, they also reported that when more experimental or quasi experimental methods have been attempted, they have not been popular with projects themselves and have been difficult to implement.

For these reasons, the review suggested that the newer theory based and realistic approaches to evaluation are becoming much more recognised within community development research as they provide a challenge to the previous lack of attention paid within evaluations to context, programme theory, and the mechanisms of change that may bring about the health outcomes. These may then provide more nuanced evidence of how programmes work in specific contexts; which people specifically benefit from them; and what things actually happen to produce health outcomes. Such a thread of understanding isn't of course any more instantly generalizable than pluralistic and participatory evaluations, but it does allow for more in-depth

considerations across programmes of the differences in contexts and how mechanisms may operate differently with differing communities and contexts.

This changing attitude towards more realistic/theory-based methods is itself a reflection of an emerging culture within the health field, grappling with both increasing demands for evidence-based practice at the same time as it recognises the complexity of health behaviours and decision making at individual and community levels.

There are a number of important elements within this changing culture:

- The shift from a bio-medical model (focussed on disease prevention and personal responsibility) to a salutogenic model of health as wellbeing (a socio-ecological model emphasising coherence and balance between people and their environments) (Burns, 2014).
- Single risk factor (often behaviour) focus to multiple causality (wider social determinants).
- Individually targeted interventions (health education) to Systems level interventions (settings and communities).
- Passive patients to Active participants.

There has also been a huge shift from ignoring health inequalities towards an acceptance that relative inequality harms the whole of society and consequently the design of policies at societal level based upon programme resources implemented and distributed according to the principles of proportionate universalism (Wilkinson & Pickett, 2007).

Reflecting the shift towards recognising multiple causality, community health interventions combine many elements beyond those traditionally recognised and they are implemented alongside a number of different non “health” programmes, but often with very similar and overlapping aims. Distinguishing the health elements within wider complex programmes is one of the main challenges for evaluators.

These cultural shifts present challenges for those seeking to evaluate community development in the 5th wave. Kelly et al. suggest that these are part of the movement from modernity to postmodern thinking and that positive health and salutogenesis is a postmodern concept not amenable to conventional scientific investigation, or to conventional (modern) scientific discussion. They conclude that new approaches are required to research into their impact and effectiveness (Kelly et al., 1993).

Hills et al. (2004) found that it is has been particularly difficult to find published evaluations of modern community development projects, any evaluations that were undertaken were most often not published for a wider audience but were written up for a much more limited circulation, such as to elicit further funding from key stakeholders.

However, since the mid-1990s a step change occurred in community development evaluation as the high profile and large-scale programmes around Healthy Living Centres, Surestart, and Health Action Zones demanded new evaluation strategies to address the complexities of these multi-faceted interventions.

These programmes paid much more attention to the contexts in which they operated than previous health programmes and were keen to identify the mechanisms and theories driving interventions. This required more active engagement of stakeholders and programme participants in the evaluations and there was also an increase in the level of rigour and systematisation in data collection and hypothesis testing.

Whilst these developments were in highly politically prominent large-scale programmes, they also stimulated a wider interest in theories of change and realistic evaluation, as well as a new level of debate on what evaluation tools were needed to help build the evidence base for policy and practice in health promotion.

Community projects themselves were struggling to rationalise their way through the minefield of challenging experimental designs and unrealistic randomised controlled trials.

It was in the wake of this that interest in realist evaluations and realist synthesis in the field of community health development grew rapidly.

Realistic evaluation assumes that the contexts within which programmes operate are crucial to their outcomes, and the key research question is not whether community development works but what works, for whom, and in what context? It is the mechanisms of change – the choices and capacities of those involved in the programme – that lead to regular patterns of social behaviour, and how the mechanisms are ‘triggered’ by their interactions with context (Pawson et al., 2004).

Specifically, within community development, this means collecting information not only on the activities of the programme but also on the way that this interacts with the particular culture and history of the area in which it is established. Working in this way means investigating how the context enables or disables the functioning of mechanisms and to identify what specific context – mechanism – outcomes work.

Like the theory of change approach, realist evaluation requires the evaluator to tease out the theory behind the mechanism used in an intervention (Rolfe, 2019). This means engaging with participants and stakeholders of the programme to explore their assumptions about the mechanisms through which change is brought about. In this sense it is not for the evaluator to propose a theory but to dig out the programme theories that are often dormant or half articulated. These need to be brought out for them to be used to test context- mechanism – outcome patterns. Once these are formulated an essential step in the process is to check out and confirm these with participants and stakeholders within a series of teacher – learner feedback processes with all parties around the programme including commissioners and policy makers.

This shares some of the epistemological features of an experimental approach as it is carried out systematically and tests hypotheses.

Closely related as an approach to realist evaluation is ‘Realist Synthesis’, which also takes the exploration of mechanisms in contexts operating within a programme. It identifies the circumstance under which a particular intervention might or might not work, and tests these against the research results available. Both approaches begin with the notion that programmes are conjectures taking the form “if we apply programme X this unleashes process Y which will result in Z”. Hence the purpose of the research process in both is to gather the evidence of whether the community development process occurs as intended and planned and, if not, then to amend the theory to account for the divergent outcomes (Pawson, 2002, p. 347).

Using both together promises a strong approach to gaining understanding of community development projects in Wales and how they achieve health and wellbeing outcomes. This research primarily uses Realist Evaluation as a lens to understand typically complex small community development project case studies in North Wales in a period of significant changes in conditions and contexts.

During the period of this study these communities and projects are still experiencing the effects of a withdrawal of the state in local service provision and an increase in the so called “austerity measures”; greater partnership development, and a joint approach to wellbeing through the implementation across all public bodies of the Wellbeing of Future Generations Act; Brexit brought a host of new contexts, but centrally one around identity and questioning of authority as well as decision making at local, national, United Kingdom, and European levels. Latterly, but perhaps the most significant context change, is Coronavirus and the lockdown measure introduced to try to manage the pandemic.

Each of these may be considered major contexts in and of themselves but they also shape a host of other specific programme contexts that need to be understood for their impact on how community development projects work.

Many research and evaluation studies grapple with finding valid ways to understand how community development programmes work and which outcomes are produced.

As noted by Hills (2004) up until the 1990s evaluations of whether community development type interventions work had been dominated by a need for small scale local programmes to prove they were worthwhile re-funding and continuing.

Only in the later 1990s did the emergence of larger community level interventions lead to a greater interest in accountability and a demand for more complex and larger scale evaluations.

Hills and colleagues mapped various evaluation strategies including experimental and quasi-experimental designs, participatory methods, and multi-method strategies, all trying to establish what works to improve health.

In this thesis, however, the question purposefully moves beyond whether these community approaches work in improving health outcomes to identifying what works, in what circumstances and for whom within a distinct North Wales context.

This is the first study of its kind, focused on providing an explanatory account of what works and what are the underlying generative mechanisms that explain ‘how’ outcomes are caused in North Wales Community (health) development projects, and the research also seeks to account for the influence of context within such projects.

1.8. Aims and Objectives of This Research

The research uses a realist methodology to study four public sector supported community development programmes in North Wales to provide an explanatory account of what works, for whom, how, why, and in what circumstances.

The aims of the research are:

- To identify the conditions (context) and underlying generative mechanisms that explain what works, how and why in relation to community health projects.
- To generate evidence and theory to guide NHS and community programme leaders to effectively implement future successful community health development projects which promote sustainable development and build wellbeing within communities.

The specific Objectives of the research are:

- To generate an explanatory programme theory about community health development projects that explains what works, how and under which contexts.
- To explore, through stakeholder engagement, decision-making processes associated with local community health projects.
- To produce recommendations about ways in which different approaches and/or strategies can help NHS managers and community programme leaders plan and prioritise projects in a systematic and efficient approach.

The realist methodology and initial plan for how the research would be completed is explained, justified, and the full programme plan set out in Chapter 2.

Chapter 3 then reports on how this initial phase of concept mapping and realist literature searched were conducted, leading to a rough working theory.

The stakeholder engagement is outlined and reported upon in chapter 4. This is the realist evaluation element of the research which enabled the initial working theories to be refined, ready for further testing.

Chapter 5 details how both realist approaches are combined to drive an iterative process of building testing and refining programme theories towards

a final set of context, mechanism and outcomes configurations to explain how community health development works to build wellbeing.

The use of a ‘Realist’ lens is appropriate because evaluating wellbeing interventions in communities is recognised as problematic for evaluators. Hills (2004) point out that in recent decades a lack of policy attention along with projects being mainly small scale meant that any evaluations undertaken were mainly to establish support for their maintenance.

> “*Include the assumption of a relatively passive set of participants, a simple cause–effect relationship between intervention and outcome, and a standardisation of input which runs contrary to the nature of the intervention, which is designed to respond flexibly to local demands*”.

This limited their usefulness as part of a wider evidence base and led to suggestions of a reality gap between the science of evaluation and the delivery of community health development in practice (Hunt, 1987, p. 24).

Within the usual evaluation paradigm, research has tended towards attempting to control variables, often with reference to a counterpoint project or control group, and towards tracking specific outcomes from the start.

These are not only difficult for community programmes (being so complex and widely based) but they also run counter to the purpose of community health development in the first place.

- ‘controlling’ people as variables is antithetical, even heretic to community health development.
- Isolating a set of main variables from other contributory and interrelated variables is considered ‘reductionist’.

A key driving force and principle of projects is that they are non-directive and dynamic, purposefully allowing goals and outcomes to emerge as the participants change and open new perspectives and horizons, hence any attempt to evaluate a set of expected outcomes from the start with a rigid framework will be resisted and if employed will miss the point.

Dilemmas like this led to a growth in the use of participatory evaluation strategies which allowed greater flexibility and tighter alignment with programme goals and hence were very useful for assessing whether a programme had worked or not for its particular purpose and participants.

Yet these were less useful methods for establishing the evidence of the approach used against a different type of intervention, or for finding portable lessons that may be applied with other communities and programmes and their use was often driven by the need to achieve programme continuance and further funding. Hence, whilst broader based methodologies than those focussed on controlling variables, these participatory methods still had limitations.

Pawson and Tilley (1997) suggested that there is a danger that participatory evaluations have played safe and not been conclusive and overly assertive about programme successes, reluctant to specify findings and testable hypotheses because they are aware of the dilemmas and limitations of the methods they have used.

In contrast with participatory evaluation, more experimental research methods have also been tried and have also been heavily critiqued in community health development practice. These methods tend to be treated as a ‘black box type experiment’ whereby the main focus is on the inputs and results, rather than the process underpinning any actions.

On the whole, using experimental research methods in community health development brings two fundamental issues. Primarily, the focus becomes if an intervention works rather than *how it* works – often overlooking the embedded theory driving it. Secondly, by allocating interventions and control groups there is a deliberate attempt to control variables and consequently human characteristics and local contexts are downplayed, however these are the very elements that those working in community programmes champion as the key factors for success.

Due to the perceived weaknesses in both approaches a range of theory-based evaluation strategies became popular throughout the 1990s (Chen, 1990; Chen and Rossi, 1992; Connell et al.,1995; Weiss, 1995).

In particular, realistic evaluation (Pawson and Tilley, 1997) gained prominence and seemed to address the challenges of complex interventions by using structured experimentation principles but drawn from a range of paradigms. Its core premise is that the contexts within which programmes operate are crucial to the outcomes produced and that there are in every programme mechanisms for change that become triggered, or fired, by certain contexts.

Mechanisms are both resources within a programme, and the choices made and capacities of people in the programme, exercised in how and where those resources are applied.

When applied to community health development this means studying the actions and implementation of a programme, but also studying the place the programme operates in and teasing out elements of that milieu that are significant such as local heritage, tradition, and culture. The consideration of context is therefore quite wide ranging and goes well beyond the socio political and economic environment of the programme.

Realist evaluation studies the dynamic between context and mechanisms and how they lead to outcomes to answer the question of not just if community health development works, but what works, for whom does it work, and which contextual factors enabled the change or sparked the actions.

This dynamic between context and mechanisms is a crucial focus as context can enable but also disable mechanisms. Pawson and Tilley (1997, p. 71) describe how in realist investigations the researcher is trying to get behind (above, around, and underneath) outcomes to examine their patterns in a “theory testing” role. In this way outcomes are analysed to discover if the theories developed on how mechanisms are affected by the mapped context can be confirmed (Pawson and Tilley, 1997, p. 215).

In practice this approach means engaging in a close dialogue with participants within programmes to find their views and beliefs about which mechanisms are important, how they activate, and how they are affected by local context:

> '*It is not the evaluator's role to provide a theory, but to dig out the programme theories that are often dormant and half articulated – it is the evaluator's task to bring these vibrantly to life.' 'In order to construct and test context–mechanism– outcome pattern explanations, evaluators need to engage in a teacher–learner relationship with programme policy makers, practitioners, and participants*'
>
> (Pawson and Tilley, 1997, p. 203)

Hence this approach lies somewhere between the two types of approaches previously seen in community health development, having a rigorous approach of experimental research but also the more nuanced touch of participatory evaluation.

This research adopts the realist lens because, fundamentally, it recognises the complexity of programmes and variance in communities and local situations, even across a relatively small geography across North Wales. More importantly, it is due to an interest in what exactly it is that works and learning the lessons that may be transportable – not to carbon copy approaches from elsewhere - but to learn how the core of programmes are constructed and grow in different contexts and starting points and whether it can be established if there are core programme theories that enable that to happen reliably?

1.9. Chapter Summary and Map of This Thesis

This introductory chapter has provided an overview of two large and complex issues, firstly unpacking the meaning of health and wellbeing and its current and rising challenges in Wales, secondly in exploring the territory of community health development and how it purports to improve wellbeing.

It is important to recognise at this stage that the research was conducted between October 2017 and September 2022. In January 2020 the first phases of research had been completed (*including a period of three months in which there was a pause of studies due to pressing family health family issues and bereavements*), and a series of initial programme theories produced ready for testing with the Community Health Development Project projects and refining in wider interpretive forums with community development specialists and researchers in similar fields and methodologies.

However, at the point of recommencement came a major obstacle in the form of the Covid 19 pandemic, and its attendant public health measures that restricted social movement and contact with people outside of close personal and family relationships (Green et al., 2020).

The societal impact was profound, yet its impact upon the community projects themselves far from uniform. This major change in conditions meant that each of the four Community Health Development Project projects changed greatly, some elements severely limited but others greatly enhanced, and new elements emerged with the impact that some project halted whilst others accelerated.

The planned approach for the remaining research phases was therefore re-worked and an amended methodology proposed for sign off by Bangor University Ethics Committee which resulted in greater use of digital engagement and online platforms for video consultations and an elongated timeline.

Despite its length this introductory chapter has merely sketched at a high level the background to this research, setting out the breadth and complexity of the research, defined the specific research question, and methodological considerations. These themes will now be picked up and expanded further in Chapter 2.

The thesis a whole is structured as follows:

- **Chapter One: Introduction, the study in context** has explored the context within which the research is set in Wales. It has introduced the complexity of both understanding the confluence and contradiction in health and wellbeing, as well as a similar lack of uniformity and clarity of understanding community development and its contribution to improving wellbeing.

  Welsh Policy supporting the use of community health development in improving health has been considered and the issues surrounding evaluation of community health development have been introduced.

- **Chapter Two: Realist Methods** drills down further into the complexities of evaluating community health development and will set out in greater detail the realist evaluation methodologies adopted as a lens within this investigation, providing critical detail on how they are applied.

  The realist approach is set against other candidate approaches and issues of ontology, epistemology, and evaluation ideology will be explored as they are relevant to community health development. Realist methodology for Synthesis and Evaluation will be compared and the blended use for using both methodologies will be justified.

  Alongside realist synthesis and evaluation specific research techniques, such as concept mapping, Community Health Development Project selection, and soft systems methodology will be outlined and explored to illustrate their function and validity within this research.

  The chapter includes consideration of several other realist research studies in related subjects and a summary of the lessons learned that may inform the methods used in this study.

  Finally, the chapter recognises the impact of an unprecedented challenge to both community health and academic research in modern

times, the arrival in the second phase of research of a global Covid 19 pandemic which acutely effected how communities' function and what remained possible to research within case studies.

The revised research model is presented, and the impact of the pandemic accounted for in a restructured approach.

- **Chapter Three: The Realist Review** describes the methodology and project plan of the realist synthesis as it was actually delivered (including the essential revisions to the methodology due to the Coronavirus pandemic and consequent public health measures implemented across Wales).

  The method and results of literature scoping and concept mapping is presented, and the Realist (Systematic) Literature Review they inform set out in detail.

  Following this the approaches used to explore case studies will be detailed for each of the initial four cases and the impact of the pandemic upon each Community Health Development Project captured.

  The chapter concludes with the main findings across the realist synthesis and evaluation that lead to the Initial Programme Theories to be tested in the phase and reported fully in chapters 4 and 5.

- **Chapter Four** explores the results and findings from the realist evaluation and synthesis methods used in the research and presents four Initial Programme Theory (IPT) Areas and how they were presented back to stakeholders for further refinement through a process called 'Teach Back'.

  These theories are assessed against substantive community health development theories and a series of "If Then" statements to support each ITP are proposed.

The evolution of these initial “If Then” statements into Context Mechanism Outcome Configurations (CMOs) is then explored and evidenced by Community Health Development Project observations and stakeholder contributions from further stakeholder engagement processes.

Finally, the testing and refinement of these Initial Programme Theories is accounted for, and the final Programme Theories laid out for the reader’s consideration.

- **Chapter Five: Final Programme Theories** presents the complete Final Programme Theory and its relevance to existing notions of community health development theory and practice.
    - Identity Theory.
    - Place Based Working.
    - Assets/What Matters Approaches.
    - Salutogenesis.

  The chapter also considers an important consideration of a potential ripple effect across programme theories and CMOs and reflects upon the implications of the pandemic upon relevance and validity of the Final Programme Theory.

- **Chapter Six: Discussion** reviews the findings and their implications for policy and practice of community health development in Wales and beyond, this includes consideration of the impact of the pandemic and the wholly unanticipated implications for contexts and mechanisms across all communities and programme sets out a series of conclusions and recommendations for future work around communities and health promotion, to guide theory and practice, plus highlights implications for further research in this field.

  The chapter also includes key consideration raised throughout the research, including.

- The contribution that the use of a realist lens brings to understanding community (health).
- The realist contribution to understanding the impact of the pandemic and its management on communities and community health projects development.
- Problematic areas within the research methods and the darker side of community health development uncovered.
- Uniquely Welsh elements emerging from the research.
- The researcher's own reflexive Journey through the research process.

- **Chapter 7: Summary** positions the findings in an already full field and reflects upon whether the research presents anything new or just presents what is already known in a novel way?

  This chapter has set the scene, Chapter Two will now further explore the use of realist evaluation methodologies to attempt to 'unpack the black box' of community health development.

  This first chapter has suggested that a theory driven approach to programme evaluation is suited to this study as it is ideally suited to penetrating the complexities of interventions, unpacking what is really working in such projects to enable a more granular learning to be applied and uniquely reconstructed in other contexts.

  Often communities look at programmes and interventions successful elsewhere and try to replicate them within in their own different local contexts but with limited results. This research provides them with the tools to build their own success, not merely patents to copy – needed more than ever as they emerge from a global pandemic.

CHAPTER TWO:

METHODS: THE SELECTION AND USE OF A REALIST LENS

2.1. Introduction – Purpose and Map of the Methods Chapter

This chapter of the thesis sets out the realist methodology chosen as the lens used for this research, it locates realist evaluation and synthesis within a specific research paradigm, explains its standpoints and approaches used, then explores its potential benefits for application to understanding community health development.

The chapter ends with a review of realist studies in related fields to community health development in order to glean any important lessons to guide the design and application of this study.

2.2. Evaluating Community Health Development and the Potential Contribution of Realist Lenses

> "*Realist approaches are appropriate for evaluating complex interventions such as community based public health programmes with wider learning potential. They are particularly useful for evaluating programmes that produce mixed outcomes to better understand how and why differential outcomes occur. It is not appropriate when how, why and where programmes work is already understood, the programme is simple, one- size-fits-all, or only the net effect of the intervention is of interest*."
>
> Public Health England (2001, p. 3)

As briefly suggested in Chapter One, there is no multi-purpose, versatile or all-purpose community health development approach in Wales, even in the wake of a national approach such as Communities First.

Just as there are a wide range of traditions to draw from in designing programmes, varying local circumstances means that programme architecture and their underpinning programme theories are diverse, and their implementation fluctuates under the influence of different sets of local stakeholders involved in different places.

This variability in interventions themselves, together with a perceived inadequacy of many of the existing evaluation methods to draw inspiration from, has led to an increased interest in using realist methods in evaluating community health development, whose interventions are always complex and have a myriad of outcomes.

The how, why, and where community health development programmes work is still not fully established, despite the long history of this field. On the surface, it may appear that there is good evidence of what works but this is most often expressed in principles and values rather than evidence, or evidence that is at a superficial level and is highly context dependent and project specific.

The extensive literature review by Hills (2004) cited throughout this thesis was commissioned by the Health Development Agency to explore this challenge and address what they termed an *'evaluation deficit'* in community-based interventions for health improvements.

> "*Although community-level approaches to health improvement have shown promise for many years now, the evidence base for this area of work was believed to be problematic and underdeveloped*".
>
> (Hills 2004, p. 4)

They identify this has been partly due to a dominance of evaluations of community initiatives that were driven primarily by the need to prove accountability or for development reasons, rather than as a means of creating generalisable knowledge.

Whereas in the offer at the heart of applying realist methodology such as this research is an assumption, or belief, that the same intervention will not work for everyone and everywhere, and that interventions are highly context dependent. It is an approach that can recognise and accept that. yet still produce learning that can make a programme more effective and provide lessons for other programmes too. This research approach offers something different from that tradition that has developed.

Hills' literature review attempted to assimilate what has been known about the efficacy of existing evaluation approaches to assessing community-based wellbeing interventions.

It also set out to map the main issues affecting the quality of evaluations, clarifying the strengths, challenges, and weaknesses of the various approaches.

They found that there are almost as many ways of assessing community health development as there are ways in which it is delivered. Even establishing the boundaries of the research itself proved difficult as the field exhibits diversity and breadth of subject matter across the various community intervention traditions, plus conceptual understanding, as well as practice in community approaches to wellbeing, remains fluid and is still evolving.

They noted that different evaluation traditions have dominated the field at various times since the mid-1990s:

- Experimental methods (testing whether a defined intervention 'causes' a change in specific outcomes). Usually in these methods the exposure to the 'event' is controlled by the researcher, although natural experiments not in the control of the researcher can also be identified, whereby the impact of an event or policy change is systematically tracked from an objective and observational position.
- Participatory methods (using systematic inquiry through engaging directly in collaboration with those affected by an issue being studied for the purpose of understanding action or resulting change).

- Multi–method strategies combining elements of experimental with participatory or ‘pluralistic’ evaluations. These attempt to bring elements of the more hard-edged experimental designs together with subject involved qualitative methods, such as ‘action research’.

This third category of evaluation approaches became championed by one of the leading thought leaders in UK based community health development, Alan Beattie (Beattie, 2002) suggested that programmes themselves prepared for and assisted evaluations by systematically collecting a portfolio of information, qualitative and quantitative, about all aspects of what they do, to illustrate the broad work of their programmes. This could then be used to explain the programme to others or be available for others to draw upon in evaluation.

This recommendation was particularly important given many community health development projects have numerous and varied funding streams whose commissioners bring different requirements for evaluation.

Heartbeat Wales is cited as an example by Hills et al. in their use of pluralistic evaluation methods to support an initial experimental design.

> “*Interventions such as the Heartbeat Wales programme are difficult to evaluate with conventional experimental designs; we need to develop evaluation techniques that combine the strengths of quantitative and qualitative research methods, especially to examine the effects of the social and economic interventions that they advocate*”
>
> (Capewell et al.,1999)

The various weaknesses of both quantitative and qualitative evaluations within the field of community health development were already well recognised by the turn of the millennium as experimental approaches were considered difficult to apply effectively and were often unpopular with programmes themselves, whilst participatory approaches were more accepted by programmes but struggle to produce generalisable results beyond each specific Community Health Development Project or evaluation.

When experimental approaches attempt to infer findings from an assessment of a particular community programme which may appear initially be more widely useable, they quickly run into difficulties of trying to understand and control differing local contexts, lack of standardisation in programme delivery (as communities and stakeholder make up varies so much), and programme aims are also-usually very specific to local drivers.

Scocozza (2000) goes further by suggesting that experimental evaluators tend to come from a different ontological place entirely, with evaluators trying to standardise programme inputs, keep subjects and actor's passive or relatively immobile so that they can be counted or assessed, and an ambition to define clear lines between causes and effects. These are anathema to the nature of community programmes whose underpinning ideologies are around empowering communities, understanding their ecology, and the organic development of programmes. Hence, community health development programmes emerge over time, evolving as the communities they work with evolve, whilst typical empirical evaluation approaches take a static snapshot position assuming no change is taking place.

Neatly summing up the tension between evaluator and typical community programme ideologies, Hills cites Hunt (1987).

> "*In order to conform to traditional scientific paradigms, evaluation research normally must try to control for extraneous variables, usually by having a control group of some sort, to be able to specify important variables in advance, and to pinpoint "outcomes" which can be assessed in relation to objectives. However, none of these requirements can be adhered to in relation to the types of activities described here. It is difficult, often impossible, to obtain control groups since, apart from the logistics involved, it is antithetical to the philosophy of community involvement that people should be "used", especially at no benefit to themselves. Relevant variables can rarely be specified because of the complexity and dynamic nature of the processes involved. The non-directive nature of the work means that "objectives" are very general to begin with and attain specificity only*

> *with the articulated needs of members of the community. There is, so to speak, no advance warning. It is, perhaps, however, the issue of "outcome" where most problems arise, since activities develop, evolve, change direction, ebb and flow. The question inevitably arises, "When is an outcome not an outcome?*"
>
> (Hunt, 1987, p. 24)

The alternative to this which can be found in using participatory approaches, is much more in line ideologically with community programme ideology due to their flexibility. The participatory programme researcher's interest in the dynamics of a changing program brings a greater attention to the programme actors and local circumstances.

However, whilst participatory evaluation may bring value to the developers of programmes as they can inform on its future fine tuning and revision, they are less useful for helping commissioners and other stakeholders decide if the approach is better than another type of approach for reaching expected outcomes (in other words hard proof of the programme's effectiveness, over softer assessments of whether it is being run efficiently and in ways commensurate with its values).

Pawson and Tilley (1997) suggest participatory evaluators of community programmes have tended to shy away from deriving testable hypotheses from their findings and in some way 'pull short' of presenting lessons on the success of their programmes for wider adoption by others.

By the end of the 1990s the methodological deficiencies faced by both evaluation traditions led to the emergence of new evaluation frameworks, led primarily by the seminal work in developing the theory-based realism approach from Pawson and Tilley.

This is grounded within the school of 'realist' philosophy which asserts that both the material and the social worlds are 'real' and can have real effects, and that by recognising this it is possible to work towards gaining a closer

understanding of what it is within a programme that causes change to happen (Community Matters, 2008).

The key elements within Pawson and Tilley's theory driven approach to realistic evaluation which set it apart as an approach include:

- Social programmes (including community health development) aim to address existing social problems and ultimately to create some level of social change.
- Social programmes are driven by theories.
- A realist approach assumes that programmes are "theories incarnate", whenever a programme is implemented, it is testing a theory about what 'might cause change', even though that theory may not be explicit.
- The tasks of a realist evaluation are to make the theories within a program explicit, by developing clear hypotheses about how, and for whom, programs might 'work'.
- Programmes 'work' by enabling participants to make different choices.
- Making and sustaining different choices requires a change in participant's reasoning or the resources they have available to them.
- The combination of 'reasoning and resources' is what enables programs to 'work'. This is termed a 'program mechanism'.
- Programmes can trigger different change mechanisms for different people so, how they work is different depending upon the differences in both reasoning and resource available.
- The contexts in which programs operate also make a difference to the outcomes they achieve. Contexts does not just mean environmental surroundings or local conditions (although they may be included).
- Contexts that are important include socio-economic and political structures, organizational context, program participants, program workers, program stakeholders, physical and human geography, cultural and historical contexts, etc.

- There is always an interaction between context and mechanism, and that interaction is what creates the program's impacts or outcomes; however, aspects of context may trigger specific mechanisms, but they may also act to prevent specific mechanisms being triggered.

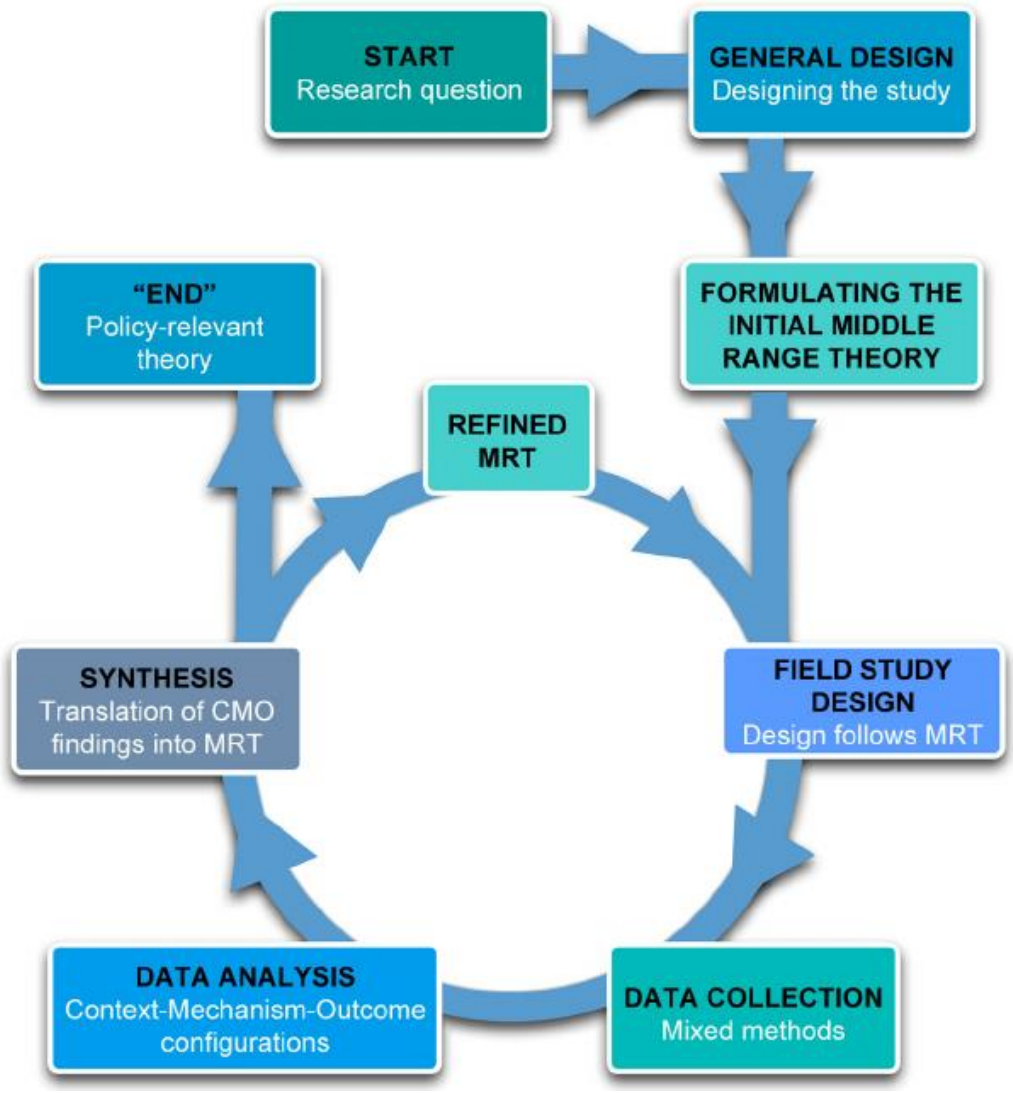
Fundamentally, because programs work differently in different contexts and through different change mechanisms, it follows that programmes cannot simply be replicated from one context to another and automatically achieve the same outcomes. This is a crucial point as one of the frustrations with participatory research was that the lessons from evaluating one program had limited application in different programs elsewhere.

The realist approach however does not itself suggest that lessons can be directly portable in this way, but it does suggest that the underlying program theories about how change happens can be learned and transported. It is the established programme theory from a realist evaluation that shows 'what works for whom, in what contexts, and how' that can be portable and be used to present lessons for other programs to learn or adopt, not by imitating at a superficial level what a programme used as a muse looked like and operated, but how its change mechanisms fired within its own unique contexts.

By understanding this programme theory and its contexts the lessons can inform another program, but only if there is a good understanding of the differences in context and potential mechanisms within both programs.

Evaluating a program through a realist lens starts with the formulation of a hypothesis of the program's implementation, and its potential evaluation, then tests those hypotheses. This means collecting data about program impacts, the processes of program implementation and, crucially, about the specific aspects of program context that might impact upon outcomes plus specific mechanisms that might be activated (or might be inhibited) so that change happens.

The classic realist cycle is laid out as follows:



(Marchal, Van Belle et al., 2012)

Figure 2.1: The Realist Evaluation Cycle (adapted from Pawson and Tilley, 1997)

Importantly, Pawson and Tilley argue that a realist approach has implications for not just the design of an evaluation but also for the roles of participants throughout the programme. In contrast to the experimental approach which may compare changes for participants who have undertaken a program with a group of people who have not, the realist preference is to compare mechanisms and outcomes within each programme, and a large part of this

is exploring the roles and reasoning of the participants themselves, how they affect and are affected by participating.

This is not to say that a realist approach cannot get involved with comparing different programmes in different places or with different people as it can be useful to pursue the question of 'if a program works differently in different localities, how and why and for whom', for example, if different population groups are impacted differently. What remains central in such an enquiry however is to focus upon the relationships and interactions within each particular programme of context, mechanisms, and outcomes, and how reasoning of participants dynamically interacts with resources.

Any comparison between areas is therefore not merely comparing programme differences but the theories behind programmes and how they are played out within each programme too.

Rycroft-Malone et al. explain how the realist approach is at heart an intuitively appealing approach for researchers who are aiming to reveal the complexities of programmes. Whilst the approach centres upon articulating underlying programme theories and then moves on to interrogating the existing evidence to find out whether and where these theories are pertinent and productive, it recognises that when setting out to develop and implement an intervention there is always an underlying theory about how it should work.

In other words, there is always somewhere to be found a programme logic, but not one that is immutable as no deterministic theories can be relied upon to always explain or predict outcomes in every context.

> "*Focussing on what it is about an intervention that makes it work (or not) in a given context should enable implementation researchers to work at the level of mechanisms of action. The premise is that in certain contexts individuals are likely (although not always certain) to make similar choices, and therefore particular contexts influence our choices such that reoccurring patterns emerge, i.e., demi-regularities*".

(Rycroft-Malone, McCormack, et al., 2012, p. 2)

The realist approach uncovers the underlying theories that explain demi-regularities (patterns within programmes) by examining the interactions between mechanism, context, and outcome.

Pawson and Tilley propose that each different set of stakeholders comes with different perspectives and motivations so, will tend to have different information and understandings about how programs are supposed to work and whether they in fact do so when implemented, they will perceive programme logics in different ways and recognise the demi regularities in different ways.

The implications of this for data collection and the evaluation processes in a realist research project is that all interviews, focus groups, questionnaires etc. should be constructed and delivered with the capacity to capture and maintain the integrity of the breadth of information that each and all stakeholder groups will have. What will then result is a suite of perspectives to refute or refine the hypotheses about how and for whom the program works.

To summarise, at the heart of choosing to use a realist lens to understand the results, value, and outcomes from community health development is the assumption that the contexts in which these programmes operate are crucial to any outcomes achieved. The lens also has a focus on the mechanisms of change, the choices made in a programme about resources, and the capacities of those using resources that lead to regular patterns of social behaviour among the programme recipients, deliverers, and stakeholder of that programme. In addition, there is a third focus which asks the question ‘what are the key elements in the contexts that trigger (or restrict) those mechanisms?’.

Within community health development this means collecting information not only on the activities of the project or programme that is set up, but also on the way this interacts with the local socio political and economic

environment; organisational and civic architecture: and specific culture and history of each place in which it is established.

A culture and history which itself is also “nested”. Each community programme is affected by its local culture and socio -political, physical, and economic environments sitting within a wider Welsh culture, distinct from the culture of the rest of the United Kingdom and other Countries; plus, there is a specific North Wales culture not found in the South of the Country that needs to be considered.

> “*I have family who lives in North Wales, and they are much more patriotic than my [family in the South]. I have no idea why this is. There is tension between North and South Wales… The Welsh in the North are very …. Welshy Welshy….. and they speak it fluently*.”
>
> (Nguyen et al., 2015, p. 15)

These layered elements of culture, heritage, and environments are just some of the more obvious elements of context to be considered, and each individual community health project will provide a set of drivers, opportunities, and barriers to unpack.

Hence this research seeks to find how the context in each of the programmes studied in North Wales enables or disables the functioning of mechanisms, and to identify what particular context-mechanism-outcome configurations work.

As realist methods begin setting out a programme hypothesis and then by finding the underlying assumptions (candidate middle range theories) about which its proponents think the programme might work it may appear counter intuitive (certainly many other types of evaluation and research start by describing the programme itself) however, a central tenet of realism is that empirical work will only make sense if it is underpinned by theory.

This corner stone of using the realist approach means that once the initial candidate theories are identified the rest of the work is not in finding

evidence to support or refute them, or challenging their logic or demi-regularities, but is in refining them.

In other words, establishing the particular community health development programme theories from the many traditions available underneath a programme is only one of the first steps in exploring how they become enacted and how they turn resources into outcomes.

This specific research project uses the realist lens by initially formulating a hypothesis of community health development programs implementation and its potential evaluation within each of four case studies, it then tests those hypotheses by refining them through attention to wider theories and evidence and engaging with stakeholders in deliberating what works, for whom, under what circumstance, and how? The specific methodology for testing these initial hypotheses is through a process of refinement through “teach back” to the stakeholders from each programme.

The teach back process is important as it is an iterative process which enables the researcher to keep playing back to people in the programme the learned understanding of the programme theory and demi-regularities, gain repeated feedback, and re-present until that programme theory is fine tuned to as fully as possible account for the programme.

‘*Realist lens’* is the preferred term used here to refer to the fact that a blend of different methods from across the field of realist research will be used in this research. The connection between the methods is that they each retain an abiding philosophy that the world is real and observable, but we filter our appreciation of it through our senses and our cultures, heritage, and life experiences (Wong, Greenhalgh, et al., 2012; Westhorp, 2014).

Realist ‘Synthesis’ (also known as ‘Review’) and Realist ‘Evaluation’ are distinct, different, but are potentially complementary forms of research. The former is an approach to literature review which is relatively systematic and uses mainly secondary data, whereas realist Evaluation uses mainly primary

data collected through mixed methodologies to collect and assess qualitative and quantitative data. (Wong, Westhorp et al., 2016).

What distinguishes them from other type of research is their conviction that programmes all contain actions, interventions, appoint roles, and utilise resources that are designed to make an impact upon a fundamentally social problem. Other forms of research may well also take this proposition, but the realist approaches recognise the key contribution of human volition in making them work. It is this social element that is of particular interest to the realist researcher, that, and the search to find the underlying programme theory (in other words, not merely defining and describing the program but uncovering its embedded drivers of change).

Examining the different approaches of realist evaluation and realist synthesis illustrates how they may be complementary, and both contribute to understanding community health development programs.

Realist evaluation is valuable in developing the initial hypotheses, the initial programme theory, and also in a later research phase when presenting back revised programme theories to stakeholders and a wider audience to test and further refine them.

Realist synthesis' use of secondary data is through a form of systematic literature review which includes a broad set of data including anything deemed relevant to the study which may help to explain how a programme is intended to work. This may be systematic process but is not so rigid as other forms of literature review that concentrate upon peer reviewed and published evidence. The Realist synthesis is much more permissive and may include grey as well as peer reviewed literature, blogs, case studies, and policy documents.

What matters therefore within realist synthesis is not the power of the data that is found but its relevance in contributing to a program theory. It brings together a rich array of data to synthesise them into findings used to test, prove, and refine a program theory to tell the story of in what circumstances

mechanisms are activated (or restricted) and how that interaction then produces outcomes.

Taking the strengths of realist evaluation and synthesis together suggests that a flow of realist evaluation followed by realist synthesis, and then further refinement again by realist evaluation may be a strong approach to utilise in this research. Certainly, the RAMESESE II project suggests combining the two approaches brings the strength of flexibility.

> "*Sometimes realist synthesis and realist evaluation are combined in the same project. For example, a realist synthesis may be used to develop a programme theory and then primary data collected to test and further refine it. Other researchers may develop a programme theory through a realist synthesis, develop a programme to put it into practice, and then evaluate it through a realist evaluation*".
>
> (RAMESES II, 2017)

Ultimately, the use of either, or both, within a single lens is with the expressed intention of not merely seeking to gain understanding of an "average" effect of a program or whether that particular program somehow "works" and produce outcomes.

On the contrary, Westhorp (2011) suggest realist approaches are most useful when the goal of the investigation is to learn about a programme and gain insight into how things that work in one programme may be replicated to improve the effectiveness of other similar programmes.

It may do this by establishing what needs to be replicated and how it might work in the new context The key here is understanding what might be different about those contexts and therefore it's not a "drag and drop" exercise of finding a magic ingredient in a programme and adopting it uncritically somewhere else, but is a thorough consideration of how mechanisms may need adapting to account for differing contexts and different people (participants and stakeholders).

The implication of this for this research is that evidence to be collected and analysed will include some primary data on outcomes across programs but as much emphasis will be placed on finding and mapping the contextual elements. These will form a large part of the results as it is not merely seeking to find the size of the impact of the programme, but how that impact happens in different circumstances and if there are commonly occurring mechanisms through which community health development produces both intended and unintended outcomes.

Transferring lessons into the research from elsewhere and suggesting results for wider consideration in community health development therefore need to be very carefully considered.

Both Pawson and Tilley (1997) and Cartwright (2011) warn that mechanisms through which an intervention works in one context may be very different, producing different results, elsewhere when dealing with social or behavioural interventions (which inevitably in community health development programmes is the case).

Using a realist lens runs contrary to the usual way research is undertaken in public health and community health programmes, which has so often been dominated by the hierarchical preferences of research methods in medicine that influenced and then became adopted within public health. The usual public health hierarchy of evidence (EBM Pyramid and EBM Generator, 2006) is exemplified in the classic approach used by the National Institute of Health and Care Excellence, who make their recommendations with “grades” from “A” which relates to Randomised Controlled Trials or meta-analyses of Randomised Controlled Trials to “D” which relates to recommendations based upon expert opinion or inferences from upper-level studies. However, community health development programmes present external validity problems that experimental methods and meta-analyses are unable to address (Worrall, 2010; Cartwright, 2011; Cartwright and Hardie, 2012).

Adopting a realist lens in this research therefore eschews the traditional hierarchy of evidence and instead builds strength by incorporating a wide

variety of data, including those derived from qualitative, quantitative, and mixed methods studies, as well as grey literature.

In contrast to a more conventional review, in which the data are extracted and aggregated across a selection of studies deemed to be of sufficient quality, in this study diverse data is sought depending on whether they bring any potential value or contribution to refinement of programme theory. This is consistent with the evolving standards for Realist Methodologies (Wong et al., 2014), and the research findings transferability will be founded upon the belief that they will establish commonly occurring mechanisms through which community health development produces both intended and unintended outcomes.

A range of existing research studies have used realism in one aspect or other of community health development. As already suggested in Chapter One, it is a complex field with several traditions and approaches overlapping within it. There are some well-defined approaches which are part of most community health development programmes or are closely related. These include community engagement, community involvement, community empowerment, and community participation.

Whilst on the surface these might all seem to be variations of one process, in practice they may vary considerably in philosophy, methodology, and expected outcomes. Each of these has been studied using realist approaches, and there are realist studies that have explored community development processes themselves as helpful research methods (for example, what worked in community engagement and participation in research).

These existing realist pieces of research are drawn upon early in this study to capture lessons on their methodological approach and may be also be revisited at a later stage to review their findings on programme theories.

In summary, this whole field of community health development is bedevilled with the problem of defining and separately identifying approaches from each other.

In (Wood, 2017) Nesta and The Health Foundation discuss the diversity of people and community centred approaches as a mosaic of activities, interventions, and approaches but all with a common purpose of empowering communities themselves to drive change and a requirement for agencies to enable them to do so. The report claims that there is a strong evidence base that says programmes within this mosaic work.

> "*While the evidence base is still emerging, there is a growing – and increasingly convincing – body of evidence from research and practice that these approaches lead to better outcomes*".
>
> (Wood 2017)

Further to broadly affirming programmes work, this work acknowledged that:

- The evidence base is at least as broad as the approaches themselves and encompasses research trials, programme evaluations, qualitative evidence, and narratives (stories) of change, plus attempts at economic modelling.
- The evidence base is still evolving.
- It is not only broad it is also complex and disparate.

This underlines the rationale for applying realist synthesis or evaluation to community health development programmes as they are the most appropriate methods in moving beyond studying merely whether these programmes work in a general sense to find what works for whom and within which particular and specific circumstances. In doing so there is potential to significantly add to the evolving evidence base and help to illuminate the fields' complexity by finding the portable lessons in the forms of programme theories and clear maps of how contexts dynamically interact with mechanisms to produce health and wellbeing outcomes.

2.3. Positivism, Constructivism, and Realism

As already asserted, realism lies somewhere between experimental and participatory research methods, between methods that assume a position of objectivity and ones that embrace the researchers own position in that research.

To unpack this further requires reflecting upon underpinning research philosophies as realism nestles between the two distinct positions of positivism and constructivism.

Hay (2002) proposed there are two initial positions to begin from in any social analysis, foundationalism (there is an objective reality external from human experience that allows us to build explanation about that reality) and anti-foundationalism (it is impossible to have a non-human perspective and consequently we must accept the best we can achieve is understanding the meaning of our experience).

A foundationalist starting point is what leads to the positivist perspective. Positivism describes reality as fixed, reliable, and measurable and our knowledge of that reality, which is neutral/value free, can be described by theories that are objective and generalizable. Positivism may also be said to be concerned with the world external to the researcher (Graham & McAleer, 2018).

Anti-foundationalism leads towards constructivism and greater attention to the internal world of the researcher, or the connection between the external and internal worlds of the researcher, with a fundamental belief that all experience is a social construct (Newman, 2019).

Across the history of social analysis, a valley has formed with two sides which generally reflect these two main starting points. Down one side, in different forms and ways they are expressed, can be found foundationalism, positivist, experimental, and quantitively dominated forms of research. Down the other anti-foundational side lie constructivist, participatory, action research, and a preference for qualitative methods.

Whilst the positivist research aims to discover what exists through prediction and control using mainly quantitative methods with the researcher being an independent observer, the constructivist researcher is an active participant in the research and may use both quantitative and qualitative methods (see comparison in table 2.1).

Table 2.1: Comparison of Positivism and Constructivism in Research

Positivism	Constructivism
Causality is directly related to effect There is one reality that exists, and the purpose of research is to provide measurable accounts of this reality (Oltmann & Boughey, 2011) Scientific knowledge alone can provide the answers to questions around the behavioural sciences (Harre & Secord, 1972), Science enables the observer to identify the causal relationships that exist between phenomena (Porter, 2001, p. 15) Closed systems 'allow constant conjunctions of events, the Human version of causality' (Mingers, 2011, p. 314).	Reality and knowledge of that reality are not fixed but socially constructed. This knowledge gives rise to multiple constructions and values The focus of research is to uncover the meaning of experience (Topping, 2010) The researcher is an active participant in the research

The common goal of positivists is generalisation (Lincoln & Guba, 2000).	

These differences in world view and approach may seem irreconcilable but there are attempts to build bridges between them. Bourdieu developed the concept of ‘habitus’ through studying power and its operation in a theory of society. He suggested that power is culturally and symbolically created and ‘habitus’ are the acquired lasting dispositions, trained capacities, and structured propensities to think, feel, and act in determined and regular ways (Wacquant, 2005, cited in Navarro, 2006). In other words, the socialised norms that become embedded in society that guide behaviour and thinking.

In a sense, Bourdieu’s concept of ‘habitus’ (Bourdieu 2002) is similar to constructivism in that it represents the framework of attitudes and dispositions through which we experience the world. However, our habitus is itself the product of our social positioning, which assumes an external causal reality (a foundationalist position) and this demonstrates that Bourdieu develops a constructivist approach yet he starts from a foundationalist starting point.

Such ‘constructivist foundationalism’ is also espoused in the work of Roy Bhaskar who developed a realist theory of science (Bhaskar ,1975). His ‘Critical Realism’ makes a distinction between knowledge (the transitive) and that which knowledge is about (the intransitive).

Bhaskar ties the two together in a layered conception of reality consisting of three main layers: ‘the empirical’ (the experience of events), ‘the actual’ (all experiences and events), and ‘the real’ (the underlying causal mechanisms that give rise to experiences and events). It is through this philosophy of layers that Bhaskar’s critical realism offers the potential to bridge the divide.

Bhaskar advances that there is a linguistic or “epistemic” fallacy in reducing the ontology of being to merely narrative and discourse (Bergin et al., 2008).

For Bhaskar, positivism attempts to fit ontological questions around the nature of reality to epistemological questions around knowing what reality is (Cruickshank, 2011, p. 7).

On the other end of the scale, philosophers (in the words of Bhaskar; 'humanists, hermeneuticists and other anti- naturalists, jointly comprising the anti-scientific romantic reaction') have striven for some time to find different ways to exploring phenomena as they occur within the social world (Bhaskar, 1979, p.160), Such an interpretivist perspective, where the focus of research is to uncover the meaning of experience lies in constructivism (Topping, 2010).

However, there are other forms of constructivism which edge a little nearer to the positivist stance on the virtual continuum. For example, Stake (1995, p. 101) believes that most researchers adopt a pragmatic 'rationalist-constructivist' perspective to the world we live in, because to do otherwise would be to believe in a reality based on illusion.

This positivist, interpretivist, constructivist, and critical realist debate is complex both linguistically and philosophically. Within that often-repeated dialogue it is tempting to suggest that the debate itself takes over from the core issue of the nature of realism and its investigation. One of the dynamics that continues to fuel discussion is whether methodologies are attempting to find the holy grail of fundamental correctness of understanding or merely a good enough approximation to be able to be useable. In other words, being absolutely right or having an acceptable level of utility.

In this sense a pragmatic constructivist stance will not sit comfortably with a positivist researcher seeking the absolute 'truth' (Parahoo, 2006), and it is for this main reason that many philosophers have sought a middle ground.

Bhaskar hence argues from a post-positivist perspective that it is more meaningful to be able to describe phenomena in an understandable way, rather than to seek the 'absolute truth' (Wilson & McCormack, 2006).

This is especially pertinent to evaluating community health development programmes, a field which is littered with internal programme evaluations and formative research reports, but ones given scant regard as “evidence” by commissioners dominated by a positivist paradigm such as may be found in much of Health Care commissioning (Hills, 2004, p. 10).

As Chelimsky and Shadish (1997) outlined, the purposes of evaluation cover accountability, development, and knowledge. All three may be pertinent to community health development but Hills et al., note that

> “*Most evaluations of community initiatives in recent years have been undertaken primarily for accountability and development rather than as a means of creating generalisable knowledge*”.

Whilst understandable in a field bedevilled by short term funding and the need to constantly prove themselves to multiple stakeholders this had led to a tradition in formative style evaluations and consequently also a lack of published research evidence,

> “*… a lack of publication, which can be very frustrating to those seeking an evidence base for this kind of work which can be set alongside the evidence base of other kinds of health intervention*.’
>
> (Hills, 2004, p. 10)

They also note that this dominance is now challenged by changes in the research paradigm and there is now greater appreciation of the complexity and dynamic interaction between many the aspects of ‘reality’ – holistic thinking increasingly captured and represented through systems, complexity, and chaos theory, has brought in its wake greater interest in contexts, and, in mechanisms.

Within the social sciences at least (less so to date in medical sciences) there is greater theoretical pluralism and equal acceptance of scientific realism, pragmatic, constructivist, and critical theory standpoints.

Both factors lead to knowledge production moving from a professional and academic dominance towards a position where it is those involved in practice who are not just actively engaged but are actually driving collaborations and engaging in action research and reflective practice.

It should be emphasised that this movement is not unique but is symptomatic of a larger cultural shift from modernity to post-modern thinking (Kelly et al., 1993).

Most pertinent for this research is their assertion that the positive notions of health (and wellbeing) covered here in Chapter One are not amenable to conventional scientific investigation ('positivist') or the modern scientific discussions ('constructivist') but require new and different approaches to prove their impact and effectiveness.

2.4. Alternative Lenses of Evaluation – Pluralistic, Experimental and Theories of Change

Community health development programmes are typically:

- Immersed in engaging communities actively to seek and achieve change in systems that affect them.
- This essentially bottom– up process has a predictable set of values, principles and a broader health perspective.
- Highly dependent upon context.
- Usually connected or interdependent upon other local programmes and interventions.

(University of Kansas, 2022)

Despite the dichotomy existing between positivist, more hard-edged, experimental research approaches and the more constructivist participatory approaches, the reality is that many evaluations of community health development have sought to incorporate some elements of both traditions. Whether to satisfy both the commissioners of programmes and. at the same time. participants interest, or a requirement for both formative and impact evaluation, there has been a search for the sort of bridging between the

research and evaluation paradigms Bordieu (2022) and Bhaskar (1975) in turn reached for.

Juggling the evaluation demands from inside and outside community health development programmes, evaluators have often gathered qualitative and quantitative data and attempted to incorporate control with which the impact is compared. However, this is difficult to achieve, as programmes are typically complex, layered with multi-activity structures and it obscures from view exactly what is being evaluated, any straightforward link between input and output not just difficult to see, but extremely difficult to describe and calculate impact size and detail in any meaningful way, certainly not in any way that would satisfy the positivist's perspective.

In contrast, constructivists are also difficult to satisfy with experimental research methods applied to community health development programmes if they ignore or simply overlook the theoretical basis of the interventions under examination, treating them as just a black box recorder that reveals with the main the inputs and results, rather than the process of the actions between those states.

Moreover, in the assumptions behind allocation to intervention and control groups in experimental methods, attempts are made to rule out the influence of variations in individual characteristics and context, yet these are the very factors which, in the view of many working in community programmes, are the key to the particular development and outcome of their work.

Dionne Hills' (2004) review found a clear distinction between experimental and participatory evaluation approaches, but also that

"*… in most cases the evaluations reviewed incorporated a broad mixture of different techniques, including hard, quantitative outcome measures (sometimes including data from comparison areas); some more qualitative process indicators; and attempts to incorporate elements of empowerment, or participatory research methods. We describe the last of these as multi-method evaluations*".

(Hills 2004, p. 21)

They then list several examples of different research designs that have been used in community health development, including:

- Experimental research designs in anti-poverty programmes in USA during the 1970s.
- Quasi experimental approaches such as evaluating Heartbeat Wales.
- Participatory and Action Research based on participants coproducing methods with the researchers, such as the Modernisation Agency's use of PDSA cycles.
- Emancipatory research, whereby participants take an active research role to foster their own self-determination (as used in the Scottish Community Development Centre's ABCD Framework).

Responding to the limitations across these approaches, a new range of theory-based evaluation strategies began to emerge in the early 1990s (Chen, 1990; Chen and Rossi, 1992; Connell et al., 1995; Weiss, 1995) and within the United Kingdom– realistic evaluation (Pawson and Tilley, 1997).

Each of these purposely sought to address the challenges of complex interventions by applying to experimentation a range of principles drawn from different scientific paradigms.

Theory-based evaluation has a number of expressions, but the form most often used in community programmes is **Theory of Change Evaluation**, which is mainly concerned with an emphasis on the **mechanisms** of action within programmes and the theories underlying these.

Like the action research and participatory evaluation strategies, theory of change evaluation requires an active engagement or dialogue between evaluators and programme participants, but the responsibility of the researcher is to bring to the surface and make explicit the theoretical assumptions that different actors within the programme are making about the link between an intervention and its outcomes.

It rests on the assumption that all social programmes are based upon some explicit or implicit theories of how and why programmes work. The task of evaluation is therefore that the evaluator should help participants in a programme to bring these theories to the surface and map them in detail for consideration and reflection.

A typical map of a theory of change makes explicit the vision of the programme; its outcomes and outputs; the interventions believed to produce those outputs and actions; any evidence or theories supporting those interventions and their selection within the programme; inputs and resources; and finally, the problems or issues the programme is meant to address. (NESTA, 2020).

The linkages between each of these components is just as important as the components themselves in a theory of change, as are the assumptions and sub-assumptions built into the programme.

The evaluation then constructs methods for data collection and analysis to track the unfolding of the assumptions. The aim is to examine the extent to which programme theories hold when the programme is delivered (Connell, et al., 1995, p. 67).

Both Theories of Change and Realist Evaluation attempt to address this challenge, in different ways. For Theory of Change approaches, the key factor is the strength of the overall model and the level of detail, which helps to identify how it may apply or differ in a new context.

Realist evaluation starts from the assumption that the contexts within which programmes operate are crucial to their outcome. The key question in a realist evaluation is not just whether a particular intervention works, but what works, for whom, and in what context.

This emphasises the study of the mechanisms of change – defined as the choices and capacities of those involved in a programme that led to regular patterns of social behaviour – and of the key elements in the context that help trigger these mechanisms.

In a community development context, this means collecting information not only on the activities of the project or programme that is set up, but also on the way this interacts with the culture and history of the area in which it is established.

The lesson for this research thesis is to focus on establishing how the *context* enables or disables the functioning of *mechanisms,* and to identify which particular *context mechanism outcome configurations work*.

> "*The basic task of human enquiry is to explain interesting, puzzling, socially significant regularities (R). Explanation takes the form of positing some underlying mechanism (M) which generates the regularity and thus consists of propositions about how the interplay between structure and agency has constituted regularity. Within realist investigation there is also investigation of how the workings of such mechanisms are contingent and conditional, and thus only fired in particular local, historical or institutional contexts (C).*"
>
> (Pawson and Tilley, 1997, p. 71)

In both theory of change and realist evaluation approaches the role of the evaluator is charged with teasing out the theory behind the mechanisms used in an intervention:

> "*Realistic evaluators examine outcome patterns in a "theory testing" role. Outcomes are not inspected simply in order to see if programmes work but are analysed to discover if the conjectured mechanisms/ context theories are confirmed*."
>
> (Pawson and Tilley, 1997, p. 215)

Both approaches mean the evaluator must engage in dialogue with participants of the programme to see what assumptions they have about the mechanisms through which change is to be brought about, and how these are affected by the circumstances in which the programme is set up:

> "*It is not the evaluator's role to provide a theory, but to dig out the programme theories that are often dormant and half articulated – it is the evaluator's task to bring these vibrantly to life*."
>
> "*In order to construct and test context–mechanism– outcome pattern explanations, evaluators need to engage in a teacher–learner relationship with programme policy makers, practitioners, and participants*."
>
> (Pawson and Tilley, 1997, p. 203)

Whilst on the surface this close engagement with participants may suggest a leaning towards constructivism, epistemologically these two approaches also echo the experimental approach in terms of the systematic construction of hypotheses and testing of that through engagement and observation.

As with realist evaluation, Theories of Change may not be straightforwardly applicable in another context, understanding of one programme may not simply be inferred to work in another programme even one looking similar in architecture and context. However, a well described and strong model should enable both policy makers and practitioners to make reasonable decisions about extending or amending a programme and learning can be captured to inform the programme theories of other programmes (but not without further consideration and critical analysis of that programme's initial programme theories).

For Realist Evaluation, Pawson and Tilley emphasise the importance of 'cumulation' of findings regarding specific context-mechanism-outcome (CMO) configurations (1997, p. 115). Rather than attempting to 'pile the bricks' of experimental studies on whole policies, the Realist approach is to explore CMO configurations using evidence from a range of studies, to provide robust theories that can potentially be applied across different policy areas (Pawson, 2006).

The strong anchor for the evaluator in a realist approach is to constantly return to the fact that the

“... patterning of social activities are brought about by the underlying mechanisms constituted by people's reasoning and the resources they are able to summon in a particular context”.

(Pawson & Tilley, 1997, p. 220).

This quote contains the fundamental components for the realist investigator:

- Patterning of social activities – outcomes.
- Peoples reasoning about the resources they can access – mechanisms.
- The surrounding factors, environment, and conditions enabling or inhibiting peoples reasoning and resource use – context.

Whilst separately important, it is how these elements work together that is fundamental to the Pawson informed realist, and the evaluator seeks to express those related elements within ‘context-mechanism-outcome (CMO) configurations’ and can be written as the formula

context + mechanism = outcome.

Or, perhaps more accurately it should be written as

Outcome = f(Context x Mechanism)

As outcomes are resultant of an interaction between context and mechanism not just that context and mechanism are introduced to each other. Therefore, there is a multiplication effect at least not merely a summative impact.

It is unlikely that in any given programme any single CMO configuration will adequately represent the programme theory, more usually there are a number which between them reflect the breadth and complexity of a programme. Neither is there a set limit on the number of pro-posed CMO configurations that are constructed for each programme under investigation; the key element is the relationship within each CMO, and what is important is the effort that the researcher expended in gathering data in order to test (and retest after any amendments) the proposed CMO configurations.

In summary there are clear philosophical difference between Positivism, Realism and Constructivism (see Table 2.2).

Table 2.2: Philosophical Differences Between Positivism, Realism, Constructivism

	Positivist Perspective	Realist Perspective	Constructivist Perspective
Epistemology	Truth and final knowledge exist	**There is no final truth or knowledge but achieving and improvement of our knowledge is possible**.	There is no way to choose between different observations and interpretations, ultimately, what we jointly believe is true
Ontology	There is an objectives reality that exists independently of us that can be observed	**There is both material and social reality and we do interact with realities**	Reality is subjective – we 'create' realities
Causation	Constant conjunction, linear causation. Programmes cause effects which lead to outcomes.	**Mechanisms 'fire' differently in different contexts generate different patterns of outcomes.**	Co-constructed interpretations lead to actions and to outcomes
Implications for research and evaluation	Evaluators tell facts. Different contexts should be controlled, Context differences should be eliminated through randomisation e.g. RCTs and Quasi experimental methods	**Evaluators explain how and where programmes generate outcomes. Mixed methods – qualitative and quantitative methods may be selected and used alongside each other**	Evaluators describe stakeholder interpretations. Mainly qualitative methods

Realism offers to community health development an alternative position that neither rejects nor endorses the different stances offered by the traditional positivist and constructivist paradigms that have so often been attempted but with limited success (Pawson & Tilley, 1997; Julnes et al., 1998).

Its belief that the real world exists independent of our understanding of it, and its capacity to be able to view and interpret the complexities of interdependencies and extensive social systems within socio-ecological programme like community health development, offers great promise.

The elements that frustrate other evaluation methods are embraced in a realist lens, to truly embrace the realist paradigm, one needs to be convinced that:

1. The real world exists even if we don't understand it.
2. Theoretical constructs also really exist.

In other words, one must be convinced that:

> "*… protons, photons, fields of force, and black holes are as real as toe-nails, turbines, eddies in the stream and volcanoes*" (Hacking, 1983, p. 21).

The realist lens opens a world of possibilities and offers a layered perspective to explain 'relations of natural necessity rather than the relations of logical necessity' (Wainwright, 1997, p. 1265).

The theory-based approaches have, in the last 20 years, increasingly moved into the mainstream of thinking and practice about how interventions (i.e., programs, policies, initiatives, or projects) are designed, described, measured and evaluated.

During that time, theory-based approaches have demonstrated their promise in helping evaluators address a variety of challenges, such as coming to terms with the inherent complexity of interventions and overcoming the limitations of experimental evaluation designs.

The main difference between a Theory of Change and a realist programme theory is one of depth versus breadth. Realist programme theory goes deeper than many Theories of Change, to hypothesise what goes on underneath the arrows that link outputs, outcome, and impact, and then test these hypotheses using CMO configurations (Blamey and Mackenzie, 2007).

In realist evaluation the CMOs form the very heart of the investigation, bringing clarity and precision to causal linkages which may otherwise have remained fuzzy and unclear.

There is a strong argument that both approaches used in tandem may provide powerful learning to the field of community health development, Theories of Change provide a high-level overview of how the programme was intended to work, and then map CMOs onto these to explain specific causal link.

2.5. Theory, and Its Place in Realist Approaches

Scriven (1998) is a strong anchor for realists and provides pragmatic guidance on working with theories to develop useful and intuitive insights but in a way that halts the descent into theoretical ‘rabbit holes’. Using a realist lens isn’t just about noticing a theory in a programme but in evaluating it, testing, and assessing its consistency and reliability. Theory driven evaluation is not just about identifying and laying out each of the theories’ components, as Scriven notes:

“*Evaluators may be led to believe that they are conducting theory -driven evaluations through a process of "identifying the components of an evaluand*"”.

(Scriven, 1998, p. 59)

It is the further step of exploring how the components are interrelated and operate together in a scheme that the real sense of the theory begins to emerge. (Merton, 1967, p. 143)

In this sense it is useful to step back to assess what a theory is in the first place. Merton suggests they are “*logically interconnected sets of propositions from which empirical uniformities can be derived”.*

In “theory in realist evaluation” (RAMESES II, 2017) the Rameses Project sets out four different types of theory that may be relevant in realist evaluations:

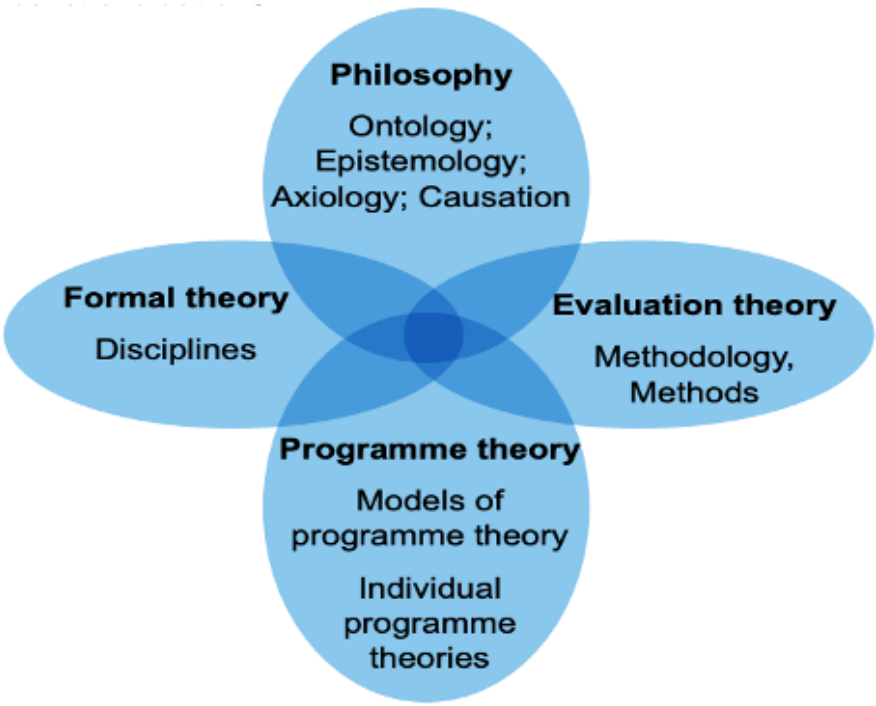


Figure 2.2: Different types of theory that may be relevant in realist evaluations (RAMESES II, 2017)

Philosophy Theory refers to the fundamental nature of things that are considered at such a level of abstraction it is difficult for them to be disproved (for example ontology deals with the nature of reality and epistemology deals with the nature of knowledge). Within realist research, the overriding Philosophy theory is therefore “Realist Evaluation”, which stands out as its very essence starts with theory and ends with theory, its purpose is to test and refine programme theories rather than prove if they determine outcomes in any of a range of types of contexts, and its eternal focus is to answer questions such as what works, for whom, in which circumstances and why?

For those working with a realist lens, the underlying philosophy is therefore the realist philosophy of science and a belief in both observable and unobservable aspects of the world that can be described.

Evaluation Theory is, just as this sounds, theories about evaluation itself. Its nature, its methods, the role evaluators take and their position in or outside the evaluation process, and if the evaluation adopts or represents any

political positionality. Using a realist lens assumes the theory will be **realist evaluation** and what follows is a specific set of choices in relation to methodologies, methods, and the position of the evaluator.

Formal, or Substantive Theory refers to that range of theories that exist in and across other domains and disciplines. An example that often is referenced in community health development is “critical consciousness raising theory” by Paolo Freire (1970), from his book “Pedagogy of the Oppressed”. Within realist research it is important to consider the contribution of formal theories within a programme, as:

- They can strengthen programmes in themselves.
- Such substantive theories can act as a bridge to other research and understanding that can help inform the programme theory, and the steps to form the evaluation, shape the inquiry and interpret findings.

Formal theory, in this way, can be used in a realist evaluation to identify potential mechanisms, understand the nature of contexts, and helps explain how findings might relate to each other.

The Use of substantive theories is important within the realist’s approach and evaluators are actively encouraged to ‘stand on the shoulders of giants’ by building on existing theory and evidence about the mechanisms through which a particular intervention works, in which contexts (Pawson, 2013).

Useful insights may also be available from quite different fields, recognising that similar causal mechanisms frequently underpin interventions across many sectors. For example, theories on social norms are relevant to a huge range of programmes seeking to change behaviour in areas ranging from corruption to contraceptive use (Mackie, Moneti, Shakya and Denny, 2015).

Building on existing evidence and theory helps to develop richer insights that are grounded in what is already known, rather than starting from scratch or relying exclusively on how stakeholders think their programme works (Pawson, 2013; Astbury and Leeuw, 2010).

In many evaluations, this step is often missed or approached superficially due to time and resource constraints. Its central role in realist evaluation can help ensure theories and findings are both well-grounded and useful to commissioners and implementers.

It is **Programme Theory** that is most often being referred to within theory-based evaluation, the “theory” as presented in different forms (words, picture, formulations) of what is intended, or supposed to be done in a programme, and how it is believed that it is expected to work.

However, even that is not so simple as there are more than 15 different models of programme theory and 22 ways it can be described according to Funnel and Rogers (2011).

A further theory that is crucial to understand when using a realist lens is Middle Range Theory. However, this is not another category or type of theory but is simply a way of describing the level of abstraction of a theory. Middle range theories are those that are close enough to data that is observed to be able to be incorporated into propositions that can be empirically tested (Liehr & Smith, 2017).

Their usefulness within realist approaches is that they are most useful in the construction of Context Mechanism Outcome configurations as middle range theories help to express clearly the phenomenon yet, at the same time, remain general enough to apply across other cases of the same type.

Whilst Scriven (1991, p. 360) challenges the utility of theory in evaluations; calling theories "a luxury for the evaluator, since they are not even essential for explanations, and explanations are not essential for 99% of all evaluations", for the realist evaluator they remain at the heart of all aspects of the investigation.

As already reviewed realist evaluation is just one of a family of theory-based evaluation approaches, alongside Theory of Change and other approaches, they are valuable because they explain why programmes work, rather than simply seeking to establish programme attribution – and ‘*when the aim is to*

learn so as to improve success or to replicate programmes elsewhere then explanations are needed' (Stern, 2015).

What sets realist evaluation apart from other theory-based approaches is the specific type of assumptions about programmes and the nature of reality, causality, and evidence, grounded in a realist philosophy of the world (Westhorp, 2014).

It is these assumptions that provide the key to its rigour, explanatory power, and practical value. There are three distinctive features of a realist approach.

1. **How realists understand 'programmes'.**
   Realist evaluators see programmes as, first and foremost, theories in action. Other evaluators may first regard the resources and interventions; actions and results, but the realist evaluator is instinctively looking for where the theories lie.

   These theories do not have to be solid and complete, in fact they seldom are, more often they are incomplete, implicit, or unconscious, and different stakeholders may hold very different theories about whether, how, or why a programme works.

   The result is that 'evaluation becomes a process of testing programme theories' (Pawson, 2003).

   As suggested here, programmes are often not neat, containing half theories and unrecognised unconscious part-theories, and whilst for other types of research and evaluation the researcher is tempted to tame and control what looks unruly, the realist embraces programme complexity.

   Because programmes are '*complex interventions introduced into complex social systems'* (Pawson, 2013), no intervention works in the same way for everyone, all the time, but will have very different effects on different people in different contexts (Wong et al., 2016).

2. How realists understand ‘causality’.

The changes brought about by the programme, outcomes, are understood as being caused by mechanisms (Pawson and Tilley, 1997).

Within realist evaluation mechanisms are important but they should not be confused with being interventions. They are the often-invisible forces, and interactions, that spark or “fire” and lead to (or prevent) change.

Mechanisms can be found in the choices, reasoning, and decisions that people make as a result of the resources a programme provides; they come from the interactions between individuals and groups; and the powers and liabilities that things, people, or institutions have as a result of their position in a group or society (Pawson and Tilley, 1997; Westhorp, 2018).

Mechanisms “fire” when programme resources (e.g., Capital, skills and competencies, knowledge) interact with specific features of the context (individual, interpersonal, organisational, or institutional factors within the programme setting).

A realist evaluation establishes a causal link between a programme and an observed outcome by focussing attention on these mechanisms, then developing and testing theories to unpack and explore them, in the form of context-mechanism-outcome configurations. This is the central process within a realist evaluation and is the way that it uses theory to as a tool help us better understand reality.

3. How realists understand ‘knowledge’ and ‘evidence’.

Realist evaluators assume that theories can only ever approximate reality as the social world is full of complexity and there are limitations on our understanding of it (Williams, 2014). Theory is therefore

> developed and tested in an iterative way, with the aim of reaching a refined theory that provides a good (enough) explanation of how and why outcomes have (and have not) occurred, while recognising that no theory can ever be fully and irrefutably confirmed as 'right' in a constantly shifting social world.
>
> Realist evaluation is therefore also methodologically eclectic, as any relevant data collection or analysis tool and any relevant evidence to test theories can be secured in the search to uncover theories. (Marchal et al., 2012)

2.6. Programme Theory and the Context Mechanism Outcomes Construct

At their core, programme theories identify how programme activities cause outcomes. The purpose of a realist evaluation is to test and refine the programme theory rather than determining outcomes in particular contexts. Assumptions to develop programme theories may be inspired by a variety of sources such as published evidence, case studies, and formal theories from specific fields such as educational or economic theories.

The 3 key concepts in realist evaluation are **context, mechanisms, and outcomes**. The evaluator develops a Context-Mechanism-Outcome (CMO) hypotheses, that is, a hypothesis about which mechanisms are likely to operate in different contexts and the outcomes that will be observed when they do.

To the realist evaluator, programmes are seen first and foremost as **theories in action**.

When developing programme theories In Realist Evaluation, programme theories are configured as 'context-mechanism- outcome' (CMO) hypotheses. This is followed by a process called retroduction (Public Health England, 2001) which is a form of logical inference using abductive reasoning to identify the most likely explanations for an incomplete set of observational data.

For the purpose of the evaluation, hypotheses/propositions can be developed by asking 4 basic questions (Westhorp, 2014):

- For whom will this basic programme theory work and not work, and why?
- In what contexts will this programme theory work and not work, and why?
- What are the main mechanisms by which we expect this programme theory to work?
- If this programme theory works, what outcomes will we see?

Because different mechanisms will be triggered in different contexts, leading to different outcomes, linked sets of hypotheses are likely to be generated. These can be recorded on a chart listing the different CMO. These charts are not simply lists of contexts, mechanisms, and outcomes, but rather each row describes the outcome generated by a specific ***mechanism in a specific context.***

Context-mechanism-outcome configurations (CMOs) are the core analytical building blocks of realist evaluation. They are variously described as propositions, hypotheses, or heuristics (Pawson and Manzano-Santaella, 2012; Wong et al., 2013) and take the form of sentences or short paragraphs explaining how mechanisms interact with contexts to form outcomes.

Context-Mechanism -Outcome Configurations:

This is the way in which causal explanations are presented in realist reviews.

They are propositions that explain how an outcome is caused (O) 'because of the action of underlying mechanisms (M) that which only comes into operation in particular contexts (C). It is important in the realist approach to present these C-M-O configurations phrase in a manner that is testable.

A summary of the key definitions:

- *Intervention*: refers to each programme's implemented activities, strategies, and resources applied purposely e.g. asset mapping, appreciative inquiry process, co-production of an action plan.
- *Mechanism*: the concept of 'mechanism' does not refer to the intentional resources offered, or strategies implemented within an intervention. Rather, it refers to what 'triggers' participants (subjects, workers and stakeholder) to want to participate, or not, in an intervention. They are the changes in reasoning and behaviour of individuals and distinct from the programme activities (Greenhalgh et al 2017a)

Mechanisms therefore most usually pertain to cognitive, emotional, or behavioural responses to intervention resources and strategies e.g., people feeling more empowered or motivated due to learning more about their wellbeing.

- *Context*: pertains to the backdrop of an intervention. Context includes the pre-existing organisational structures, the cultural norms, history and heritage of the community, the nature and scope of pre-existing networks, social capital, and geographic location effects e.g., pre-existing levels of trust and mutual recognition in and between communities and organisations or previous experience of community health development interventions.

They are usually considered for how and whether they trigger a particular mechanism to operate. (Greenhalgh et al., 2017b).

- *Outcome:* refers to both intended or unexpected intervention outcomes e.g., sustainability, quality integration of services (macro); citizens' level of involvement in health and care services (meso); citizens' health and wellbeing outcomes (micro). Outcomes refer to any observable patterns of changes due to a programme's implementation (Pawson and Tilley, 1997).

2.6.1. Context

Context determines whether mechanisms work during a programme. For example, outcomes may vary depending on economic, geographic, historical, social, and political circumstances and the cultural values of participants.

Variations within the programme's target group (for whom) can also influence which mechanisms may operate.

A Realist Evaluation postulates which components of context will affect how, and for whom, a programme will work, and data is collected about those components of context.

Context: influences whether a mechanism is triggered or not.

It may include macroeconomic conditions (pandemic lockdown), cultural practices (trust and respect across organisations), and interpersonal relations (professional – personal interactions).

Pawson suggests that understanding context may involve any or all of focussing upon

1) individuals/stakeholders.
2) their interrelationships.
3) institutional niche.
4) surrounding infrastructure.

2.6.2. Mechanism

Mechanism can be defined as the "… underlying entities, processes, or structures which operate in particular contexts to generate outcomes of interest." (Astbury et al., 2010).

Because mechanisms need the right context to work, any changes, anywhere in the system can affect the causal process.

Within social interventions, the mechanism is the cognitive or emotional reasoning of members of the target group responding to the resource, opportunity or constraint provided by the programme (Pawson and Tilley, 1997).

Mechanism: Refers to what it is within a community health development programme that causes outcomes.

Mechanisms are most often unobservable and are embodied within the subject or stakeholders 'reasoning'.

Most often they can be conceptualised and identified as responses to the resources found within the programmes (for example fear, concern for reputation, need to be recognised as competent, desire to express human values)

2.6.3. Outcomes

The outcomes of a programme can be intended or unintended and can be short, medium, and long-term. There can also be multiple outcomes with varying importance for different stakeholders.

"*In summary, realism holds that mechanisms matter because they generate outcomes, and that context matters because it changes... the processes by which an intervention produces an outcome. Both context and mechanism must therefore be systematically researched along with intervention and outcome. By implication, research or evaluation designs that strip away or 'control for' context with a view to exposing the 'pure' effect of the intervention limit our ability to understand how, when and for whom the intervention will be effective.*"

(Wong et al., 2013)

Outcomes: From a realist point of view outcomes in a community health development programme are inherently difficult to tie down to the satisfaction of all stakeholders.

There is a fundamental problem of pathogenesis versus salutogenesis running through concepts of community development that remains unresolved inn most programmes and leads to undercurrent debates about whose outcomes most valid – various stakeholders, commissioner or the subjects themselves in each programme.

There is also a contentious issue of time frames in community development as

Community health development is a notoriously slow cook process not the fast fry expectation of quantitative evaluation

(Huang CL, Wang HH., 2005)

2.7. If – Then Statements and Their Relationship to CMOCS

Development of programme theory for an intervention involves the identification of causal mechanisms that produce outcomes; outcomes can be desired or undesired, predictable or unpredictable. Whether or not a mechanism triggers is dependent on the context the intervention is applied in. This will determine what works, for whom, under what circumstances, how it works, and why it works.

Those not familiar with the precise language and use of terminology in realist research can find the way commonly used terms such as context, mechanism, outcomes, and the concept of CMO constructs initially hard to understand and work with. For this reason, there is recently a developing tendency for researchers to frame programme theories in an early stage of deliberation, while they are being refined, as “If – Then “statements (Brocklehurst, Hoare et al., 2021)

In their study utilising a realist lens alongside a pilot RCT to compare dental therapists and dental practitioner health outcomes in low – risk patients, Brocklehurst and research partners describe a process of

*"involved working with a stakeholder group to develop IPTs, framed as IF-THEN statements. This was followed by a process of testing and refining the IPTs using semi structured interviews to develop 'mid-level' programme theories, to provide an explanatory framework for role substitution in NHS dentistry.*105 *It then culminated in a final stakeholder group to 'sense-check' these theories and place them in order of priority."*

(p30)

They chose this direction rather than relying only upon the CMO configurations as they had found that the process of apportioning with any sense of accuracy important factors as either 'context' or 'mechanism' can prove to be rather tortuous and confusing both for the researchers themselves but particularly for stakeholders trying to understand and input into the research process.

This is important throughout the research but most important at the early stage when initial programme theories are being constructed and deliberated.

Other researchers have also commented upon the difficulties of the CMO construction process and the language used being a little opaque for stakeholders. Byng et al., (2005), Rycroft-Malone et al., (2010), Byng et al., (2008), Marchal et al., (2010a), Wand et al., (2010) all describe the difficulties of differentiating between and ascribing important factors as either context or mechanism or both. Rycroft-Malone et al. also commented upon the lack of available practical guidance in this regard.

Hence for pragmatic reasons and to diminish barriers to stakeholder understanding and enhance engagement the use of if -then statements as a step towards constructing CMO configurations was adopted in this study.

2.8. Realist Studies Reviewed to Inform the Methodology

Whilst this research is the first of its kind studying community health development in a Welsh context, there have been some high-profile studies in closely related or overlapping fields to community health development to look towards for inspiration, and from which to learn methodologic lessons on using a realist lens.

Beginning with reviewing key citations in the realist studies undertaken by the members of the supervision team itself key studies were identified that had informed their previous research as they contained strong descriptions of methodologies used.

From this initial base a broader collection of realist informed studies was built. This was partly achieved through citation ‘snowballing’, backwards tracking the reference used by these initial core studies and then through forward tracking exploring other studies that cited the original papers. (Hirt et al., 2021)

Whilst initially productive, only a small group of key papers that were found to be regularly cited were identified. However, at the same, the research student was steadily building a network with other realist researchers in community health related programmes. This was either through posting or responding to posts on the RAMESESE mailing list (Ramesese@JISCMAIL.ac.uk), or through making contact at various online and face to face conferences on realist methodologies attended between 2020 and 2022.

A loose network of collaborating students undertaking realist PhD studies was formed and ‘favourite’ or ‘useful’ studies were shared amongst the group alongside conversations on what was found to be useful in those studies.

Each paper collected was then reviewed for their relevance to the topic and methods used in this study. If they contained important or interesting things to contribute in terms of either community health development or realist methodologies they were retained and reviewed for key messages, others were discarded. A series of key lessons gleaned from each study were recorded:

1) Addressing diversity and complexity in the community engagement literature: The rationale for a realist review

(Richardson, Bandewar, et al., 2021)

Richardson et al., found that community engagement is nebulous – in that it appears across most areas of human endeavour and public policy, whether that be health, environmental, judicial or any other area of civic and government life. The aims are equally nebulous and almost impossible to classify in a meaningful way. There is great elasticity to the very idea of community engagement and no single academic discipline can convincingly claim it as their own. It is a field beset by ambiguity and even trying to tease apart the difference between engagement, consultation, and mobilisation results usually in confusion or most often a resignation to accept the ambiguities.

> "*… our review reinforced our initial sense that these terms are often used interchangeably, or without sufficient stipulation of their meaning in the specific circumstances or contexts of application*".
>
> (p 4)

They found that many previous studies and approaches had tried to 'average out' context rather than effectively unpack its contribution and role; too often studies relied on too narrow a focus on a narrow set of variables they tracked over the course of a programme and missing out on potential evidence that may be gathered from elsewhere (for example grey literature and people's own narratives of experience and change).

The most useful contribution for this research was their postulation that there may be 'portable program theories' across a range of intervention and implementation contexts which are being missed by existing research methodologies. They suggest this is a missed opportunity to navigate the complexities of practice and how it relates to the literature of community engagement.

Their use of a realist approach in studying community engagement was founded upon a belief that complexity and context are considered more effectively, and that realism brings a balanced approach to the use of evidence results from including the full range of types of evidence available including quantitative, qualitative and narrative, published and grey literature.

2) Achieving successful community engagement: a rapid realist review

(De Weger, Van Vooren et al., 2018)

This rapid review also considered how community engagement interventions interact with context and mechanisms and how these impact upon the engagement activity's effectiveness.

They found the use of a 'local reference panel' to review a set of eight guiding principles for community engagement that they had constructed was an effective method. These were established firstly from the literature resulting from a realist review, combined with a secondary set of observations from six community engagement interventions.

The local reference panel included stakeholders and participants of those interventions, and community engagement and public health professionals. The benefit of this panel to this research study is that its use conferred face validity. It was also one of the ways in which the research maintained a flexible and dynamic approach, able to explore a rich diversity of evidence and acknowledge complexity.

A methodological lesson they offered was that many realist papers show that CMO configurations are dynamically related to programme theories, but few actually describe how the CMO configurations then led to the programme theories.

> "*Within the papers that do describe this analytical process, there seems to be no consistency as to whether the theories are centred on the contexts, mechanisms, or outcomes of the configurations*."

(De Weger et al., 2018, p. 16)

Whilst acknowledging the flexibility of a realist approach, the authors questioned the generation of results and whether there is an inevitable bias in practice of exploring one or other of context, mechanism or outcome (with the implication that a more concentrated focus on any one of these would have produced different conclusions).

They suggest a tension between recognising that all contexts within programmes are unique, and the generalisability of the findings for other similar programmes.

> "*This tension is only partly addressed by searching for the same mechanisms and outcomes in different contexts. Ultimately, if the methodology is to continue to evolve and improve, realist evaluators should not only be transparent about how they constructed CMOs and generated theories, but also why they choose that specific approach and endeavour to show that the results are indeed generalisable across different contexts and care settings*".
>
> (De Weger et al., 2018, p. 16)

3) What approaches to social prescribing work, for whom, and in what circumstances? A protocol for a realist review

(Husk et al., 2016)

This protocol drew upon realist methods to find why different methods of referral in social prescribing programmes (and encouraging adherence to certain prescribed activities) do or do not work in certain circumstances for certain populations.

It explores the causal mechanisms within social prescribing and what impacts social contexts may have on shaping decision making and outcomes. Their proposed method blends different approaches to seeking suitable evidence:

- Scoping searches ideas and approaches for social prescribing to develop the researchers' own familiarity with the theory and practice models.
- Literature search to find candidate programme theories.
- Targeted (or purposive) searches to find suitable evidence to challenge and refine the candidate theories.
- Candidate theories to be then used to create a series of "if-then" statements to be tested and then refined through discussion.
- Further refinement of programme theories following targeted searches for evidence.
- Further anticipate key features of the search strategy include extensive searching of grey literature to respond to an anticipated diverse and dispersed evidence base, forward and backward citation tracking and direct contact with authors to fully exploit major sources of evidence.
- Relevance and rigour of evidence assessed using a hybrid classification tool and standard quality assessment tools.
- A Synthesis will be via seeking recurring patterns across the whole of the data.

In addition, the method also relies upon engagement with an expert advisory panel whose role is to check the methodological approaches and develop the everyday theories about how social prescribing works, for whom and in which circumstances.

4) Supporting successful implementation of public health interventions: protocol for a realist synthesis

(MacDonald, Pauly, et al., 2016)

This paper discusses the design of a realist review protocol to investigate why public health interventions vary in implementation (or not) and as such it provides this research with both subject matter considerations as well as methodological suggestions.

It addresses how the hierarchy of public health evidence applies to community health development and notes that NICE public health guidance cites three issues that pose challenges for systematic reviews in the field (Kelly, Morgan, et al., 2010)

- The breadth of the public health evidence base is both broad and extensive, as it covers and integrates very broad fields of environmental, social, political, economic, and cultural factors.
- Further to this breadth there are also multi-level explanations of impact, change and effects in public health.
- Public health interventions have a long and complex causal chain, very unlike clinical interventions against which they are often compared, which are more comfortable with measurements that are proximal or direct.

These barriers to using experimental types of research (like Randomised Control Trials) apply equally to community health development as they do to broader public health approaches.

They propose that realist review is more suitable for public health as a research tool for assessing how programmes are actually implemented (as opposed to idealistic descriptions of how it might work). As it is more inclusive, the theory driven approach in realism moves beyond whether implementation is effective to explain by what mechanisms it is effective, and how outcomes occur in different contexts.

As described by the other papers reviewed they describe three types of programme theories as a series of levels:

1) Initial ‘rough’ programme theory, which is expressed in general terms, not with specific reference to realist concepts of context, mechanism, and outcomes.
2) A refined programme theory that is expressed in these realist terms and specifies their configurations.
3) And a third, final, middle range theory that is “detailed enough and close enough to the data that testable hypothesis can be derived from it but abstracted enough to apply to other situations”.

(Wong et al., 2013).

A significant point about the approach taken by McDonald et al., is that they set out to follow closely the realist synthesis quality standards and publication guidelines (RAMESES) that they had previously established.

They also relied upon an advisory reference group throughout their research and provide the lesson that it establishing one enables an iterative approach to knowledge development, as either data or theories emerge they can be analysed and refined, prompting a deeper dive in a new direction, or can be revisited in the light of new data or emerging theories.

5) The government cannot do it all alone’: realist analysis of the minutes of community health committee meetings in Nigeria

(Abimbola, Molemodile, et al., 2016)

A slightly different approach to using a realist lens was offered by the work of Abimbola et al. (2016) as they used realist evaluation to gain understanding of how community health committee meetings work for whom and in which circumstances in Nigeria.

They used a Community Health Development Project approach to examine four different areas of the country and analysed the committee meeting minutes from 150 communities across those areas. Using what they termed as the ‘stepwise approach to realist analysis’ (Danermark et al., 2002) they outlined four steps to find and articulate context, mechanism, and outcomes.

- Reviewing meeting documentation to identify outcomes.
- Further reviewing the materials specifically to find data on context by looking for enablers and constraints of outcomes.
- Using abduction techniques to re-describe the programmes in each committee theoretically.
- Using retroduction techniques to identify mechanisms.

It is the illustrated use of abduction and retroduction as embedded parts of the realist process that is the key learning point from this study.

Abduction as used by Abimbola et al., is a method of making judgements on which theories seem to offer the best or simplest explanations of what works. Through looking in different ways at a set of ideas found in the data, reinterpreting and recontextualising them, greater understanding may be gained and new interpretations designed.

Retroduction on the other hand is a research technique that seeks to identify hidden causal forces that lie behind identified patterns or changes in those patterns by essentially asking the simple question why things appear as they do? (Olsen, 2010). It involves a similar process of looking at ideas in a wider way, by looking back from, or below observed patterns (also often referred to as regularities) to identify any hidden causal forces that lead to the changes in those patterns.

One of the main lessons offered by this study was the flexible and iterative way in which realist research can be used as the authors tested the use of realist analysis to develop and enrich programme theories and it provided them with a basis upon which to further develop the approach to future realist evaluation in other settings.

Hence a reminder to not be so methodologically set and time bound in the research and to take a longer time horizon, not seeking a definitive answer by a certain date but a longer more continuous process of refining better questioning of a subject.

6) Can community-based peer support promote health literacy and reduce inequalities? A realist review.

(Harris, Springett, et al., 2015)

This study offered learning on using a participatory approach to realist synthesis, as they used a substantially participatory approach to investigate how community-based peer support may increase health literacy and reduce health inequalities, for whom, and in which circumstances.

They chose realist synthesis as the prime method for the review based upon its benefits as an approach when unpacking the black box of complex interventions in that it seeks to find explanations about effectiveness, not just whether an approach was effective.

They also recognised the utility and flexibility of realist methods as having inbuilt inclusivity which allows a wide range of study types to be included.

This is important because different types of study may have identified different facets or key features of interventions, and how they reveal different elements of the intervention are important in fully understanding the mechanisms, and how they are dynamically related to context and outcomes. As with all other types of community centred activity, evidence on community-based peer support is most often found in grey literature and the lens used to search for evidence was therefore required to be sufficiently wide to capture this alongside peer reviewed literature.

The research team point out that in a realist analysis of the results of such a broad net of evidence, it is not the quality per se of the data discovered that is important, but it enables a more nuanced appraisal to be used to establish how the data contributes to the development and testing of theory. The

analysis aims to develop insight into local interactions between context and mechanisms, while aiming to develop an overall set of patterns or demi-regularities that can explain variations in how things work.

Finding a lack of published literature on the process of peer support, the use of an advisory network became more important than anticipated in this study. To search out the more detailed descriptions of how interventions work, participatory methods were used with the Network members to establish how workers and stakeholders believe peer education works and, through an iterative process, these initial descriptions were built into theories and models and represented back to the network to refine them.

The key messages to adopt from this study is in taking a pragmatic approach to realism that includes several methodological variations to combat an initial lack of evidence from published literature alone, relying more on a network of practitioners than anticipated and using more of what they termed "supplemental searching methods" to purposefully seek out clusters of relevant articles and data.

It illustrates a pragmatic approach of blending methods for a stronger result – here by synthesising evidence from the literature and participatory workshops with the network.

7) Supporting social prescribing in primary care by linking people to local assets: a realist review

(Tierney, Wong, et al., 2020)

Following on from Husk et al., (2016) and their realist review on enrolment, engagement and activities in social prescribing, Tierney et al., (2020) used a realist review method to explore the specific role of the link worker/community connector within a social prescribing programme.

They closely followed the "5 steps" of undertaking a realist review established by Pawson et al. (2004) to construct a methodology that resulted in two concepts underpinning a final programme theory. This was based on

29 separate Context – Mechanism – Outcomes configurations which, when refined, led to a final high level programme theory showing that "*those likely to benefit from seeing a link worker are patients able to change their outlook on life, who can build and sustain their social capital. This may only happen when motivation and engagement are present*".

The steps they used were:

1. Clarify the scope of the review
2. Search for evidence
3. Appraise search results (and extract data)
4. Synthesise data (including engagement with substantive theories (formal theories already recognised in a contributory discipline)
5. Disseminate and implement evidence

It is worth noting that the research, in addition to providing lessons for practice and policy, also suggested a number of recommendations for further research. This is a reminder that realist research often seems to reveal further questions merely by applying a realist lens.

In this case the questions raised were not around what works as this was already clear from the substantive theories available to the programme, but it was not so clear when using the theory was necessary, who does it work for, and if it works at all stages or in all circumstances.

It provided a prompt for this research that these more nuanced questions need to be pursued as they may stimulate a much deeper consequent range of subsequent investigations.

8) What is Asset-Based Community Development and How Might It Improve the Health of People with Long-Term Conditions? A Realist Synthesis

(Blickem, Shob, et al., 2018)

Blickem at al. undertook research in a very similar subject area and with similar methods to this research, so this study was reviewed with particular interest. They had developed a realist synthesis to understand the mechanisms involved in asset-based community development and how they might work in which contexts to improve the health of people living with long term conditions.

Asset based community health development being the tradition given most attention in theory and practice in recent years, its original expression was mapped and expressed most recognisable by Kretzmann and McKnight (1996). It has become prevalent in a United Kingdom context since the millennium and proposed as an approach to tackling rising social and health inequalities by Morgan and Ziglio (2007), Marmot (2010), and Foot and Hopkins (2010).

Their rationale for using realist methods to investigate Asset Based ways of working (Kretzmann & McKnight, 1996) was that its more organic approach may deal effectively with review questions that are emergent or exploratory. As asset-based community health development involves changing the dynamic between increased support from within communities whilst diminishing reliance on service driven support, the evidence required can be complex and continually evolving as it requires changes in both the “helper” and the “helped” and, consequently it impacts their relationship too.

Their finding that along with that complexity comes the need to account for a wide range of value positions taken across multiple stakeholders is a note to observe how in a programme if the “helper” is changed their employing organisations themselves are also challenged to change and, here again, is where realist methods have their strengths (Pawson, Greenhalgh, Harvey and Walshe, 2004) as all those changes can be taken into account.

Following the RAMESESE standards (Wong et al., 2013) they approached their search over two stages. A scoping search initially to shape the more comprehensive literature search once key concepts were mapped and understood.

Their results include the foundational community health development traditions underpinning the more developed asset-based approach; however, it is instructive that they found it is

> "*… difficult to assess whether ABCD achieves the outcomes …because the quality of the empirical studies is poor…. and there appears to be no published study which explicitly sets out to implement and evaluate an ABCD "model" of delivery*".

This is highly significant for this research as there are such core common traditions across Asset based Community Development and Community Health Development that it is unlikely a study of the community health development literature will reveal any greater depth of explanation of how exactly outcomes are delivered.

What they did find however was that there is great potential to go further with the application of context-mechanism–outcomes configurations than they had managed if the "fuzzier" outcomes are considered thoroughly. This is undoubtedly needed as they found a lack of compelling evidence that this approach actually does produce impacts, despite its strong theoretical and practitioner support. They summarise this observation neatly.

> *"…. approaches which seek to build capacity within communities, and which promote connectedness may have **some potential** to improve the health and well-being of its citizens. **But enthusiasm and rhetoric must be backed by a clear set of objectives and procedures to ensure a rigorous and effective methodology***".

This is a poignant as there is an obvious gulf between values and principles and practical delivery across almost all traditions of community health development that needs to be bridged (and the point of this particular thesis is to provide that bridge by establishing what works, for whom, and in what circumstances …).

9) A realist evaluation of community-based participatory research: partnership synergy, trust building and related ripple effects.

(Jagosh, Bush, Salsberg, et al., 2015)

The final paper selected and reviewed explores community-based engagement as part of participatory research methods. In this study Jagosh et al., built upon a previous realist review to go further in investigating original emerging findings that were not covered by the literature they had drawn upon.

They had already established that Community Based Participatory Research helps to ensure research that is culturally sound and deliverable, enables participant recruitment, builds partnerships between communities and academics, facilitates productive relationships and synergies, plus can lead to better achievements of goals, outputs and outcomes (Jagosh et al., 2012).

This further study employed a combination of realist synthesis and evaluation. The realist synthesis was used to inform the subsequent realist evaluation and primarily qualitative data collection methods, and this was justified from an ecological perspective as it had the breadth and flexibility to gain insight into

> "… *multiple intervention strategies implemented in diverse community contexts dependant on the dynamics of relationships among all stakeholders*".

This research, and the fact it is a follow on from previous research members of the team had already conducted, is a further reminder so emerging from the earlier papers reviewed) that a central tenet of realist research is that the result aimed for is not an estimation of the effect or impact of a program but a refinement of the middle range theory being considered. Hence, an almost continuous iterative cycle of finding new ground, considering the factors in and around those findings and developing new questions to investigate further.

What works, for whom, why, and how is therefore a complex and fluid set of questions that can't be treated in a linear fashion as the constant attention to

whether the same mechanisms produce different outcomes when tested in different contexts is much more like a three-dimensional rubric.

Jagosh et al., illuminate this well by considering the ‘Ripple Effect’ and how it links to Context-mechanism-outcome configurations, quoting the work by Hawe et al. (2009) they describe how Community Based Participatory Research may be considered as just one event in the longer history of a system which, rather than merely producing a result, may be the link and flow to other new structures and meanings evolving.

They identify ‘trust’ as an element that exemplifies how this ripple effect may work. Initially conceptualised as part of the context, they also identified that trust could be considered as a mechanism and also, at times, be described as an outcome. Trust could be a resource, to draw upon, it could be how stakeholders changed as a result of being involved in a partnership, and it could be seen as the result of participation.

The lesson for the methodology of this research is to be open minded to the possibility that important factors identified in exploring community health development may be at any point considered as either context, mechanism, or outcomes. The same factor may then become something else in this configuration, indeed may transition as the program unfolds through time, and its very transition may change the unfolding of the program as a whole.

2.9. Key Methodological Lessons Derived from a Review of Realist Approaches Within Similar Fields

Assimilating the lessons from across this collection of studies utilising realist methods has highlighted a number of recurring lessons to be used in this particular research into what works in community health development, for whom and in what circumstances.

Reviewing them has enabled a more considered reflection on the initial design of the study and provided a reminder that the methodology should be rigorous as a framework and follow sound realist principles but does not need to be slavish in its application. It is perfectly appropriate in a field that is

so complex, dynamic, and organic to choose to use a realist lens and maintain a flexible approach to the research by utilising a mix of realist research tools and techniques in a comprehensive study, as long as they are applied with precision and reference to the established Realist standards as set out by RAMESES (Wong et al., 2014).

Key lessons to apply in the design of the research methods therefore emerged from across these various existing studies using realist approaches as a series of themes.

Theme 1- tools to capture evidence need to be broad based.

Despite its long and varied history, community health development is still evolving and, hence, its evidence base is too, a broad net needs to be cast to capture that evidence including quantitative, qualitative, and narrative evidence in peer reviewed and grey literature.

Include a complementary set of different search strategies (scoping, systematic and purposive) to find and refine theories

Theme 2 – for community health development both realist synthesis and evaluation may be used together to add strength, depth and flexibility.

Realism should provide the lens for this broad based approach incorporating methods, but both realist synthesis and realist evaluation should be included alongside each other as the core.

Theme 3 – use a participatory approach.

To ensure portable programme theories are captured, work closely with a local participant reference panel to help identify emerging themes, test face validity, and refine them using an iterative process.

Theme 4 – maintain an iterative approach throughout.

Consider all programme theories as temporal, not end points in themselves, and they do not need to be perfect at any one point in time. Rough theories are appropriate as they can be refined and tested further.

Embrace abduction and retroduction. Abduction can be used to judge which theories may seem to offer the best explanation of what works in a specific circumstance, and retroduction offers to identify hidden causal forces behind or underneath any patterns established.

Such an organic and open approach will enable the research to respond to emergent review questions, accommodate the breadth of value positions encountered and divergent ideas to be explored. This means looking beyond the more obvious and clearly stated propositions supported by the community health development rhetoric (values and principles) to test what actually works in practice,

Remaining open to fluidity in the evolution in programme theories brings the opportunity to look for the ripple effect as key factors may move from being a context, mechanism, or outcome throughout the longer history of a system.

Theme 5 flexibility and a broad methodological frame does not mean a loss of rigour.

Whilst the realist lens provides a broad methodological scope, it still requires the component parts of the research methods to be conducted consistently, with high standards of realist rigour, and be a valid and transparent approach which searches not for an answer, but for more refined research questions on what works in community health development in Wales, for whom, and in which circumstances.

2.10. Summary of the Methods Chapter

In summary, for this chapter on the research methodological approach, what is meant by ‘using a Realist Lens’ for this study was fully explored, establishing that it primarily utilises realist evaluation methodology (Pawson, 1997) informed by a realist synthesis (Rycroft-Malone et al., 2012).

It is based largely upon qualitative research methods for data collection (Pawson, 2006), alongside extensive review of relevant literature, case studies, and emerging thought pieces such as blogs, plus considers a range of contributing substantive theories.

Alternative approaches of evaluation were considered and its place within research paradigms explored.

As the central tenet of realist methodology is that programs work differently in different contexts, four very different case studies of community health development have been selected to study, with varying types of programmes, participants, and available resource. Between them they offer to demonstrate a variety of local contexts and potential programme theories.

A range of existing realist studies were reviewed to gain insight into methodologies and to learn from their challenges and successes.

Following these deliberations, exploration of realist methodologies, and after an initial high level scoping review of the theory and practice of community health development in North Wales, a study design was completed and submitted for Bangor University ethics approval in April 2018 and approved in June 2018 (**reference number 2017-16222**). This is included in full as **Appendix One.**

CHAPTER THREE:

RESULTS OF PHASES 1 AND 2: CONCEPT MAPPING AND THE REALIST REVIEW

3.1. Introduction: Purpose and Map of the Results Chapter

The main purpose of Chapter Three is to present the planned methodology and project plan that sets out how the Initial Programme Theories **(IPTs)** developed from concept mapping, realist synthesis, and workshops with Community Health Development Projects were tested through observation and engagement with stakeholders in and around projects to produce Modified Programme Theories **(MPTs)** and then, through discussion with wider expert stakeholders, resulted in Final Programme Theories **(FPTs)** supported by Context Mechanism Outcomes propositions **(CMOCs)**.

In other words, exactly how the Context Mechanism Outcome configurations were initially devised from initial concept mapping and the results of the literature searches, then refined through working with stakeholders in practice, observing projects, debate with stakeholders and experts, consultation back with projects and eventual refinement into programme theories. n later chapters the analysis of how these gradual changes impacted upon programme theories will be discussed, along with a substantial consideration of which contexts and mechanisms became even more vital in the success of programmes when the impact of a pandemic became fully realised.

Therefore;

- 3.2 sets out the proposed plan for the research (attached Appendix1) as submitted and approved by the Bangor University Ethics Committee.

- 3.3 Sets out the implications of the pandemic (that affected the research from February 2020 until its conclusion) for that plan and then accounts for the revised research plan, also approved following a revision request to the Ethics Committee.
- 3.4 Is a brief pen picture of the Supervision Team for this research indicating the range of local situational knowledge, research expertise, and community health development specialist knowledge and skills collectively brought to the research study.
- 3.5 Reports on Phase 1 activity in concept mapping, a scoping review to establish the theoretical territory of community health development and stakeholder workshops to develop the broad theories to look for in the phase 2 Community Health Development Project workshops.
- 3.6 Reports on Phase 2 activity in conducting a realist synthesis of literature.
- 3.7 Is a summary of Phases 1 AND 2 Concept mapping and realist search for evidence.

There is an old Yiddish proverb, "*Men tracht und Gott lacht*".

Roughly, this translates as "Men plan and god laughs". It is a phrase often repeated in and beyond the Jewish faith. However, this aphorism has its roots in the bible (specifically in the Old Testament in Psalm 2:4) in which God laughs at the plans and plots of nations. The usage of the term ‘laugh’ should not be mistaken for amusement for in this usage throughout Psalms it refers to laughter as derision. (English Standard Version Bible, 2001, Psalms 2:4).

It is a perfect reference point for this chapter on the research plan and how it was conducted, as it frames the story of how a thoughtfully prepared plan for the research was slowly and deliberately constructed and submitted for approval only to then be severely tested and challenged by unforeseen events that proved significant for each, and all, of the research, case studies, the researcher, and ultimately wider society.

The unprecedented events that came with the Covid 219 pandemic cannot be minimised as they were truly ‘biblical’ in proportion and for a while halted society operating within and between nations.

More importantly here, the impact of attendant public health measures that brought society, public sector service provision, and even communities themselves, to a standstill, should not be overlooked. At their most basic projects brought communities together and the key measure of the pandemic was keeping people apart.

Its impact was devastating upon health and wellbeing and reshaped expectations for future wellbeing across society (Green et al., 2020; Green et al., 2021). Yet in this research it also brought with it new opportunities for insight and a unique chance to study community health development projects before, during, and emerging from the grip of conditions never previously experienced in their history.

Chapter Three therefore describes the intended methodology and project plan initially set out for the research, and then proceeds to describe the subsequent essential revisions to the methodology due to the emergence of the Coronavirus 19 pandemic and consequent public health measures implemented across Wales from the start of 2020, accounting for how these new conditions and their impact upon actors was accounted for.

3.2. Methods – The Research Plan

As established in Chapter One, this research project was constructed in order to use a realist lens in a planned approach through four phases with the purpose of:

- Formulate initial hypotheses of community health development programs implementation and its potential evaluation.
- Testing those hypotheses by refining them through attention to wider theories and evidence.

- Engaging with stakeholders in deliberating their views on ‘what works, for whom, under what circumstance and how’?

The key within these steps is the iterative nature of the research processes and the constant attention to refining programme theories, mainly in this research through teach back with those involved in delivering programmes.

It is this social element that is of particular interest to the realist researcher, that, and the search to find the underlying programme theory (in other words, not merely defining and describing the program but uncovering its embedded drivers of change). It is also this social element that became subject to new forces during the research due to the pandemic.

Both synthesis and evaluation approaches begin with the notion that programmes are conjectures taking the form “if we apply programme X this unleashes process Y which will result in Z. Hence the purpose of the research process across both is to gather the evidence of whether the community development process occurs as intended and planned, and if not, then to amend the theory to account for the “divergent outcomes” (Pawson, 2002, p. 347).

The main value of realist evaluation tools is in building the initial hypotheses, developing the initial programme theories, and also in a later research phase when presenting back revised programme theories to stakeholders and wider audience to test and further refine them.

However, this is preceded by the use of secondary data in concept mapping and a systematic realist literature review, gathering together a rich array of data to synthesise them into findings used to establish potential programme theories, or ‘Initial Working Theories’ (IWL) to look for in an examination of practice through selected case studies.

It may also be drawn upon in later stages to test, prove, and refine the program theories (in what circumstances mechanisms are activated or restricted that then produce outcomes), but the main purpose of the review is to develop those Initial Programme Theories to start the realist enquiry.

This flow of realist synthesis followed by realist evaluation and further refinement by realist synthesis is a strong approach, but it is not necessarily as linear as it sounds. In fact, it is much more organic and iterative (and the flow altered so that evaluation can be followed by synthesis and then evaluation returned to once again depending upon the demands of the specific research topic).

In this chapter the methodology as originally submitted and approved by Bangor University Ethics Committee (as designed from the Realist principles in Chapter Two) is presented initially as it was intended to be delivered. It demonstrates its promise rather than its reality, as wider events prevented it from being carried out as planned.

The chapter therefore proceeds to account for the impact of Covid 19 and societal lockdown measures upon the research methodology and its major (but variable) impact upon each of the case studies.

Finally, the methodology and project plan as it was actually delivered is described and reflected upon.

> "*Realist data analysis is driven by the principles of realism: realist evaluation explains change brought about by an intervention by referring to the actors who act and change (or not) a situation under specific conditions and under the influence of external events (including the intervention itself). The actors and the interventions are considered to be embedded in a social reality that influences how the intervention is implemented and how actors respond to it (or not).*"
>
> Better Evaluation (2022, p. 2*)*

The social reality for programmes, actors reasoning, resources, and expectations upon outcomes shifted dramatically in the face of the pandemic. This was also very time contingent in that perceptions of what it was and what it meant for individuals, communities, societies, etc. changed dramatically from its first emergence, through each of the pandemic's various

phases and our collective understanding of it, plus our response to its mitigation (WIPO, 2022).

Reflection and learning in this research thesis are therefore not merely concerned with the use of realist lenses to reveal and test programme theories on what works in community health development in North Wales, for whom, how and in which circumstances.

It also tests the impact upon programme theories when fundamental shifts in how the programme operates are imposed and all parts of the programme are subject to new forces, from change in the interventions possible, actors' engagement, resources, and contexts, to the new barriers and opportunities that are presented for mechanism to fire.

The pandemic provided an opportunity to also test just how practical, adaptable, and flexible the realist lens approach is in unprecedented times, and if it was a valid and reliable way to regard and understand these shifts in community health development practice.

This will be a sub theme for reflection through the remaining chapters but will be primarily picked up in the Discussions Chapter Six.

3.2.1. The Research Plan as Submitted for Ethics Approval and IRAS

The original Methodology submitted, and subsequently, approved by the Bangor University Research Ethics Committee is attached **(Appendix 1)** together with a copy of the IRAS and HRA schedule of events.

As already discussed, the selection of a realist lens is suited to this study as it helps to penetrate the complexities of community (health) development programme evaluation through providing important evidence about what works regarding the process of engagement, the conditions which are conducive (or not) to the success of the programme, and the factors that lead to programme outcomes (Pawson & Tilley, 1997).

The Aims and Objectives of the research are:

Aims

I. To identify the conditions (context) and underlying generative mechanisms that explain what works, how, and why in relation to community health projects.
II. to generate evidence and theory to guide NHS and community programme leaders to effectively implement future successful community health development projects which promote sustainable development and build wellbeing within communities.

Objectives

I. Generate an explanatory programme theory about community health development projects that explains what works, how, and under which contexts.
II. Explore, through stakeholder engagement, decision-making processes associated with local community health projects.
III. Produce recommendations about ways in which different approaches and/or strategies can help NHS managers and community programme leaders plan and prioritise projects in a systematic and efficient approach.

One of the main features of using realist approaches is that the process is cyclical, starting with theory and ending with theory, and it may also have sub cycles within an overall theory finding, testing, and refining cycle.

This research was designed to be conducted across four phases overall (notwithstanding the potential to repeat phases, if necessary, as the research unfolded).

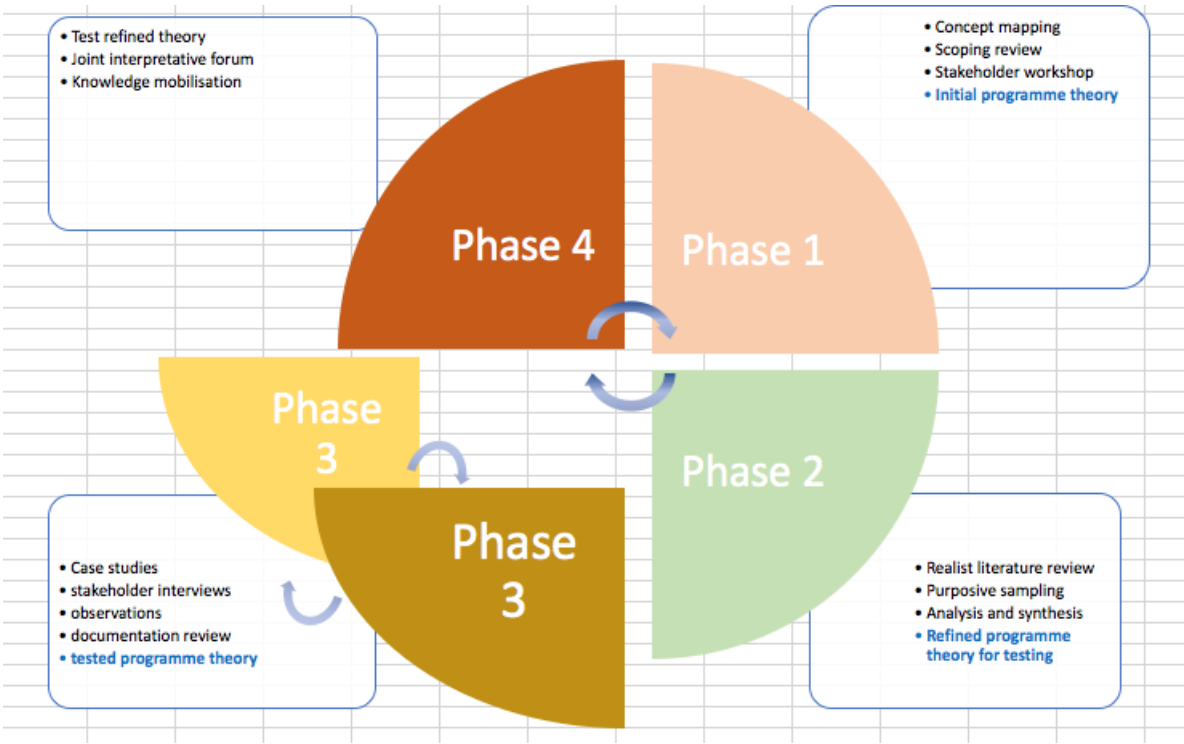


Figure 3.1: Initial Project Plan as Submitted and Approved by the Ethics Committee

N.B. In this diagram text in black denotes activities and processes, text in blue denotes expected research outputs from each stage.

Phase 1 begins the search for, and generation of, any initial working theories alongside a process of relationship building with Community Health Development Project participants and all key stakeholders. The processes to be utilised in Phase 1 included:

- Concept mapping to capture the existing understanding of theory and practice of community health development.
- This includes a review of the drivers for community health development.
- A systematic approach to search for, select, and synthesise, existing published knowledge across the breadth of the field (including grey literature, blogs etc.), in order to map the concepts, understand the

evidence base and the different forms of evidence, and find any gaps in the evidence base relevant to the research (Colquhoun, 2014).

- Relevant existing scoping/systematic/meta-analysis/rapid reviews will be analysed to identify key theories.
- A review of existing scoping/systematic/meta-analysis/rapid reviews in community health development.
- Testing initial concepts mapped with wider stakeholders across North Wales to gain assurance on their use and acceptability to the community wellbeing field.
- Throughout these searches, a specific Welsh aspect to the enquiry is maintained to assess any differences in focus, application preferences of theory and practice.

As stakeholder engagement is integral to the realist approach and the development of initial programme theories, a stakeholder analysis to determine which stakeholders are 'essential,' 'important,' and/or 'necessary' to involve during the study was built in.

Three stakeholder workshops with a range of programme stakeholders (e.g., Consultants in Public Health, Community Support Workers, Council workers, Housing Associations, Health Board and Primary Care staff, researchers, and representatives from the relevant communities) were undertaken to map understanding of community health development theory and practice. The information sheets telling participants about the research and the forms to gain their consent are all attached as Appendices (2, 3, 4 and 5).

The stakeholder workshops' contribution was to help build the initial rough or working theory development to then explore more thoroughly in a search for evidence-based papers and in observation and engagement with case studies.

The anticipated outputs from Phase 1 included:

- A theoretical platform on which to build the research approach.

- A scope of the literature.
- A set of ‘rich pictures’, models, field notes, and comparison charts.
- An identified set of tracer issues and an Initial Working Theory.

The IWL is set out as rough, though informed, theory and at this stage of the cycle is not necessarily framed in a realist manner with CMO supporting constructs.

Phase 2 concentrated then on developing the IWT in a more in-depth realist review of evidence in the literature, to test the initial programme theory (theories) identified in Phase One.

This purposive (Pawson et al., 2004) methodology consists of an in-depth scrutiny of the literature seeking evidence related to the initial working theories. Each theory area has a specific and dedicated list of relevant and related search terms generated to guide the searches. This iterative approach is ‘purposive in the sense that as results emerge that have resonance for the initial programme theory they can be followed, and the search is only ended when significant findings ’dry-up’ and saturation point is reached where no new evidence or theories emerge. Hence the watch word for knowing when to cease searching is not volume of papers found but relevance to the theory being tested.

This approach to literature searching is unpredictable, however key steps are undertaken to ensure it is not random and unending:

- Decide and define a purposive sampling strategy.
- Define search sources, terms, and methods to be used.
- Set thresholds for halting searching at saturation point.

The quality of the evidence, its rigour and relevance are then analysed using two basic questions:

- does the research address the theory under test (relevance)?

- does the research support the conclusions drawn from it by the researchers or the reviewers (rigour)?

(Rycroft-Malone et al., 2012).

The proposed results of Phases 1 and 2 was a general description of how interventions lead to outcomes, some sense of in which conditions which mechanisms would generate the outcomes, and what features of the context will affect whether (or not) those mechanisms to fire. It was based on the concept mapping, scoping review, and stakeholder engagement from Phase One and the systematic search for evidence from Phase Two.

NB: Whilst this is the plan as submitted, it contained a flaw that was soon realised once the research had started.

In reality, at this point, the mid-range theory and C-M-O propositions were not yet made explicit. Merely beginning to be framed in order to provide a way to understand the data collected and tested in Phase Three (the exact types of data collected required will follow on from the specific hypothesis constructed).

The submitted Project Plan had originally anticipated that, by this stage of the research, it would have been possible to frame these initial theories in a realist manner, and it suggested it would be possible to approach the engagement with Community Health Development Project areas with a set of Initial Programme Theories set out with supporting context mechanism outcomes propositions, but the breadth, complexity and lack of agreement on core elements of community health development in both literature and the experience of workers consulted did not enable this to be synthesised at that stage.

This adjustment is clarified later in section 3.2.3

Phase 3 is built around using soft systems methodology to work with programme participants. The specific projects will be selected from geographically distinct community projects across North Wales that Betsi Cadwaladr University Health Board (the research partner and funder) has a

stakeholder interest or some involvement in the delivery (through either commissioning some aspect of it, providing funding, or by employing some of the staff involved in its delivery).

The work with selected projects involved a range of evidence informed processes including stakeholder interviews, non-participation observation, and documentation review. Through observations, the comparison charts from Phase One representing what ‘good’ might look like compared with reality were verified, and it was anticipated that later observations of the case studies may provide rich data for a deeper understanding of local context and milieu (Mulhall, 2003).

Documentation review was also anticipated to provide a means to triangulate and verify the data from stakeholders and provide further breadth and texture to the background of each Community Health Development Project.

The learning from each Community Health Development Project was to be then further tested through stakeholder interviews and non-participant observations.

It was planned to capture real time data on how the community projects operate and, using Spradley’s nine dimensions of observation (1980), form an observation guide which would maintain a critical focus on the aims of what is to be observed, why it was observed, and also to ensure that all relevant social dimensions were captured (including space, actors, activities, objects, acts, events, time, goals, and feelings).

Observations were to be undertaken in different places and across different activities depending upon the nature and stage of the community project in each Community Health Development Project.

The purpose of the Community Health Development Project data analysis was to develop and refine the links between mechanisms, context, and outcomes to meet the study objectives.

Comparisons across the Projects were intended to determine how the same mechanisms play out in different contexts and produce different sets of outcomes, leading to a set of theoretically generalisable features.

The expected outputs from phase three included:

- Findings from cases of two geographically distinct community projects/programmes.
- A tested and Modified (refined) Programme Theory.
- Data on context, mechanisms and outcomes arising from Community Health Development Project's methods.

Phase 4 is the completion of the realist cycle as it further tests and refines the programme theory, or theories, using a joint interpretative forum, which provides an opportunity for different communities to reflect on and interpret information from the emerging results of the study (Bartunek, Trullen, Bonet & Sauquet, 2003).

This is an essential step given the 'boundary spanning' nature of community projects as their outcomes often cross multiple professional and organisational domains. A range of professionals and practitioners should be included in considering the emerging findings (boundary spanning refers to the way individuals in each organisation or sector provide linking and translational connections with those in other organisations and sectors trying to align or work towards common goals).

The wider reference of this group allows for a broad consideration of the data, different perspectives, and ways of understanding the data, and application of existing knowledge paradigms.

With such a broad nature of perspectives and levels of experience and expertise in a forum of this kind, strong group facilitation is required and was to be conducted by members of the Project team with a high degree of experience and qualifications in group dynamics, as well as realist methodologies.

Participants were to be facilitated to challenge and interpret these propositions from their own perspectives, and their deliberations and findings captured through the relevant multimedia (audio, images, and written documentation). This range of data was synthesised and used to further refine the programme theory.

Given the nature of the projects being evaluated; community (health) development's re-emergence as a foremost driver in contemporary health policy in Wales; and the surge in popularity in theory and practice of asset-based approaches to wellbeing, the forum was planned to be followed by a wider knowledge mobilisation phase to ensure engagement with key communities and fully exploit the results of the study.

The planned outputs from this final phase:

- Theoretical generalisability of the findings mapped.
- A wider field engaged in some knowledge – transfer activity.
- Final Programme Theories.
- Draft publications and formats for open learning to be prepared.

3.2.2 The Pandemic Response Implications for the Research Plan

Whilst the initial stages of Phases 1 and 2 were completed to plan, the outputs of concept mapping, literature searching, and stakeholder concept workshops did not produce the anticipated early result of an initial realist programme theory of geographically distinct community (health) development projects. This was not a failure of methods, but of the expectation that it should do so.

It was clear from the early outputs that the field of study and how it is understood by practitioners across North Wales was (as has been proposed earlier in Chapter One) widely varying, conceptually confused, complex and demonstrated little consistency in how even central ideas such as "empowerment" are considered and applied. This ever-present idea of 'empowerment' in community health development being framed by some as an essential outcome from programmes; a requirement for programmes to

flourish by others suggesting it is a context; and, as a mechanism expected to fire when programme participants gain some sense of health agency.

Thus, it was decided by the research team to not artificially force important themes and ideas at this still relatively early stage into realist constructs but, following the approach used by Brocklehurst and Hoare et al., (2021), to keep initial broad working theories at a more general operating level when searching the literature in Phase 2 for theories of what works, for whom etc.

This is also methodologically correct, as whilst Realist evaluation is theory driven, it is not so driven by the C+M ⟹ O configuration that it must be defined at the earliest possible stage. Rather, theory merely tells researchers where to look and what to look for (Pawson, 2013). It helps to explain the vital components and their relationships to each other, plus what brings about those interrelationships.

As Fletcher and Hackett (2021, p. 2) explain,

> "*Programme theories are fluid models describing fluid situations. They are refined by combining multiple data 'snapshots' and iteratively amending the theory to develop a sharper image (abductive reasoning). The success of any intervention in a social context depends on the extent to which the programme theory/theories predicted or controlled the spiral of ideas and changes that occurred because of that intervention…. enough data snapshots must be taken so that the programme theory can describe 'demi-regularities', or 'semi-predictable patterns or pathways of programme functioning*".

Therefore, at an early stage, the programme theory can remain quite broad with high level and wide angle 'snapshots', more of a conceptual framework that gives the researcher hooks and runners to focus data collection upon, some basic broad hypotheses to work around that only at later stages can be refined into causal chains of explanation.

Ultimately the programme theories that are sought are 'units of explanatory potential' (Fletcher, 2017) but these explanations are developed, tested, and

refined though the iterative accrual of data, during the process some theories may be discarded, and others, not initially noted, be considered.

Therefore, it became important to hold back until after both the realist searches and soft systems workshops with case studies before assimilating learning into the Initial Programme Theories. Data analysis was iterative in order to build explanations over time and enable us to focus subsequent data collection in areas of productive enquiry, not leap straight to programme theory constructs, but to use a combined inductive and deductive approach to ensure a process continually focused on the building of propositional evidence and supported by literature and Community Health Development Project data (Rycroft–Malone et al., 2015).

This pragmatic and methodological decision was important also to avoid forcing the development of realist theories which may emanate from the researchers' own prior knowledge and experience in the field, as opposed to objectively being unearthed in the research process.

This was already proving a worthwhile amendment to the original research project plan when the shock and awe of a new coronavirus brought a much greater challenge to the research, almost halting it entirely.

By almost any metrics, the Covid 19 pandemic emerging at the turn of 2019 – 2020 is probably the greatest single epidemiological event of the last hundred years, and possibly even eclipses the previous flu pandemics and the cholera pandemics of the 1830s for its impact on closing down societies and social interaction, as well as severely impacting morbidity and mortality across all communities (Green, Morgan, et al., 2020).

Unforeseen at the start of this research, or on approval of the methodology, was the all-encompassing impact of the Pandemic and attendant social and behavioural measures to control its spread and minimise its impact.

Within the lifecycle of this research. this was after Phase One had been completed but mid-way through Phase Two when initial workshops with Community Health Development Project participants had been concluded but

follow up workshops to undertake teach back workshops with stakeholders to test and refine candidate programme theories were just beginning to be planned.

The emergence of coronavirus disease 2019 in Wuhan China in late December 2019 very rapidly escalated to a global pandemic, its development, spread, and various control measures have fluctuated greatly over several phases and, at the point of writing first drafts of this thesis (In Summer 2022), the third major variant (Omicron) is becoming the dominant strain, being more transmissible than earlier variants, yet also apparently less severe in symptom causation. Globally, the vaccination and prevention programmes combined with mutations of the virus itself means that mortality has fallen dramatically, morbidity however is still a very real threat and transmission is kept under constant scrutiny by organisations like the European Centre for Disease Prevention and Control, who produce a weekly ECDC variant surveillance data report (ECDC, 2020).

> "*Covid-19 remains a serious threat and we are likely to have a period of less predictable waves of infections to deal with, particularly if new variants emerge or as immunity wanes. We have seen over the last two years how quickly the virus has been able to evolve. We have experienced distinct and significant waves from the original strain, and variants known as alpha, delta and omicron. Internationally, other variants, such as beta, have also driven large waves of infection*".
>
> (Welsh Government, 2022*)*

However, in April 2020, at the point that re-engagement with Project stakeholders was scheduled to undertake "teach back sessions "on initial programme theories, Wales was in effect 'shut down' and strict social control measures in place meant that

I. Community Health Development Projects themselves had frozen due to the fact they were so reliant on personal interactions to operate. Following public health guidance in

place at the time they had to stop, and no in person face to face interactions could be conducted.

II. The research methodology for ‘teach back’ authorised in the original Ethics Submission required face to face engagement with Project stakeholders, this was now impossible,

III. Both these factors meant that Phase 3 observations of Projects could not be undertaken, nor any face-to-face interviews conducted,

IV. The impact of both the virus and pandemic itself, along with before unforeseen public health control measures, was likely to have new impacts upon programme theories, contexts, mechanisms, and also possible outcomes.

It must be recognised that, looking back at events further back in an earlier time and trying to understand them and the decisions taken at that time, demands that we put aside our knowledge of things that happened subsequently. Our current knowledge of what course the pandemic took reframes our understanding of the way that things were then, and the experiences and decision were taken in the research at that point in time.

In April 2022 there was no vaccination in view, let alone various vaccines that eventually were delivered at scale and pace.

The decisions were made in an atmosphere of pragmatism and with a belief that, above all else, it was still important to complete the research started, if possible, but without any risk taken at all to researchers, stakeholders, or the participants in projects.

Such a climatic event also suggested that there might now be even more important reasons to continue with the research and to further assess, if:

I. Programme theories initially constructed retained their importance, validity, and utility in such a major change in conditions.

II. Whether any new elements of context and mechanism could now be identified and if any mechanism were now snuffed or enabled to fire to produce outcomes in the new conditions,

III. Any new Programme theories developed,

IV. If The research methodology itself could be flexed to enable completion even within such societal and social distancing measures,

An indication of the severity of the pandemic is that as of September 2020 when the research activities were re-started after an eight month pause, there had been 857,448 confirmed deaths due to covid – 19 worldwide (Ourworld in data, 2020), and the UK had experienced 41,501 confirmed deaths due to Covid -19.

At the point when the methodology demanded engagement with the four-community health development case studies, the level of the societal control measures was at their most restrictive and the threat of the virus was growing. Also, at this time no vaccine was being confidently predicted let alone one which may have been thought to be effective.

Lockdown measures in Wales in April and May 2020 meant most people were working from home, retail and leisure were restricted, local authorities duties for assessing and meeting care needs were relaxed, and they were only mandated to meet needs in the most serious cases where someone was at risk of abuse or neglect, most health consultations moved to online or phone communication only, and, the summation of these was that people had to conduct their lives in minimal social contact in tight ‘bubbles’ of nuclear families and attached carers.

The rapid advancement of social communication between people conducted via telephone, social media, and video calls was significant at this time but there was a great variation across populations and generations in its adoption due to digital poverty, digital literacy, and uneven digital

environment across urban and rural areas. These factors affected not only communities but also the organisations and workers that served them. (Havers, Durrant, Bennett, 2021)

On two separate levels this major change to the environment within which the research was being undertaken was very significant.

Firstly, the operation of a methodology that required direct engagement with participants and stakeholders through workshops and observations of programme delivery was radically curtailed but, more importantly, the working of community projects themselves, given human interaction is at their heart, needed to be understood.

- How could they continue without face-to-face contact?
- How would this superordinate shift in so many aspects of the socio political, civic, and human environments translate into altered contexts for the programmes?
- What altered or new mechanisms might now fire?
- Which mechanisms would be hindered and not now fire?
- Could programme architecture and programme theories adapt?
- And what might any of these shifts in context and mechanisms mean for outcomes?

In essence, this already complex research study became even more complicated and the challenge for a revised methodology was to adapt it to enable a realist leans approach to studying the four case studies in ways that could still be carried out effectively given the societal restrictions.

It is against this stark backdrop that the methodological changes that were made to this research must be considered, it was an unprecedented point in time and its impacts were profound at personal, family, community, societal, and global levels.

3.2.2 Research Plan Amendments due to the Covid 19 Pandemic

Three questions needed to be addressed within the submission for a “temporary adaption to methodology “presented to the Bangor University Ethics Committee in March 2020.

1. How has Covid-19 affected your project?
2. What changes could be made to your work plan to mitigate these issues?
3. What additional actions are required to mitigate the impacts on your project?

These questions helped to focus the redesign of what might still be achieved in methodological terms, given that lockdown had made the planned Phases 3 and 4 of the research, as originally planned, undeliverable.

1) Interviews and project observations could not be undertaken.
2) Key stakeholders were unavailable, and two programmes had stalled.
3) Those projects still running had radically changed how they were operating, mainly through using social media and virtual platforms as the means for engagement across the programmes.

Above and beyond these, the nature of community health development itself appeared changing radically in these projects,

- Projects shifted in the way interventions could operate and at distance from communities.
- There was an observed shift in the engagement of funders and commissioners with programmes with both an increase in support for what they were doing but at the same time less monitoring demands being made.
- New partners became involved in programme delivery (such as the members of the food industry who had commercial kitchens standing empty who became involved in food hub work on Anglesey).

Each of these major shifts in conditions around programmes context needed to be understood for how they shaped context and for their potential impact upon both the outcomes and mechanisms of programmes.

A theme running through all four case studies researched in Phase One are isolation and disenfranchised communities. The social distancing measure that was implemented were a very significant change in contexts for these case studies as one of the biggest impacts to become very evident soon after lockdown was on increasing isolation and the disproportionate impact upon the already disenfranchised from social distancing measures. (Suleman et al, 2021; Hwang et al., 2020)

It was therefore important to refine and re-focus the research further into seeking whether programmes, and specifically their mechanisms, were now likely to be “firing” in different ways or at least to different degrees of power.

Even in March 2020 when the research had paused the concept of a new normal was being raised and became a major part of normal parlance. (McKinsey, 2022)

Prior to news about potential vaccines, there had become a major debate about whether the way people had lived, worked, socialised etc. would ever be the same again, and the idea of the new normal was a way of adjusting and harnessing technology to continue community development at a distance, becoming both digitally organised and largely delivered in a manner that was “*socially connected but physically distanced*”. (Geisinger, 2020)

This would also require a major shift for some of the four Project’s communities as they were often considered to be digitally as well as socially excluded, and projects that were previously dealing with plugging that gap as just one of their activities were now forced into a position of needing to operate fully digitally or not at all, changing their very basis and operation as programmes.

These all-presented challenges to the research methodologies, but great potential for further learning too. For example, would operating digitally bring new participants into community programmes or simply put up barriers and restrict participation?

Phase 3 activities that would be curtailed were in relation to further face to face workshops for teach back, observation of interventions, and face to face interviews.

However, once projects had begun to settle down into a new pattern of delivery and online consultations were able to be conducted, using:

- Video conferencing.
- Webinars to deliver “teach back sessions”.
- Online collaboration tools to explore outcomes.

Many aspects of the methods were able to be simply tweaked and continued if the programmes were still operating and could themselves connect into these methods.

This required relatively minor alterations to the research methods so that they could be safely undertaken whilst maintaining social distancing guidelines.

Care, however, was needed to be taken to fully account for how theories developed in pre-covid 19 contexts operate in a peri covid 19 context, it is this element that made the original research now even more important and relevant for future community health development across North Wales.

A switch to new methods could not be immediate, a little time was needed for that current situation to settle and the new working methods to “bed in” within projects so that that it could be more certain that what was being researched demonstrated the “new normal”, not merely an emergency response and temporary way of working.

The technical tools to enable online research and collaboration were already in place and required little extra resources, and some minor rewording to programme governance documents and methods of recording data.

The reworked proposal enabled a continuance of the research to both ground the original hypotheses undertaken and to account for the impact of Coronavirus and lock down measure on community wellbeing and the community development efforts to sustain it.

The summation of the amendments in a very practical sense was that

- All face-to-face workshops interviews and observations halted.
- Where possible, online workshops and online interviews to replace them.
- Observations to proceed dependent upon what could be observed online.
- Teach back sessions to be extended to incorporate two reflections upon Initial Programme Theories – how they applied pre pandemic and whether they still applied peri pandemic.
- Phase 4 engagements with a wider Joint Interpretive Forum to also be conducted online.

More fundamentally, this pause and reflect point also revealed some minor flaws within the original research project plan. As discussed, this included stating that Initial Programme Theories would be the output from Phase 1, however concept shaping through mapping testing and general literature searching could actually only generate a broad general working theory and tracer issue.

This general working theory could then be used as the basis upon which to refine through abductive and retroductive reasoning the range of further data collected in Phases 2 to 4 in a quest to find the demi regularities, or “semi-predictable patterns or pathways of programme functioning” (Dieleman et al., 2011, p. 27) that strengthen the likelihood of programme theories being able

to be applied in different interventions. (i.e., the more general lessons learned that can be applied elsewhere).

It is this General Working Theory that guided the searches for evidence in Phase 2 and became revised and reframed into the Potential Initial Programme Theories to explore with research participants within the Case Studies in the first part of Phase 3.

Whilst certain elements of the research such as observations of Community Health Development Project operation became severely curtailed, other elements now became more crucial and rewarding in terms of building and testing the programme theories.

Online ‘Teach Back sessions’ with community health development projects and stakeholders became a much higher priority as they were extended to include reflection upon:

1) Testing the accuracy and validity of programme theories for programmes in case studies as they were working pre-pandemic.
2) Testing the impact of pandemic and public health social distancing measures upon each programme and the programme theories.
3) Refining programme theories through a peri and post pandemic set of lenses.

Hence, each teach back session was altered from its original single intervention format to be extended to three sessions (new actions in the revised mode in figure 3.2 are in blue)

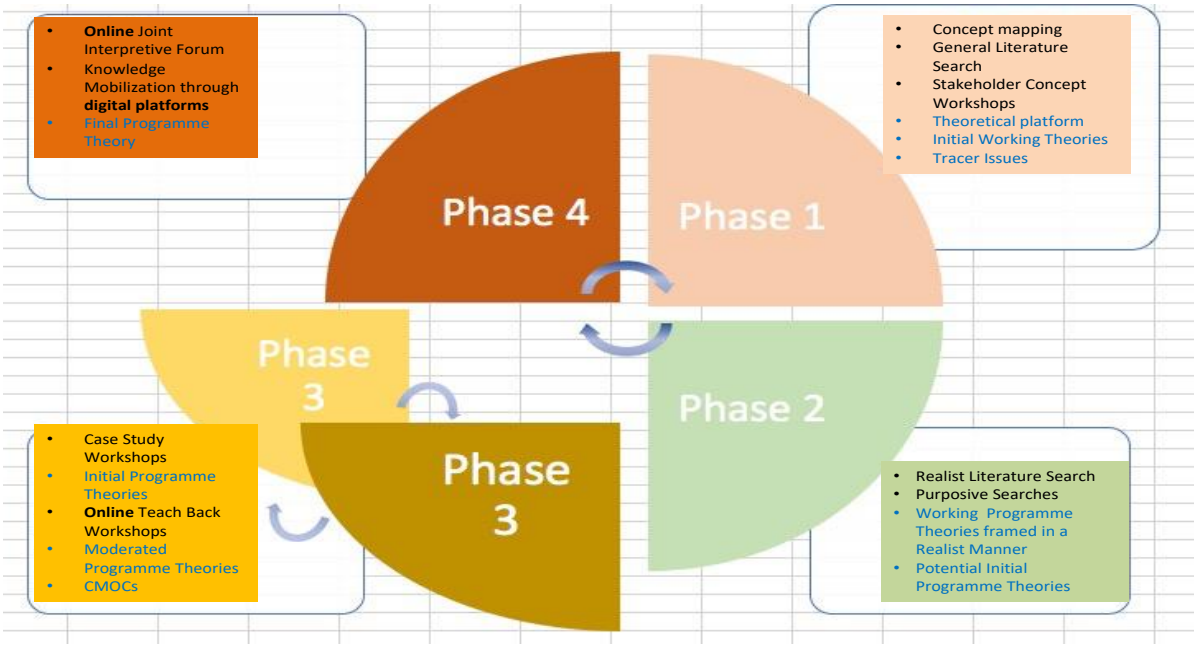


Figure 3.2: Revised Project Plan Following Pandemic Interruption and Approval of Revisions to Ethics Committee

The most important thing to highlight in this revised plan for conducting the research is that methods may have had to be fine-tuned and how they were delivered amended, but the overall research process remained in place.

The anchor points during these different phases were the development of the programme theories which initially expressed as If – then statements became iteratively re-examined and refined at specific points of engagement with stakeholders and the wider group of experts in the JIF.

3.3. Supervision Team

A very important element of research was the selection and guidance secured from a supervision team for the research that brought experience and competence in both community health development and research methods, in particular experience in researching and supervising realist methodologies, and in the local heritage and practice of community health development across North Wales.

This range of experience was a crucially important factor in this research as it acted as a reference point to temper the instincts of a late career researcher and challenge the ingrained assumptions of the field the researcher had worked in for over three decades - ensuring that ideas presented came from the research and not from preconceived ideas and experiences.

Proving those ideas to a supervision team full of knowledge and experience in both subject matter and research methods became invaluable.

Beyond the advice on the research methodology, the supervision team were also invaluable in ensuring abduction and retroduction were appropriately undertaken, and that context, mechanisms, and outcomes, as well as CMO configurations, could be justified and defended robustly.

Professor Paul Brocklehurst

Was the Director of a UKCRC registered Clinical Trials Unit (NWORTH #23), Deputy Head of the School of Healthcare Sciences at Bangor University, Honorary Consultant in Dental Public Health, and Specialty Co-Lead for Health Services Research across Wales. Paul provided leadership and direction as well as research methodology advice.

Dr Lynne Williams

Has over 30 years' experience in nursing practice, research, and education. In her current role as Head of School and Reader, School of Health Sciences, Bangor University, Lynne brought specific knowledge and experience of using a realist lens to the study. Lynne's interests are implementation research and realist methodology, and her own PhD study was in Nursing (The role of Intermediaries to Promote Best Practice in Infection Prevention -a Realist Evaluation).

Professor Gail Findlay

Gail provided leadership on the Well Communities programme across London and development of evidenced based health improvement

approaches linked to the Institute for Health and Human Development (IHHD) research agenda. She is recognised nationally and internationally for her expertise in the field of community development in health. She was Director of Camden and Islington Health Action Zone (2000-02), worked for the Health Development Agency and then NICE as Regional Associate Director for London (2002-06) and with the London Health Commission, (2006-11), before joining IHHD in 2011. Gail provided research methodology guidance and in community health development theory and practice.

Dr Jo Charles

As a Research Fellow in Health economics with an interest in public health, Jo provided a focus on outcomes and social value within the research.

Dr Glynne Roberts

As Director for the company partner, Betsi Cadwalladr University Health Board, Well North Wales Programme, Glynne provided experience and knowledge of both the heritage and delivery of community health development across North Wales (over 30 years) and also linkage to Community Health Development Project areas, stakeholders, and into the health economy.

Changes during the programme, exacerbated by the complications of the pandemic, including retirement and new career directions meant the supervision team itself flexed over time and Lynne, Jo, Glynne, and Gail all left the research before its end.

Fortunately, further support from Bangor University came in the form of **Dr Sion Williams.** Sion is Reader in Health Research in the School of Medicine and Health Science at Bangor University and provides a wealth of experience in Thesis completion as well as methodology advice.

3.4. Phase 1 Initial Scoping and Concept Mapping

As set out in Chapter One, the field of community health development is broad, with numerous well-developed traditions, and strong heritages.

Numerous attempts have already been made to build models and taxonomies to illustrate the scope and complexity of the field however, despite them, the field remains contested and confused without a unified and commonly acknowledged terminology (Carlon, 2021).

In this study, it was decided not to undertake a very extensive review of the literature to map the initial concepts owing to the expertise within the supervision team and the extensive experience of the research student, having taught theory and practice of community development within public health at Masters level for over two decades.

The researcher had maintained a personal library of texts and research reports and conducted community health development projects himself throughout a thirty-year career in wide ranging contexts (including post war zones in Bosnia Herzegovina and Kosovo, Youth Projects throughout Ukraine in communities affected by the Chernobyl Nuclear disaster, non-communicable disease programmes in Nairobi, community development programme in ex coalmining, and ex slate mining communities across Wales).

This extensive library of theoretical, training materials and case studies in hard form, as well as in digital media, was maintained and regularly updated to enable teaching at master's level in programmes at several universities.

Hence the predominant theories, models, and practice modes were studies already very familiar to the team (see Chapter One).

There has also been in recent years several key attempts to systematically review the community health development concepts to organise them into taxonomies, the most notable of which were constructed by South in 2015 and Brunton et al in 2017. These have both already been presented in chapter 1 as Figure 1.4 and Figure 1.5

Despite attempts like these to tidy the conceptual field in this way, Carlon proposes that its eclectic nature should not necessarily be tamed or ordered.

> "*The strength of this conceptual openness is that it creates space for communities and their knowledges, values and interests. Its weakness is that, without general agreement on the nature of community development, the concept is applied inconsistently and becomes a 'buzzword' which is high on application, yet low on meaning*".
>
> (Carlon, 2021, p. 1)

The researcher's own initial uncritical simple recognition of the various traditions found within the community health development field (figure 3.3) attempted no critical analysis, only to recognise there are overlapping domains of theory and practice, each of which has dominated the field at one point or other.

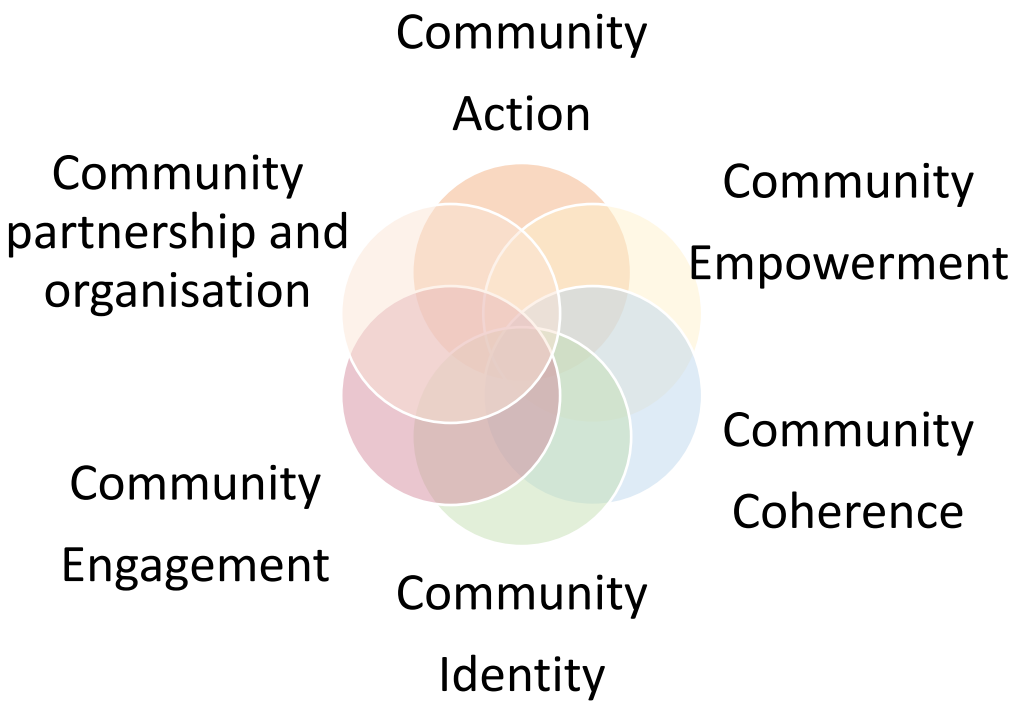


Figure 3.3: Six Tradition of Community Development Evident in Health and Wellbeing

The Kings Fund developed an “explainer” on communities and health in 2018 (further updated in 2021) (Buck et al 2021), noting that despite their long history there remains great variation in the way that approaches are understood and applied, their contribution to a solution is to set out an ‘explainer’ SIC) formed of a series of definitions and a reading list of 100 titles containing the links to key systematic reviews, UK Policy Papers, icons of best practice, and further conceptual frameworks.

Included in the list are some of the go-to sources for practitioners wishing to access theories to guide their actions, values, and principles to underpin programmes, and evidence of what works best. Both the full texts of the Brunton 2017 and South et al., 2015 Taxonomies are referenced and linked to in the list, plus the following websites and collections of tools and case studies:

- **What Works Wellbeing**
  A collaborating centre and hub for wellbeing connecting evidence and practice, which includes guidance and understanding on relationships and power dynamics in communities and how they affect health and wellbeing.
- **Health Matters**
  Guidance from Public Health England on community centred approaches for health and wellbeing, locating community – centred ways of working as a central component of public health and as an effective way to tackle health inequalities.
- **NICE Guidelines on Community Engagement**
  Guidance on community engagement approaches to reduce health inequalities, and to support effectiveness of health and wellbeing approaches.
- **Engaging and empowering communities: our shared commitment and call to action.**
  Think Personal Act Local is a national partnership spanning UK local and national government organisations (including health and social

care commissioners and providers) and voluntary and community sector bodies. This is a consensus view from them on the need for health and social care to transform the relationships they have with communities to enable better prevention and wellbeing, ensure communities are connected and improve self-care and coproduction of wellbeing outcomes.

Not included in the Kings Fund list but also widely considered as pre-eminent sites globally for community health development are:

- **SCDC, the Scottish Community Development Centre**
  The lead body for community development in Scotland, formed in Glasgow in 1994, a charity with a commitment to a set of values and principles in community development and linked to the European Community Development Network and to the International Association of Community Development.
- **The Community Toolbox**
  The Community Toolbox is hosted by the University of Kansas and is a global, online resource for those working to build healthier communities and bring about social change, its reach is extensive and is used by practitioners in over 230 countries around the world.

Its resources include toolkits, case studies, and frameworks for guiding, supporting, and evaluating the work of community and system change.

Reviewing each of these sources in turn and drawing upon the researcher's own career in the field and in teaching community health development did not lead to a more definitive map of the scope and conceptual map of community development beyond the approach suggested in a blog by Chad Renando, a social scientist working in community development. (Renando, 2016).

Renando sought not to replace or recreate the existing models, taxonomies, and countless definitions of community development, but to merely cluster

ideas about community development around 21 common principles he established across three focus areas.

- How do we see community?
- Who do we engage?
- What describes our outcomes?

He suggested these three questions may be used as a tool to help cut through ideologies and become clearer about the nature and purpose of specific activities. Hence, the way to avoid dogma is to analyse the values and principles underpinning any community intervention or programme; the theories of change they draw upon; and any evidence they use to support their approaches.

Renando then presented an example of the principles as they apply to five Community Health Development Project examples of practice (figure3.4).

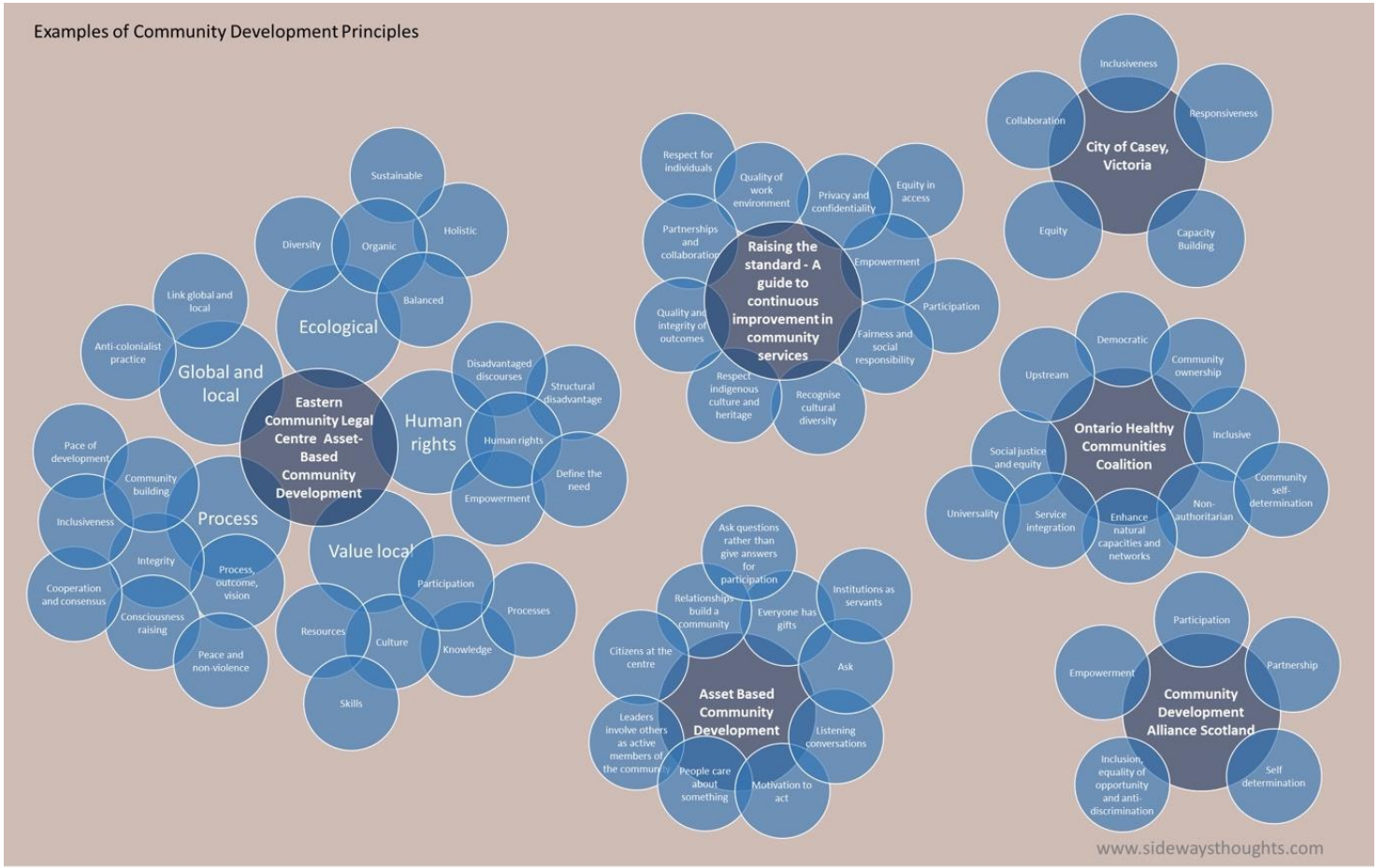


Figure 3.4: Examples of Community Development Principles; Chad Renando (2016)

In this way, he echo's' the position of the Scottish Community Development Centre who claim community development theory and practice is almost defined by its strong connection to values and principles and how they are used in where to focus effort, how to work with people, and which outcomes are sought.

> "*Community development is fundamentally based on the values of human rights, social justice, equality and respect for diversity. The principles which underpin its practice are Self-determination … Empowerment … Collective action … and, working and learning together*",
>
> (SCDC, 2022)

To summarise this initial overview of concepts, not only is the field vast with contested elements; complexity in definitions and understanding; politically permissive; and with little concrete agreement on its boundaries (what it is and what it is not), it is also driven as much by value and principles as it is by specific theories and models of practice.

What does seem to be consistent across taxonomies and models is that:

- When people together take social action it generates health gains, people feel better when they act together with other people to make changes in wellbeing.
- Where there is strong community development in a community, health and wellbeing are likely to increase.
- Characteristic methods for building community health are by starting with what is important to people themselves, building trust in and with that community, and, maintaining activities from the 'ground' or 'bottom' up, in other words led by people in the community themselves.
- The benefits of using a community health development approach are layered - for people taking part themselves as they become 'empowered', for other people around them as it influences social

capital to form, and through building better relationships between people and organisations/services.

Returning to the original simplistic typology of six community health development traditions, it seems sensible to suggest that some observers will consider it just at that high level and recognise the plurality of selecting and applying different traditions in mixed methods programme of interventions.

Similarly in practice, this may be the way that practitioners also use the more formal and recognised models from Brunton and South et al, not really exploring the depth and complexity of the model but picking and choosing elements that provide utility and support for their programme.

Others, however, may ignore the whole and follow one or other of the traditions and its specific ideologies value and traditions. As can be seen in figure 3.5 in an expanded illustration of the traditions, merely adding in the main ideas that are associated with each tradition doesn't help to add any greater understanding of what exactly it is that might work in community health development, for whom, and in what circumstances.

Figure 3.5: An Expanded Schematic of Six Traditions of Community Development in Health and Wellbeing

Laid out in this way however it does provide that simple reminder that within this conceptual field at least, there is space for those who maintain an essential top-down approach – that perspective that communities are a useful focus for interventions, but the nature of the relationship between community and wider society need not change (Popple, 1995) even though more prominent is the idea of bottom-up change, for which there is much more critical support.

This illustration is also a reminder that political ideologies from across the spectrum of capitalist, liberal, and socialist can all be found to champion the idea of community health development. Merely modelling concepts does not necessarily clarify that (although it can easily be argued that Brunton's Taxonomy does bring these political ideologies more clearly to the surface).

Jacques Boulet, Director of the Borderland Cooperative (an Australian Community Development organisation with 25 years' experience) in his foreword to "Theory and Practice of Dialogical Community Development: International Perspectives" (Westoby, Dowling, 2013) strongly asserts that it is:

> "*about time to leave the rather unproductive and often superficial debates about left and right and bottom up or top- down and where community sits*"

in what he says are just dimensional frameworks. Boulet suggests that the left and right distinction is becoming inert in established politics, and, in an emerging neo liberalist world, a lot of people and ideas are brought into a middle ground, and he calls for greater depth of analysis to get beneath the skin of community health development, and

> "*…invites practitioners and others interested to re-imagine community life and work, soul-fully, critically and with depth; an approach that focuses on transformation and care, rather than on offering a 'cure' for situations not of the community's making … and certainly beyond the community's reach*"

(Boulet J, in, Westoby & Dowling, 2013, p. XIV)

The purpose of this initial concept mapping phase is to search through different bodies of information that could help build potential candidate theories.

It started with a detailed analysis of the go to sources, popular in the field of community health development and leading policy documentation on engaging with and involving communities in coproducing their own health and wellbeing.

Whilst this is clearly inconclusive, it provided a body of material to use in consultation with people working generally across North Wales in the field of community health and wellbeing to map what it is that they follow or rely upon for their practice – whether they follow any particular tradition, have a clear concept or theoretical construct on what community oriented actions lead to health and wellbeing outcomes, or if their practice is driven by values and principles as recommended by such as Renando and the Scottish Centre for Community Development.

Of the taxonomies available to explain the territory of community health development, it is the South et al., Community Centred Approaches for health and wellbeing that dominates across the UK (even though it was aimed just at an England level).

3.5. Phase 1 Concept Testing with Stakeholders in Public Health and Community Projects

The initial concept mapping created a rich vocabulary of key words. Core theories and traditions but also what was emerging was inconsistency in how they are used across different theories, professions, and programmes. Even among seasoned practitioners and long running programmes it sems there is great variation in the understanding and use of even central concepts.

Consequently, an emergent theme from concept mapping was pursued and an additional step added into the early stages of a revised methodology to

help to unpack this seeming lack of clarity in the way the various traditions and approaches across community health development are considered and applied.

Even within a defined geographical area such as North Wales, great variation was immediately apparent in the use of foundational concepts such as “empowerment”, which was presented as the goal of some programmes, a methodology for engaging support in others and even as a condition required for activities to be successful (in other words it could be an outcome, mechanism or context).

This variation was observed by researcher observations through attendance alongside local projects at a number of the Well North Wales Network Events during the first phase of the research.

The concept of Well North Wales was initiated by the Betsi Cadwalladr Health Board in 2016 to develop its role in supporting the health inequalities agenda in North Wales. Well North Wales was managed within the Public Health Directorate enabling the work to be closely aligned to the priorities of the Local Public Health Team and contributing to the delivery of several core Health Board strategies.

Well North Wales aimed to:

- Drive good practice to reduce health inequities and outcomes,
- Help people stay well through an integrated approach to improving the nation’s health and wellness. With a focus on rehabilitation, reablement, and recuperation, provide active support to keep people healthy, maximise recovery and maintain independent living.
- Promote understanding of A Healthier Wales within the health and social care workforce and provide practical examples to champion transformative, crosscutting change.

It provided an infrastructure and networking platform for local community projects working on food poverty and food security, homelessness,

substance misuse, loneliness and isolation, social inclusion, and social prescribing/arts and health.

Almost all these programmes were reliant on short term funding and the network provided an infrastructure to assist their stability and sustainability. It also worked toward building a system that can help monitor the impact and value for North Wales, with a focus on social value and economic benefits across all sectors, linked to robust evaluation (Roberts G, 2022).

The Networks' education and training programme provided the opportunity to run a series of focussed workshops on "Community Health Development Concept testing" early in the first phase of this research.

Three separate workshops were held across locations in the West, Central and East of North Wales, with a total of 45 participants from across community projects and Health Board employed Community health development workers (see table 3.1), hence these 45 individuals represented a broad-based resource of experienced public health, community programme, and voluntary sector expertise from across the wider North Wales footprint.

Table 3.1: Participants in Concept Mapping Workshops (total 45)

Workshop 1 Shotton	Workshop 2 Rhyl	Workshop 3 Llanfairfechan
Health Board Director of Well North Wales, Housing Association Representatives, Care and Repair Manager, Workers from five Community Projects, Community Police Officer, Mental Health Nurse, Trussell Trust, Public Health Wales – Consultants and Practitioners, Housing Department, Flintshire Council, Partnerships Manager – Glyndrw University, General Practitioner.	A joint workshop between BCUHB Public Health Teams and Dietitians working in Community Projects, a wide range of health workers experienced in delivering community-based projects across the whole of North Wales	Three community Engagement Workers representing the Red Cross, Social Prescribers from three different programmes, Public Health Wales Practitioners, Representatives of Local Voluntary Councils across North Wales (Wrexham, Flintshire, Denbighshire, Conwy, Gwynedd and Ynys Mon,

Treating the Cardiff Advisory Group (2002) definition (figure 3.6) as an anchor point to begin to explore understanding across participants and projects, a workshop design was developed to explore familiarity and use of the concepts that had emerged from the concept mapping and scoping review.

Broad taxonomies and the high-level traditions for community health development were presented to each workshop and the Cardiff definition considered in detail.

Community Health Development Network for Cardiff Advisory Group 2002

Theory/Model

Lay Beliefs

Social ecology

Value/Principle

Holism

Local voice

Active participation

Act Locally

Community Health Development is founded on the principles and practice of the long established community development approach and is undertaken with a specific concern for improving community health and well being. Health is interpreted broadly and **holistically.** Therefore, health is seen to include all aspects such as mental, spiritual, sexual, social, emotional, as well as physical health. Within communities, health is recognised as being linked to a range of **environmental and sociological** factors such as poverty, education or jobs. All of these factors impact upon people's wellbeing and quality of life. Community Health Development is about using an **empowering "bottom up"** rather than an imposed "top down" approach. A **lay** understanding of community health issues and needs being positively listened to **and prioritised** over the "professional" perspective. It is essentially working with people not doing something to them. As such it is a longer term approach which allows for the personal **development of the people involved**, through providing support in gaining new skills and knowledge, increasing self confidence and enabling them to take an increasingly **active part in community** activities. Thus Community Health Development encourages and supports people **to participate** in addressing issues that impact upon their community's health and wellbeing. It is particularly effective in **engaging with the most disadvantaged** and **difficult to reach communities**. It enables groups that are experiencing inequalities in health and who generally have the poorest health, to express their views, participate in activities and **make positive changes** to improve local health and wellbeing within their communities.

Outcome

Empowerment

Capacity development

Access

Equity

Figure 3.6: Cardiff Definition of Community Health Development (Goosey S, 2010)

Once the participants had considered the broad scope of these traditions and taxonomies, discussed in small groups how they fit against their own understanding of what community health is and what it achieves, the methodology of workshop then turned to participants working initially alone, and then again in small groups, to generate lists of the things they believe are most important in the success of a community health development programme.

Once key ideas and words were listed, participants then were asked to allocate them to three categories:

1. Ideas closely related to **underpinning theories** of community health development.
2. Ideas closely related to **values and principles** driving community health development.
3. Ideas mainly relating to the expected **Outcome**s of community health development.

Ideas were added to individual post it notes and then placed on flipchart sheets, the placing of them vertically up the page dependent upon whether each idea was an absolutely “core’ idea or was “contributory”.

In this way a ranking of ideas under the headings of theory, values/principles, and outcomes resulted clearly mapped spatially across the page.

Blank post it notes were also available so that participants could add in any key terms they consider important that they felt were not included or recognised in the original definition.

Participants were then facilitated through a reflection process of how the Cardiff definition and models/taxonomies fit with their own ideas and experiences in this field, and on how their own understanding and working definitions concurred or differed with published concepts.

In a larger group, participants compared their rankings (including the new terms added by participants themselves) before deciding if each term was

primarily an underpinning value or principle of community health development; whether it was an expected outcome; or whether it was an underpinning theory that is fundamental to community health development. This resulted in some movement of ideas between different categories.

Participants were encouraged to discuss the clustering of terms and positioning in depth and to be decisive, but if they could not agree over the placing of any concept as a “value”, “theory”, or “outcome” they were encouraged to duplicate it, writing it on a separate note and include it in multiple places.

Through this process the identification of key concepts was possible and, at the same time, concepts that were more contested also found in that they were concepts that could and were attributed in different ways.

Whilst not yet being at all considered in the research process as context, mechanism, or outcome in any realist sense this still enabled the start of a reflection around concepts and the potential for multiplicity of meaning and portability of terms to be aware of in the next steps when engaging with case studies and Community Health Development Project participants.

The inherent danger within this could have been to close the researchers’ thinking and listen only for identification and recognition of concepts familiar from concept mapping and testing but, in contrast, if properly handled, it could also enable a more permissive and open approach to capturing a wide understanding of terms and how they are applied.

The resulting categorisation and rankings proved to be very illuminating, these are the initial categorisations from the first of the three workshops: -

Figure 3.7: Initial Theory Ranking

This flipchart captures participants views on what are the most important theories and ideas supporting community health development and their position on the page reflects whether they are core ideas (at the top) or if they are contributory (towards the bottom of the page).

The green line drawn between ideas was explained by participants as the link between core ideas, and the arrows suggestive of the direction aimed for when working with communities (for example collective action, collaboration and “bottom-up change from below” as the broad goals and increasing over time as the programme builds.

Figure 3.8: Initial Values Ranking

This flipchart captures the results of participant discussions about the driving values and principles underpinning community health development practice. As with the previous flipchart they were ranked from contributory to core.

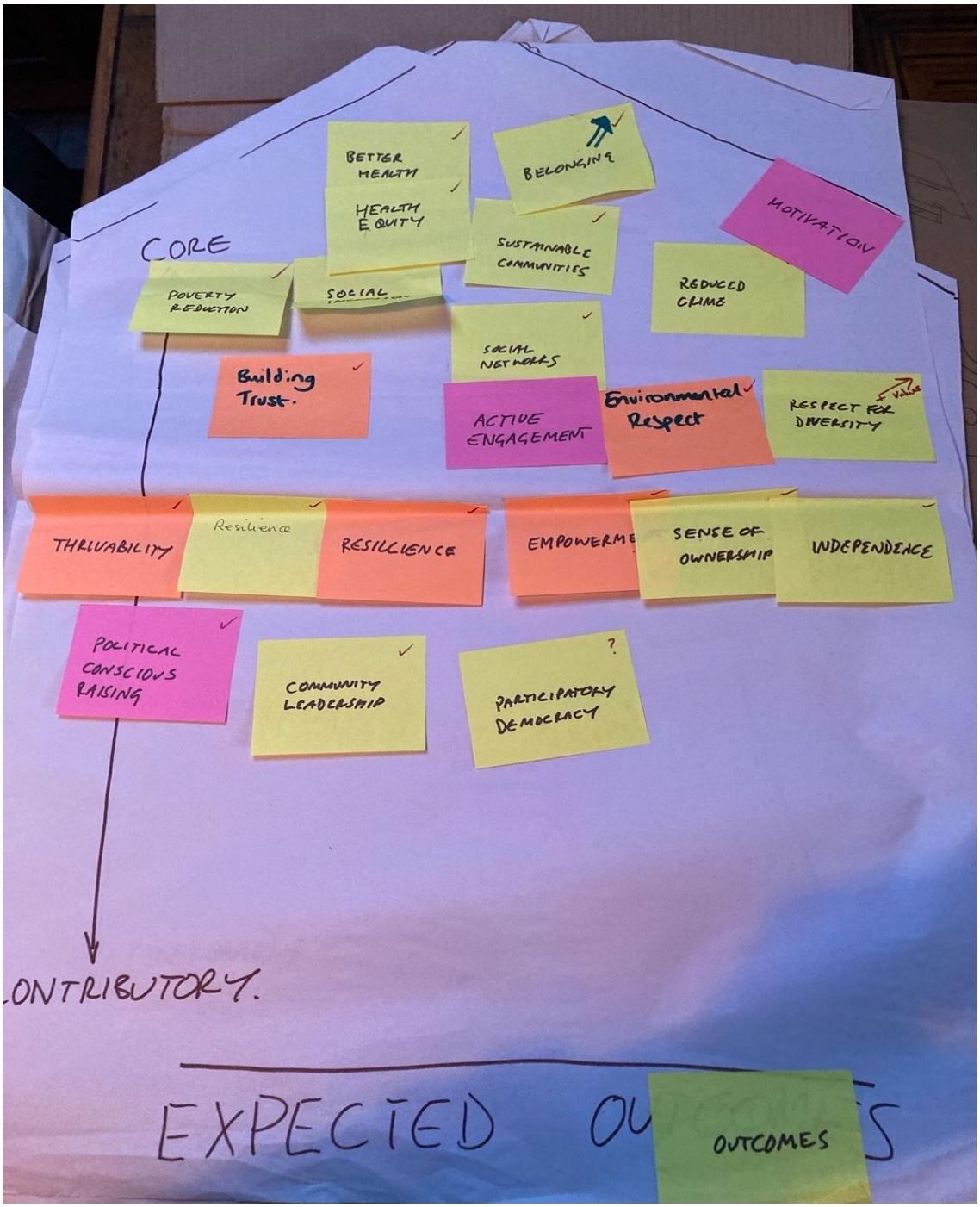


Figure 3.9: Initial Outcomes Ranking

The original coding of post it notes for ideas illustrated here was

- orange = values and principles
- pink = underpinning theories
- yellow = expected outcomes

The first observation, consistent across all three workshops, was that there was substantial movement across categories of some key ideas, despite original listing of theories in pink, these appeared on flipcharts in theories, outcomes and values after discussion with others. Similarly with orange slips for values and yellow slips for outcomes.

- **Empowerment** was A significant idea as a value/principle, outcomes and also a theory.
- Building Trust was the same.
- **Salutogenesis, the Assets based approach and coherence** were often put forward, but little agreement on whether they are a values-based way of working or if they are a specific theoretical construct.
- **Respect for self-determinism** of programme participants was dominant in the discussions but workshop participants could not decide its nature, only that for programmes to work it is a central idea.
- Collective and collaborative action.

The last stage of the workshop process was to integrate the ideas, as in the illustration below, and to undertake a final edit upon the core concepts and those that are contributory (noting the core ideas at the point of each flipchart and therefore at the centre of the collated charts).

Figure 3.10: Combined Ranking of Theories, Values and Principles, Outcomes

Given that across three workshops it was not possible to gain agreement across participants and anchor these ideas as ‘theories’, ‘values and principle’, or as ‘outcomes’, only to recognise that they are consistently

ranked as the “core” ideas, these were then captured and recorded as potential ‘**tracer**’ issues (table 3.2) to be kept in view when undertaking the next stages of the research (undertaking a realist literature search and running consultation workshops with the Community Health Development Project programmes, set out in the methodology as Phases 2 and 3).

Table 3.2: Tracer Issues towards Defining an Initial Working Theory

Tracer Issues towards Defining an Initial Working Theory	
Central ideas from concept mapping and practitioner workshops	Community health development takes a holistic approach to wellbeing and involves connecting people to form communities, finding common issues they will participate in to jointly make positive changes to create wellbeing
Community development is built upon a small range of essential components	➢ Empowerment ➢ Respect for self-determinism ➢ Building identity between people ➢ Recognises and builds upon people’s strengths ➢ Requires ‘walking alongside people and coproducing action ➢ Forming social capital and citizenship ➢ Community led (bottom up) change ➢ Respect and diversity (inclusion and participatory democracy) ➢ It is concerned with social justice

Using a set of tracer issues in this way is consistent with the theory – tracing processes in realist evaluations suggested by Mirzoev et al. (2020) who described tracing as a process of ‘gleaning, testing, consolidating and

refining', hence establishing early in the research process with a broad theory of change to start to explore the programme architecture and logic.

In Phase 2, a more extensive literature searching process enables a process of retroductive reasoning to develop broad theory areas into high level programme theories.

3.6. Phase 2 Realist (Systematic) Literature Search

The aim of this stage of the research was to further articulate those underlying theories emerging from Phase 1 and then to interrogate the existing evidence to test whether these theories are pertinent and productive to help formulate the mid-range theory to further test in Phase3.

The concept mapping and stakeholder workshops produced a range of tracer issues to help develop potential search terms to utilise in the next stage of theory development work, undertaking a realist literature search and a series of purposive searches of peer reviewed and grey literature.

3.6.1. The Search Process

The purpose of the realist search sets out to establish whether (and what) empirical evidence there is in the literature that may support the researcher's initial four propositions and explain how they may operate in specific contexts and with specific individuals or populations.

Unlike other methodologies of literature searching, this methodology is typically iterative and although distinct methods and stages can be identified they are flexed and flexible, responding to how the evidence emerges, moving between inductive and deductive reasoning to examine the causal power of the programmes studied ((Pawson and Tilley, 1997; Greenhalgh et al., 2017; Emmel et al., 2018).

This meant that it was appropriate, maybe even necessary, to move backwards and forwards, in and out of methodologies and the literature, in order to build a picture and develop deeper understanding of how community development programmes produce health and wellbeing outcomes and how

strong the evidence is when applied across populations and contexts. Hence throughout the search process there was a constant reflection upon wider application and testing of the relevance of the evidence.

The work by South (2015), setting out a family of community centred approaches that had emerged as highly significant in the concept mapping, shaped this stage of the research significantly, mainly because it has become so central to the field of community health development in the UK.

The Taxonomy of a family of community centred approaches for wellbeing has rapidly become the go-to source for a theoretical expression of community health development becoming almost ubiquitous as it was actively championed on the websites of NICE, Public Health England, Kings Fund, UK Health Security Agency, and a range of others.

This taxonomy resulted from a knowledge translation project, ‘Working with communities: empowerment, evidence and learning’ (2014-5), that was jointly funded and steered by NHS England and Public Health England (PHE) (Bagnall et al., 2015).

The core of this project was the scoping review undertaken by a team from Leeds Beckett University, led by Dr Bagnall, a rapid review of reviews to identify major sources of evidence and intervention types.

The project aimed to draw together and disseminate evidence and learning on community-centred approaches. Professor Jane South of Leeds Beckett University was seconded to PHE to lead the project.

The results “made a significant impact within public health and community health development and led to the production of a briefing document ‘family of community centred approaches’, and an accompanying “guide to community-centred approaches for health and wellbeing”, according to the authors themselves (South et al., 2015). It has certainly become one of the most predominant “go-to “guides to the field of community health development in the United Kingdom since its publication, becoming one of the most often cited publications in community health promotion research.

The ‘family’ mapped out included community development but also other community health approaches such as ‘community empowerment’, ‘volunteering and peer development’, and ‘area-based initiatives’. As one of the current leading resources for community health initiatives, this scoping review, as well as the taxonomy it led to, is also well respected and often cited so provided an important foundation to inform this research.

As a review of reviews, it considered 168 publications and studies grouping them into key themes:

- Systematic reviews (32)
- Non-systematic reviews (25)
- Practice Reviews and Evaluations (32)
- Guidance/Policy/Briefing Papers (16)
- Theoretical and Conceptual Frameworks (30)
- Commentaries (7)
- Practice Syntheses (22)
- Social Return on Investment (1)
- Generic Studies (3)

Given its pedigree within the fields of public health and community development the decision to use this review of reviews as the basis for the literature search was an obvious one, however as it was 5 years since it was undertaken and there appeared to have been considerable developments in the field since then (in particular relating to the gaining popularity of so-called ‘asset based approaches’) the main elements of the scoping review were repeated but for publications from 2014 onwards.

The results of this repeated search with new time parameters were then considered alongside Bagnall’s original bibliography.

Repeating the scoping review, however, was only part of the required search as it is only likely to overlap the field of this realist research partially. The

review of reviews was likely to cover the general parameters of the field of community health development, but not necessarily any purposive search for realist elements of whin figure 3.11 there are elements of the family of approaches that are not relevant and vice versa, this review therefore extended beyond South's recognised family of approaches.

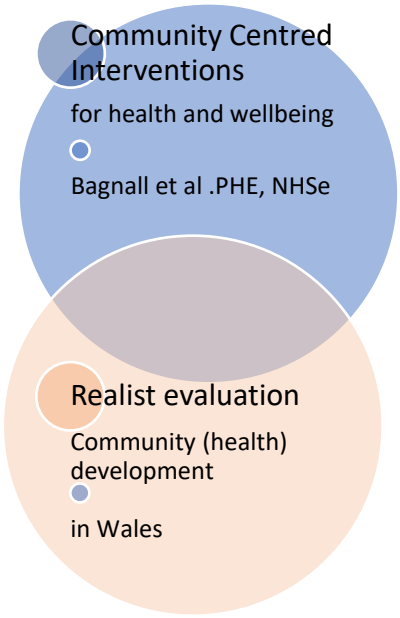


Figure 3.11: Relationship Between Searches

The searching process itself was both systematic and transparent. In conducting the search:

- It was driven by the aim of the research and a focus on the four initial propositions.
- A wide range of sources were used to identify documents that are likely to identify data for theory development, refining, and testing.
- There was no restriction of the study or document type that is searched.
- Further searches were undertaken as a greater understanding of the theory areas developed; hence it was iterative and reflexive.

- The searches were designed to find additional data to enable further development, refinement, and testing of the programme theories.
- The search design overall was also iterative, as the synthesis progresses, new elements required further information to explain certain findings.
- The search design deliberately sought out information from outside the programme, where it could by hypothesised that the same mechanisms may be in operation.
- In line with realist practice, inclusion and exclusion decisions were based on just two criteria, on whether results exhibited:

    - Relevance
    - Rigour

    (Wong et al., 2013)

- Quality standards for selecting and appraising documents were defined as per Wong et al., (2013)

    - Selection of a document for inclusion into the review based on what it can contribute to the process of theory development, refinement and/or testing (i.e., relevance).
    - Appraisals of rigour judge the plausibility and coherence of the method used to generate data.
    - During the appraisal process limitations of the method used to generate data are identified and taken into consideration during analysis and synthesis.
    - Selection and appraisal demonstrate sophisticated judgements of relevance and rigour within the domain.

This search reflected layer one of a funnel model which shaped the overall process. The next layer was to conduct a series of more purposive searches around the tracer issues emerging from concept mapping and stakeholder workshops in Phase 1 (although it was not strictly 'necessary' to do a full search for these 'essential components'), consultation with experts in the field, looking for existing reviews, and specific leading journals dedicated to community health development such as Health Promotion International, and the Community Development Journal.

In addition, these purposive searches included other topics related to those concepts considered essential - empowerment, self-determinism etc. For example, "safe space", "ways of working", "leadership" and "organisation support", all relate strongly to the main ideas that emerged from concept mapping and testing.

Hence the sub steps within this stage of the research were as follows in figure 3.12:

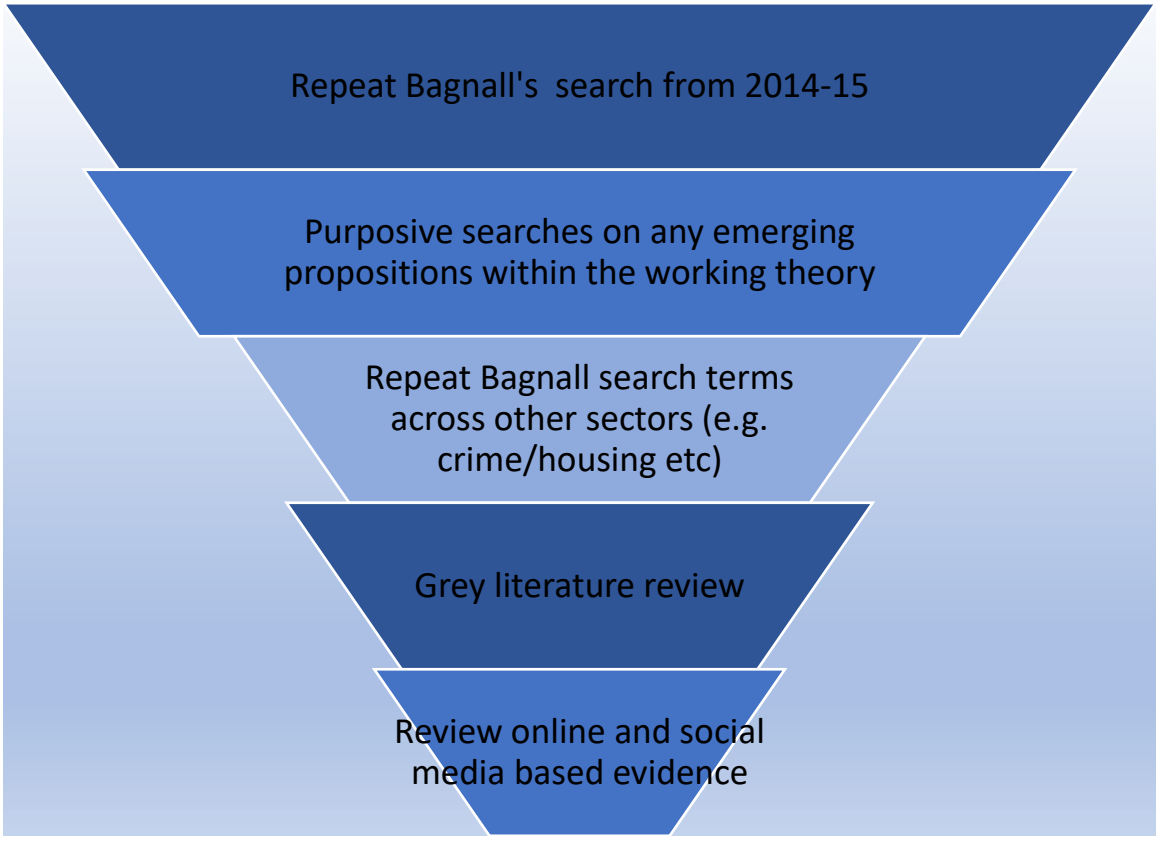


Figure 3.12: Stages of the Search Processes

The final layers were to conduct a search of grey literature including audio and video material in TED talks, You Tube, blogs, and across social media platforms.

An example of this is “Social Care Online” which was included within the grey literature searching (wellbeing as much related to social care as it is to health from a clinical perspective). Other related fields considered include ‘environmental wellbeing’, to reflect the close connection between personal, community, and environmental wellbeing (Knez et al., 2020).

Stakeholders were also requested to suggest relevant publications and propose their own favourite sources of knowledge and evidence.

This mixing of evidence from peer reviewed publications and from a wide range of other sources including opinion pieces, oral histories, and sources of inspiration on value and principles developed from practice is a theme that was strongly supported in the concept testing workshops. Very few of the ideas that were suggested as key concepts had been traced back to academic sources by the stakeholders, more often they were cited from case studies or from blogs and web resources from inspiring workers in community programmes.

Once these search processes had been undertaken a replica series of layers was undertaken (although not in the same depth) in a different field to health and social care/public health, such as housing or criminal justice, to compare the results and find any commonalities and differences in understanding of what and how community development works.

3.6.2. The Search

Electronic databases search (from 2014 onwards) of MEDLINE, CINAHL, ProQuest (Social Sciences Premium Collection), using the following search strategy, which was a slightly adapted version of Bagnall et al., (2015).

1. (Communit* OR citizen OR public OR population OR stakeholder OR “community development” OR lay OR public OR social OR volunt* OR “asset – based” OR peer OR “social planning”).
2. (Concept* OR framework OR definition* OR theor* OR models OR typolog* OR categories OR categoriz* OR dimension* OR domain* OR construct OR review OR “evidence-base”).
3. intervention* OR "best practices" OR engagement” OR “empowerment,” OR “involvement,” OR “participation,” OR “representation” OR “collaboration” OR collaborative OR consultation.
4. evaluation* OR program* OR project OR strategy OR "lessons learned" OR outcome* OR action* OR activit* OR MESH heading for programme evaluation OR "outcome evaluation" OR "process evaluation" OR "programme evaluation" OR (MESH headings "Program Evaluation+" OR "Evaluation Studies") OR effective* OR success* OR outcome* OR improv* OR Health OR wellbeing OR “well-being” OR resilience OR “health improvement” OR “health promotion” OR “health development’ OR “delivery” OR “development” OR “organisational delivery” OR “organisational change” OR “organisational development,” OR “planning” OR “provision”.
5. Panel OR forum OR neighbourhood.

Initially tested in MEDLINE, abstract only since 2014 onwards, refined, and repeated, then using CINAHL and ProQuest repeated the searches (in ProQuest “Sociology Collection” which includes ASSIA, Sociological Abstracts and Sociology Database).

This was then tuned up or down using title only or full text to check what difference that made in the volume of results.

This search returned 640 key papers. The research and supervision team were not satisfied that this search was refined enough to focus down on community development, rather than the wider range of approaches that just happen to be delivered in or at a community level (for example interventions

delivered top down from services whose only recognition of community is that it is a target for outputs), therefore an amended ‘South’ search specifically focussed on “community development” rather than simply “community” and combined with “health” or “wellbeing” was undertaken:

This search returned 2815 titles and abstracts**,** of which 639 unique references were retrieved in full, plus a further 130 documents were sourced from notable community development websites, personal libraries of the supervisors, shared by other PhD researchers through networking, and grey literature. (see figure 3.16 for a diagram of the process used).

A framework to sift the results for eligibility and capture data and ideas at an initial high level was then designed as shown in figure 3.13 below.

Document ID/Title	
Author/s	
Date published	
Source of paper	*Search – webinar – conference*
Type of study	*Mechanism – context – outcomes*
Study’s aim	

Study size						
Community orientation People/place/power						
Intervention/subject focus (if applicable)						
Theory area	*Community engagement*	*Community empowerment*	*Community identity*	*Community coherence*	*Community action*	*Community Partnership/ organisation*

Figure 3.13: Sifting tool and data capture sheet

Whilst in practical application this was flawed as it forced consideration at too early a stage on whether papers were reporting on realist concepts of context or mechanism or outcomes, at a much more basic level it did allow an analysis of whether papers provided useful data or ideas against the community health development traditions mapped when reviewing concepts.

These papers were therefore collated under the six traditions for further consideration.

3.6.3. Initial Results

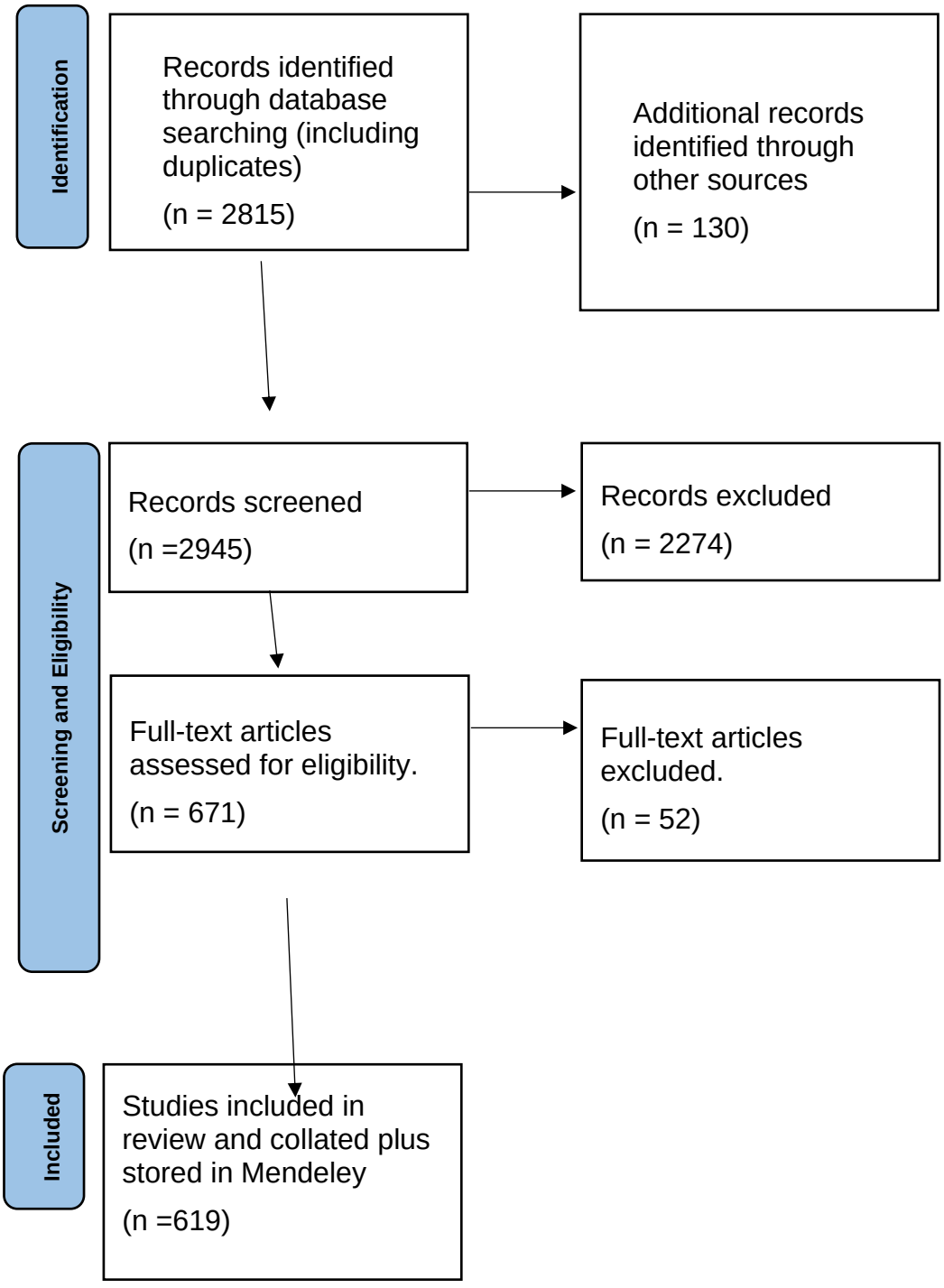


Figure 3.14: Study Selection flowchart (PRISMA)

Following the system of sifting the references the following papers were deemed to have relevance at some level to the research question:

- Concepts of community development and theories on what works – 109 references.

- References related to individual traditions:
    - Community Engagement – 162
    - Community Empowerment – 119
    - Community Coherence – 46
    - Community Identity – 89
    - Community Action – 12
    - Community Partnerships – 42

- Case Studies – 40 (it should be noted however that a number of these are collections and typologies of case studies and that the individual; case studies far exceeded 150).

At this stage a very early attempt to categorise papers within those overall categories against realist methodological principles was also made (i.e. papers already included in the numbers above as some papers talked to a particular community development tradition whilst also being relevant to realist methods.

- Context – 30.
- Mechanisms – 6.
- Outcomes – 14.
- Realist Methods, including theories of change and community engagement within research– 84.
- Research Methods and Evaluation – 59 (including ‘Ripple Effect mapping’).

The main findings from this more recent set of searches were that all the tracer issues were strongly supported in the literature, prominent of which were ideas around community engagement, empowerment, and the building of community identity.

With specific respect to realist studies of community health development, none could be found. Although there were numerous in closely related fields

such as a rapid realist review from De Weger at al., (2018), a realist review of community empowerment in low- and middle-income countries (Westhorpe et al., 2014b) and Realist Synthesis of Asset Based Community Development by Christian Blickem et al. (Blickem, 2018).

It is this last aspect of community development, Asset Based Community Development, and its dominant ideology of salutogenesis that emerged as the most frequent theme that emerged from the searches post 2015.

Salutogenesis is the theory driving the ‘What Matters Approach’ which became popular in Wales within both health and social care delivery since 2019, (Social Care Wales, 2022) and more generally underpins the asset-based approaches to community development (Rippon and Hopkins, 2015).

The term salutogenesis is a reaction to, and mirror of, the term pathogenesis which underpins biomedicine and is the way both health and care services have operated. Whereas pathogenesis is associated with risk factors involved in disease generation, their treatment and prevention, salutogenesis looks for the factors which cause wellbeing, literally asking the question “what are the origins of health?”.

Reframing the way that people understand their health and wellbeing, and what influences both, is an anchor point of using this approach and it is an essential element of what Antonovsky was trying to achieve with his model as its fullest sense goes much further than simply exploring assets. Antonovsky posited that life experiences help shape one’s **sense of coherence**, which means that their life is understood as more or less comprehensible, meaningful, and manageable.

It is through balancing this understanding, meaning and motivation for their wellbeing that he proposed people move towards wanting, and manging, to take control of their wellbeing.

Reframing starts the journey; however, it is a more complicated next step that helps people work through those elements of **understanding** the things that affect their health and wellbeing; **motivating** them to want to change

and gain better wellbeing; and having the faith that doing so will be worth the effort that they expend doing so (in other words it has **meaning** for them.

Since 2015 Asset Based Community Development and how it offered an alternative and complementary lens to “deficit based” community development has become one of the predominant discourses in the field of public and community health. The other attendant themes that grew vigorously during this period were ‘community resilience’, social prescribing’, and ‘place based’ working. Each of which are all parts of a shift towards people being facilitated to take control of their own health, when a more facilitative approach to helping them to achieve this from helping services, together with more attention to context which the place-based approach signals.

The growth of papers and conversations on the asset-based approach to community development has largely been built upon a constructed and possibly false dichotomy. Whilst it has much to support its approach from an ideological and evidence-based point of view, much of the popular arguments made in its defence are about what it is not. By framing other types of community development as deficit-based its champions create a dichotomy of approaches and few have a challenged this as a false dichotomy.

Kevin Harris had called this false dichotomy out as early as 2011 in a short article published in The Guardian (Harris, 2022)

> *“… you don't have to be a card-carrying sceptic to wonder what the first two initials add: all community development is asset-based or should be*.”

He goes on to cite Gabriel Chanan of the Community Development Foundation:

> “*To justify AB you have to caricature CD as having been deficit based. It isn't, but it could do with the boost. Our protagonists presented ABCD as a ‘glass half full’ model. In the past, they claim, too much*

intervention has implied a half empty glass, focusing on what is wrong in localities – crime, poverty, ill-health, poor housing – and is thought to need fixing from outside. Such interventions may be insufficient but should not be mistaken for community development."

(Chanan and Miller 2013)

Harris suggested that it was indeed time for a makeover of community development and that, after such a long history of highs and lows, it did appear to be back in vogue, but needed vigorous refreshment and, despite the new gloss of ABCD, with rising tides of austerity the whole breadth of community development is needed to build health and wellbeing, not just the aspects focussing on recognising existing strengths in people.

The 2015 onwards search does indicate that some ideas were refreshed, however they were greatly dominated by these notions of a "Glass Half Full" (Foot & Hopkins, 2010) or 'Asset Based Approaches to Community Development for health'.

In summary, the outputs from the searches that updated and extended the bibliography from Bagnall's 2015 work had strengthened support for the tracer issues in the working theory and suggested that two separate streams of theories and evidence base were now developing alongside each other. Perhaps in reality these were not so much parallel fields but a double helix, much more entwined conceptually, but it is not within the scope of this thesis to unpack that further at this point.

At this stage of the research, following concept mapping in Phase 1 and literature searches in Phase 2. several interim outputs had been established:

- A strong theoretical platform to work with.
- Wide-ranging evidence base.
- A working theory that was standing up to being tested against the contemporary ideas in practice.
- A strongly supported set of tracer issues.

This presented the research with a sound foundation with which to undertake a realist evaluation approach with case studies in Phase 3 to compare whether a similar set of concepts to the working theory and its tracer issues came from programmes themselves.

This building of a potential evidence base, only to put it aside to undertake a different type of research and then return to it to compare and contrast sets of data and emerging findings, is entirely appropriate in realist research as part of the iterative process.

Greenhalgh, et al., (2009) suggest that across a research process several steps may be revisited and, whilst there is a general forward momentum through them as new ideas emerge that seem relevant, earlier evidence can be returned to test if it helps strengthen the programme theory, such as:

- Repeated writing and rewriting of fragments of each Community Health Development Project.
- Presenting, defending, and negotiating interpretations of actions and events both within the research team and to the stakeholders themselves.
- Testing these interpretations by explicitly seeking disconfirming or contradictory data.
- Considering other interpretations that might account for the same findings.

The Initial Working Theory therefore at this stage (figure 3.15) was only slightly amended in presentation to emphasise the double helix of deficits (needs) based, and, assets (strengths) based forms of community health development, and the strongest supported tracer issues are presented in **bold**.

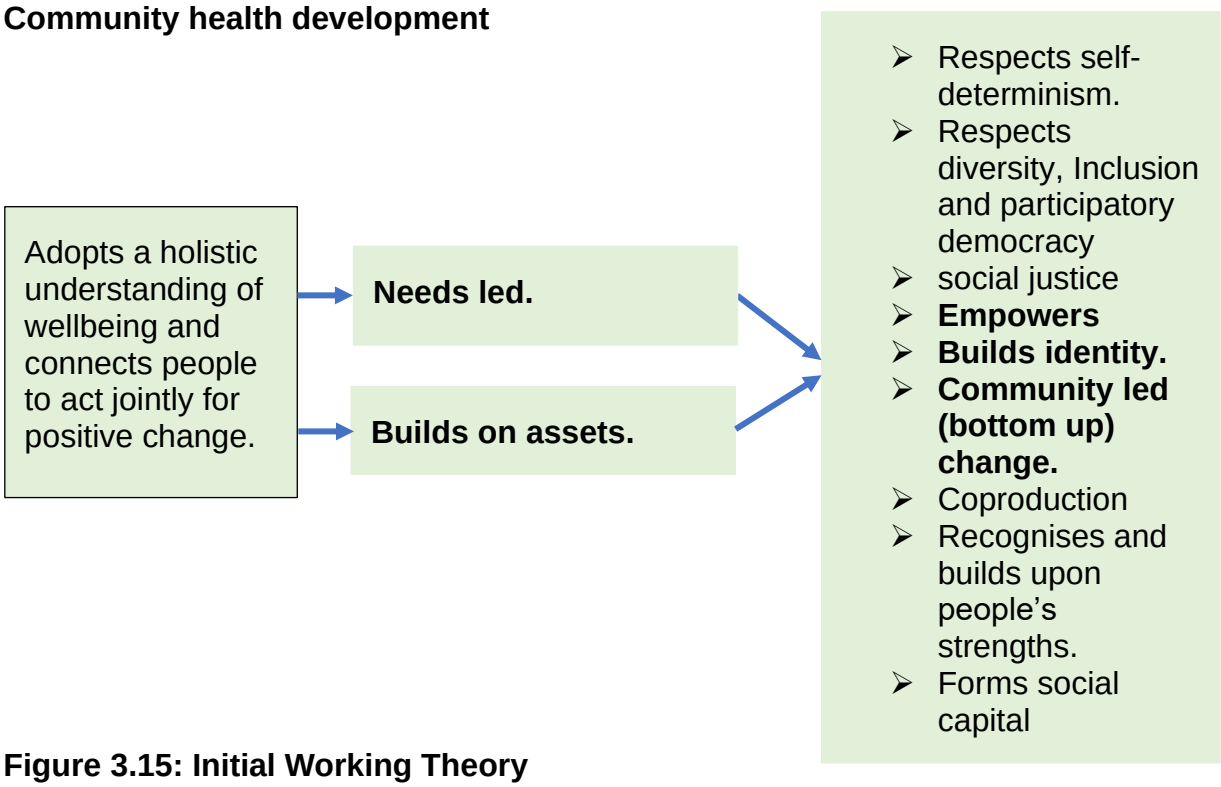


Figure 3.15: Initial Working Theory

3.7. Summary of Phases 1 and 2 Concept Mapping and the Realist Search for Evidence – An Initial Rough Working Theory

In summary, Chapter Two argued that using a realist lens is appropriate and valuable for community health development as it is well suited to assessing the complexity within which community health development programmes typically operate, and because it is method neutral so, can draw flexibly upon a wide range of evaluation methods to test the surface programme theories.

This Chapter Three has then set out the initial choices made on data collection (both qualitative and quantitative), analysis methods and tools.

The chapter also covered how those were amended when complex programmes became almost chaotic in the face of unprecedented changes in the conditions within which they operated due to a global pandemic.

The Initial Working Theory strongly aligns with findings from literature searching and the ideas and the concepts that practitioners in public health and community health programmes identified and prioritised.

It presents an idea that two strong elements are working alongside each other, although it is not yet so clear whether and how these elements influence programme theories – whether each element inspires particular programmes or, alternatively, if programmes contain elements of both.

This question is addressed within Phase 3 of the research, outlined in the next chapter, which explores the experience of four case studies using soft system methodologies to explore with stakeholders in programmes what they believe makes ‘good community health development’.

CHAPTER FOUR:

RESULTS OF PHASES 3 AND 4: FROM A WORKING THEORY TO INITIAL PROGRAMME THEORY

4.1. Introduction to Phases 3 and 4 Results

This chapter primarily reports upon the further development and refinement of the Initial Programme Theories emergent throughout Chapter Three, as the iterative process of developing middle range theories and sense checking them with stakeholders and an expert group unfolds.

It also covers how the methodology had to flex and utilise new methods to still progress the core methodology of the research whilst ensuring safety of all the participants (programme recipients, deliverers, stakeholders, and the research team).

The purpose of the Initial General Working Theory is for it to be used as a ‘tracer issue’ within Community Health Development Project workshops to give a frame of understanding, what to listen to, and be aware of in the description by participants on what makes ‘good community health development. This part of the process does need great care on the part of the researcher to be open and sensitive to the tracer issues, but not too devoted to it, in order to avoid only looking for those issues and miss important elements of programme theories not already captured through other processes.

Therefore, a delicate balance is required to ensure heightened sensitivity to what may be presented by participants, without being blinkered by potential elements already recognised (Mirzoev et al., 2020).

Lockdown made this phase of the research, as originally planned and presented, undeliverable as interviews, teach back sessions, and project

observations could not now be undertaken in person, and those programmes still running had to radically change how they were operating.

Above and beyond these, the nature of community health development itself also appeared to be changing radically in the projects as they reacted to the fundamental shifts in societal conditions, and the fact that everyone inside and outside projects was being prompted to reconsider their perspectives and attitudes towards their own health and wellbeing. Whilst this centred upon the prevention of Covid 19 transmission, it had consequences for all aspects of health and wellbeing.

- Projects had to shift and operate online and at distance from communities.
- It was observed that due to restriction of statutory services ways of operating there was a consequential increased interest and commissioning from councils and Social Care organisations in what the projects were able to do to fill the vacuum left from state retrenchment.
- Whilst support and resources followed. so did an increase in control and expectations by local and national government in some projects, whilst in others the reverse was true, and projects suddenly saw a lessening of expectations.
- New partners also started to get involved in programme delivery (for example businesses such as restaurants that could not operate flexed and became part of food hub development).

The additional purpose for this phase therefore, over and above that intended in the original research plan, is to understand if each of these new major shifts in conditions brought alongside the pandemic represent (or led to) changes in context and if in turn those changes in context made a significant impact on both the mechanisms and outcomes of programmes.

Although the research activities originally planned were curtailed, it was still possible to engage and observe those case studies that still operated due to

their harnessing of digital communication technologies. The research itself could therefore be maintained using similar technologies.

- Video conferencing.
- Webinars to deliver “teach back sessions”.
- Online collaboration tools to explore outcomes.

Using virtual platforms, only minor alterations to the research methods were required so that they could be safely undertaken within social distancing guidelines. Hence, workshops with stakeholders were now organised using Zoom as a platform. This had the benefit of being recordable so that transcriptions of the discussion could be made with the participants authorisation.

In fact, the main methods for this stage of research remained constant, only the platform for delivery of it changed.

The chapter begins by explaining briefly the methodology used for teaching back sessions, how the methodology flexed to also capture learning from the impact of covid 19 on community programmes, and then reports upon how each of the four initial programme theories were refined to form the basis of the final programme theories to be presented fully in Chapter Five.

It also covers the relationship of programme theories to substantive theories, the programme theories alterations due to the pandemic and societal lockdown measures, and it suggests an overarching programme theory and model for community health development from a realist perspective.

4.2. Community Health Development Project (Soft Systems) Workshops

These workshops were undertaken just prior to lockdown so, as per the original plan, they were conducted face to face, although follow up questions to key Community Health Development Project stakeholders to check out the details had been recorded correctly were undertaken virtually soon after lockdown.

4.2.1. Community Health Development Project Selection

. For this research there were existing set parameters in the industry partner, Betsi Cadwalladr Health Board, through its Well North Wales Programme which required the projects to be selected for study to be within its North Wales footprint and ones they had existing resource input to through attached staff or part funding.

The meaning of selecting from that set of programmes was not necessarily to achieve a balance of different types of case, or achieve comparison between them for any particular aspects, as Pawson and Tilley (1997) remind us that "*the objective of realist enquiry is to explain social regularities*", the selected projects only need to be able to be investigated to reveal those internal regularities, any relevance to them as a set of contrasting "case studies" was confined to whether, by having different types of communities (range of common participant characteristics and interests/places) and range of types of programme (different community health development 'traditions'), may reveal common regularities across them, irrespective of programme differences.

From a range of 12 possible identified community health development programmes that the Health Board part funded or supported directly in some way, four were selected that fit the criteria of:

1) Demonstrating different types of health and wellbeing issues focussed upon;
2) Range of participants to reflect age, gender, social circumstance; range of stakeholders engaged;
3) Geographical spread across the Health Board footprint;
4) Maturity of the community health development programme.

Using these main criteria, the supervision team including the Health Board's representative, selected the following Projects for inclusion in the research.

Figure 4.1: Four Programmes across North Wales in Community Health Development

Seiriol Project, Ynys Mon

This Seiriol Building Communities programme **has** grown from initial work begun in 2013.

An event was held in January 2014 at Beaumaris Primary School, at which community members came to express their thoughts and opinions about what was important to them.

The event started with presentations that provided the context in which a process of community asset mapping and engagement was taking place, and then asked community members to record their views, ideas, and questions on post-it notes and on large sheets of paper on the tables.

These resulted in visual ‘maps’ of the ward’s current assets, gaps that needed to be filled, and priorities for the future. Following the initial event, participants were asked whether they would like to stay involved in the process by putting their names forward to become part of a reference group (community members). The steering group (officers) would then collate all the information and feed back to everyone who attended and organise the first reference group meeting mid-March.

The process from the initial idea highlighted the will from the community, third, and public sectors to work together and has provided a sound basis from which to continue the discussion. It also highlighted the level of resources and assets that are already available and being used by the communities. From these beginnings grew a strong community partnership that, over time, began to control a devolved council budget for the area and then on to taking ownership and management for key community facilities.

Seiriol, whilst primarily being a placed based project, also reflects the driving need to tackle loneliness and isolation in an area whose physical environment is dominated by a tourist industry that has significantly affected the civic and retail infrastructure in a negative manner for people who live in the area all year round.

Wrexham Homelessness Project

The Community Care Collaborative (CCC), led by a local GP, established the Wrexham Homeless Hub in 2017. The Hub, delivered in partnership with the Salvation Army and the Association of Voluntary Organisations in Wrexham (AVOW), helped over seventy-five people every week at the point that they were engaged in the research. Between 1st January 2018, and 28 January 2019 it received 1,847 client visits.

The Hub uses an ‘Everyone in the Room’ approach - bringing together many agencies to wrap information and support around the service user, rather than business as usual, which means they spend inordinate amounts of time navigating their way around service to service, attempting to gain access through varied and different gateway processes.

This results in enabling homeless people to access services in one room, once a week. On average, twenty-four different agencies attend. This method means problems are resolved and queries are answered much faster. It also prevents people from being consistently redirected, unable to get the help they need when they need it. The agencies attending regularly include the BCUHB mental health team, Job Centre Plus, Wrexham Council Housing Department, and homelessness charities.

The individuals attending the hub whilst mainly attending due to issues around homelessness, have a range of multiple and complex needs and a main aim of the hub is to help them take control of their lives and to reduce demand on services be addressing need as a whole, not just the presenting issue of shelter.

Youth Shedz Denbighshire

The Youth Shedz project is a unique initiative that provides a safe place for young people to explore who they are, to develop pro-social relationships with suitable role models, and develop and learn new skills. The first Youth Shedz project started in Denbigh and has an ambitious vision that every town in Wales will eventually have their own project, hence is not only a programme, but part of an eventual movement, if they are successful.

At its core is a belief that young people need to be listened to, encouraged (and challenged!) and that through providing them with a 'space' wider communities will meet them where they are at in their lives and “walk with them” into a brighter future.

Services and a range of people in the community provide their time and skill set to work with young people. and the Youth Shedz provides a place for those opportunities to take place.

The young people who developed the Denbigh Youth Shedz model established core principles for involvement in the project which have become totemic in the programme:

- *We beg, we borrow, but we do not steal.*
- *Everybody matters – everybody is valued.*
- *There has to be give and take, it's not a one-way street.*
- *We live for the moment, but we plan for tomorrow.*
- *We accept and we are accepted.*
- *We create a safe and secure space where people can turn to.*
- *We leave a legacy for other young people to be a part of.*
- *We serve our community not just ourselves.*
- *We might not have skills – but we will learn the skills we need.*
- *We eat together, we BE together.*
- *We enjoy the journey together, the highs and the lows.*

(Youth Shedz, 2022b)

The core of the Youth Shedz initiative is its aim to provide a safe place for young people to proactively engage and develop new skills. In January 2017, a youth worker/facilitator was commissioned by a housing provider (Grwp Cynefin) to work with a group of young people from Yr Hafod, a supported housing project for young people aged between 16-24. Always looking for an opportunity to promote activity based, experiential learning, the facilitator challenged the group of young people to come up with a solution for anti-social behaviour and lack of engagement amongst young people. The first step was for the youngsters to reflect on their own lives in the town of Denbigh and research into anti-social behaviour, the costs to society, and the contributing factors.

As a result of this research, the young people came up with the concept that they needed a space to positively engage in something productive, a place to be listened to and a place to learn new skills in an environment surrounded by positive role models. The seed was sown, and the Youth Shedz project was born, the first of its kind in Wales.

From the very beginning the young people have been at the centre of the project, ensuring ground-up co-production resulting in a young person's project that is created, developed, and ultimately run by the young people themselves. It provides training and education plus volunteering opportunities, and the space is being used to develop a range of practical projects from woodwork, furniture restoration, jewellery, to bike repair.

The project was at a stage (at the point of interacting with this research) where they aimed to develop the young people further so that they become the future project workers that will create the change in other communities to become Youth Shedz projects.

The Holway Estate, Flintshire

The Holway estate is situated on the outskirts of Holywell in Flintshire. There are 406 houses on the Holway, around half of which are privately owned and separated from the social housing side of the estate by a road which runs from the top to the bottom of the of the steep hill upon which the Holway is situated. This road is the only access point for the estate and contributes to the feeling of insularity and isolation which the Holway has from the wider Holywell community around them. Most of the social housing is council owned, with around ten properties owned by Clwyd Alyn housing association.

Public services have been heavily involved with the Holway for several decades, and residents have experienced investment in many forms previously via Communities First and other community programmes. It is well recognised as an area of deprivation with wide ranging social problems affecting the people who live there, although standard statistics at ward level do not represent the situation on the Holway as they are skewed by the more affluent areas which border directly onto the estate. Problems are now multi-generational and public sector partners recognise two things:

1. *that the demand on their services from the Holway estate is a disproportionate drain on their resources; and*

2. *a different approach is needed to change the feel of the estate, make it a nicer place to live, and give the residents and their children the opportunity for life to be different in the future.*

(Flintshire County Council, Social Services Annual Report, 2019)

When Flintshire were preparing their first Wellbeing plan for their Public Services Board 2017-23, they identified Community Resilience as a key priority. Within that, a small number of area-based projects were identified, including the Holway. The objective was to work collaboratively with partners (30 statutory and third sector partners are actively involved with the project on an ongoing basis) and the community to develop a community-owned plan which would set out for partners how they needed to flex their services and the way they delivered them, to meet the needs that mattered most to residents.

Community leaders were identified and work directly with a project team to define the roadmap and set direction. These members of the community are encouraged and facilitated, taking responsibility for the organization of weekly play sessions, which are attracting up to 80 people each week. A Holiday Hunger programme was also set up over the summer to support these sessions and provide free breakfasts.

Across the workstreams are elements of social prescribing, asset-based working, and more traditional community development activities aiming to disrupt some of the social determinants of health that are recognised as existing for generations and getting worse, not better.

- Investing in properties to give residents nicer homes to live in (17 homes in phase 1 to May 2019).
- Clearing and tidying gardens and public areas to make the community cleaner and nicer to live in.
- Installing recycling units to remove excess rubbish which overflows into gardens and streets.

- Securing money to improve paths between the Holway and Holywell to make it easier and safer for people to be active and walk into town.

Hence, as a whole the Holway Project covers three types of overlapping community programmes.

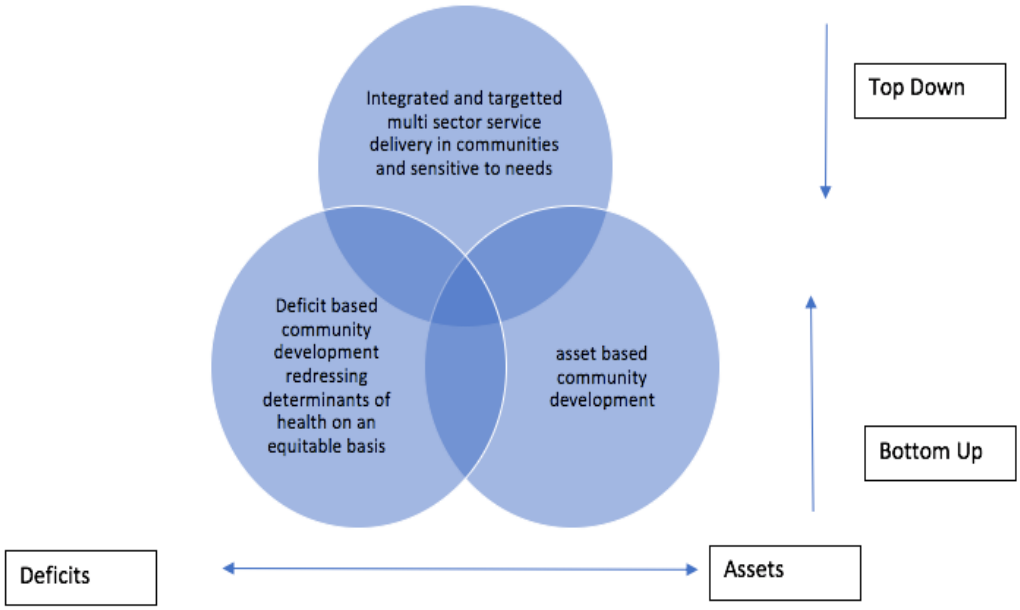


Figure 4.2: Overlapping Programmes in The Holway

Across all four of these projects studied the workshop attendance and active participation was achieved through an eagerness shown by project workers to capture some learning of their own successes and possible failures. They led with enthusiasm recruitment of colleagues and project recipients. Involvement was hence achieved across the full range of potential stakeholder groups – participant/end users of the programme, workers and volunteers who delivered the programme, managers and commissioners of programmes, and any organisation or professionals associated closely with the programmes.

4.2.2. Community Health Development Project Methodology

Having already undertaken a high-level review of extant literature to understand how evidence-based community health development may be designed and operate, and having followed this with a series of concept

testing workshops, the Projects themselves provided an opportunity to begin to narrow the focus upon building initial programme theories and, through stakeholder interviews, non-participation observation, and documentation review, be able to tease out the underpinning contexts, mechanisms and outcomes of each programme.

Soft Systems Methodologies (SSM) (Checkland, 1981) were harnessed as the approach to facilitate this as it is complementary to the realist paradigm, accounting for multiple perspectives when developing the Initial Programme Theories (IPTs).

The approach offers an interpretive perspective of the complex and adaptive nature of human systems within the 'real world' (Lane & Oliva, 1998).

It is an approach that, reminiscent of realist evaluation itself, explores the relationships among system components and the interactions of the system with its environment to produce a given set of outcomes. This mirrors the mechanism dynamic relationship with context to drive outcomes.

SSM recognises systems are dynamic entities and are constantly subject to various forces and reacting to feedback and challenges. Some of those forces result in system stability whilst others are de-stabilizing.

System dynamics modelling is used in this way to help understand the behaviour of systems over time, identify the driving variables so that system behaviour may be positively impacted, and predict future states.

The approach is facilitated using a particular set of questions to ask of those in or affected by the system; Checkland sets these out with the mnemonic "CATWOE":

- Customers
- Actors
- Transformations
- World Views
- Ownership

- Environment

Using CATWOE as a frame for discussions with stakeholders in a Project enables the researcher to “make explicit a variety of stakeholder perspectives separately and understand their implications” (Dalkin et al., 2018).

This is useful when building understanding across different case studies as the range of perspectives within and across cases are at least structured and can provided a rigour to how the perspectives are recognised and understood. (Checkland & Scholes, 1990)

To complement the use of CATWOE with Community Health Development Project stakeholders, each session also utilised the technique of joint production of “rich pictures”. A rich picture in qualitative research is:

> “*… a pictorial representation of a particular situation, including what happened, who was involved, how people felt, how people acted, how people behaved, and what external pressures were present. Rich pictures may be artistic diagrams or stick-figure diagrams. They are intended to show features of interest and the interactions between them according to the perspective of the drawer*”.
>
> (Cristancho, & Helich, 2019, p. 1)

The value of the rich picture, jointly constructed through discussion and drawn by participants themselves, is that they are enabled to ‘stand back’ and see their own picture and, in doing so, gain new perspective on what it is they think and value about the thing they are jointly discussing. This viewing back enables recognition of things they may have initially missed or the significance of may have been downplayed. They can be used to help people share and express things that are meaningful but hard to express in words.

Rich pictures can reveal a host of personal meanings and the challenge for the researcher is to work through conversation with participants about their

pictures, to interpret them, and bring salient points to the surface. The value of this is that it enables the researcher to encourage a holistic, rather than reductionist, exploration of an issue which can be the result in simply working through a list of research questions.

> *"… the value of the rich pictures doesn't lie in depicting everything in a situation but in gaining understanding of what a person sees happening in a situation. The quality of a drawing is irrelevant. What is relevant is the articulation of all that is perceived as problematic or significant: emotions, thoughts, and actions, as well as relationships of various sorts*".
>
> (Christancho & Helich, 2019, p. 918)

Rich pictures and CATWOE (table 4.2) are complementary processes within SSM, and they bring out in conversations a rounded perspective on how things are and the way things happen, which provides the researcher with great potential insight into context and mechanisms.

4.2.3. Community Health Development Project Workshop Participants (By Role or Responsibility)

Table 4.1: Community Health Development Project Participants

Wrexham **23 participants** **22/02/19**	**The Holway** **19 participants** **18/01/19**	**Youth Shedz, Denbigh** **9 participants** **7/12/15**	**Seiriol, Ynys Mon** **21 participants** **18/12/18**
Police Officer, Counsellor, Interior Designer, Shelter, BCUHB Drugs Outreach, GP, Social Worker, Citizens Advice Bureau, Community Mental Health Worker, Volunteers (5), Programme Participants (6), Community Drugs Team,	PCSOs (2), County Councillor, Play Team (Sports Development) Social Worker, Youth Worker, Housing Association, Community Development Workers (3), Local Residents (4) Volunteers (5)	Youth Worker, Housing Association Community Development Worker, Programme Workers (2 now volunteering after being involved as participants), Participants (5)	GP, Medrwn Mon Officers (CVS) (3) Volunteers (4) Participants in Projects (6) Community Development workers (2) Adult Social Services Children's Services Local and County Councillors (3)

In each workshop the selection of participants was mainly determined by the Projects themselves with the parameters that the research required a broad mix of who would represent the usual/normal operation of the Project, and every participant was to take part freely and knowledgeably in that they were

given full details of what the research was for, what it entailed and the workshop processes to be used. Signatures of assent to be involved in the workshops were then obtained.

The ‘broad mix’ in practice meant that project participants/service users/clients were the main group in each workshop, along with project workers and managers, and a third grouping was commissioners of Projects or key stakeholders from those commissioning services (such as elected members).

The varying numbers of participants across Project workshops reflects the relative size of each Project, but also its complexity brought about by number of stakeholders involved in it rather than numbers of service users in each project, as in effect this was fairly constant across the Project workshops.

4.2.4. SSM Workshop Outputs

The specific questions participants were asked to discuss in groups and write down their reactions to on flipcharts were:

Table 4.2 CATWOE Headings

Customers	**Who are the beneficiaries of community health development?**
Actors	Who is necessarily involved in community health development
Transformations	What changes and adjustments to the usual way of s of working/living/community life must be taken for effective community health development to result?

World View	What are the underlying conditions, culture and challenges for community health development?
Ownership	What factors affect people engaging in the programme?
Environment	What factors around the programme constrain or support it?

The simple focussed question that small groups of stakeholders were then asked to discuss and draw their rich pictures around was:

“What is good Community Health Development within your Programme/project?”

The collated results of CATWOE and rich pictures, plus transcript of participant descriptions of their visual narratives is appended in Appendix 3 “Soft Systems and Rich Picture Community Health Development Project Workshops”, the main points from each of these follows:

4.2.4.1. Seiriol CATWOE and Rich Picture

Twenty-one participants, including one project beneficiary from the men in sheds project and various workers (current and retired), with a wide range of community development experience.

Introduction to the workshop and its position in the research process was given by way of slide deck, and questions were few, but were fully responded to.

1) Rich picture and feedback

“What would make a good/successful project?”

Figure 4.3: Seiriol Rich Picture 1

Key ideas:

- Conflict between truly bottom up and who defines the initial need or asset.
- What matters conversation is a key process.
- Changing dynamic between third and public sector.
- New acts are having a distinct impact on changing that dynamic.
- Informal processes more effective than formal project management tools and measurement – the power of a good story.

Group Two

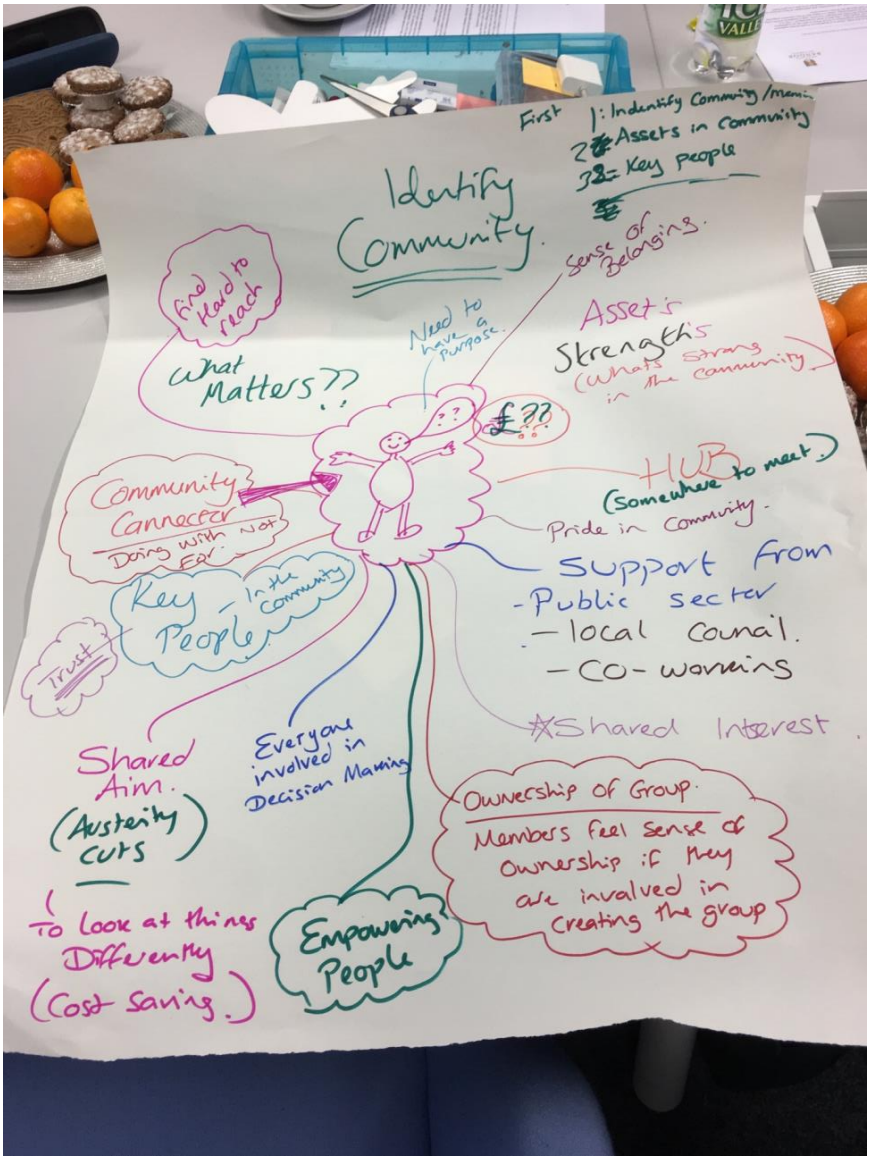


Figure 4.4: Seiriol Rich Picture 2

Key ideas:

- People skills are crucial in community connectors.
- Now a new environment in which bottom-up working has a chance of being supported.
- What matters conversations a real facilitator.
- Everyone involved in decisions making.
- Community ownership.

4.2.4.2. Wrexham Homelessness CATWOE and Rich Picture

Twenty-three participants from across a range of agencies and programme recipients themselves, all stakeholders had been actively involved in the programme for several months.

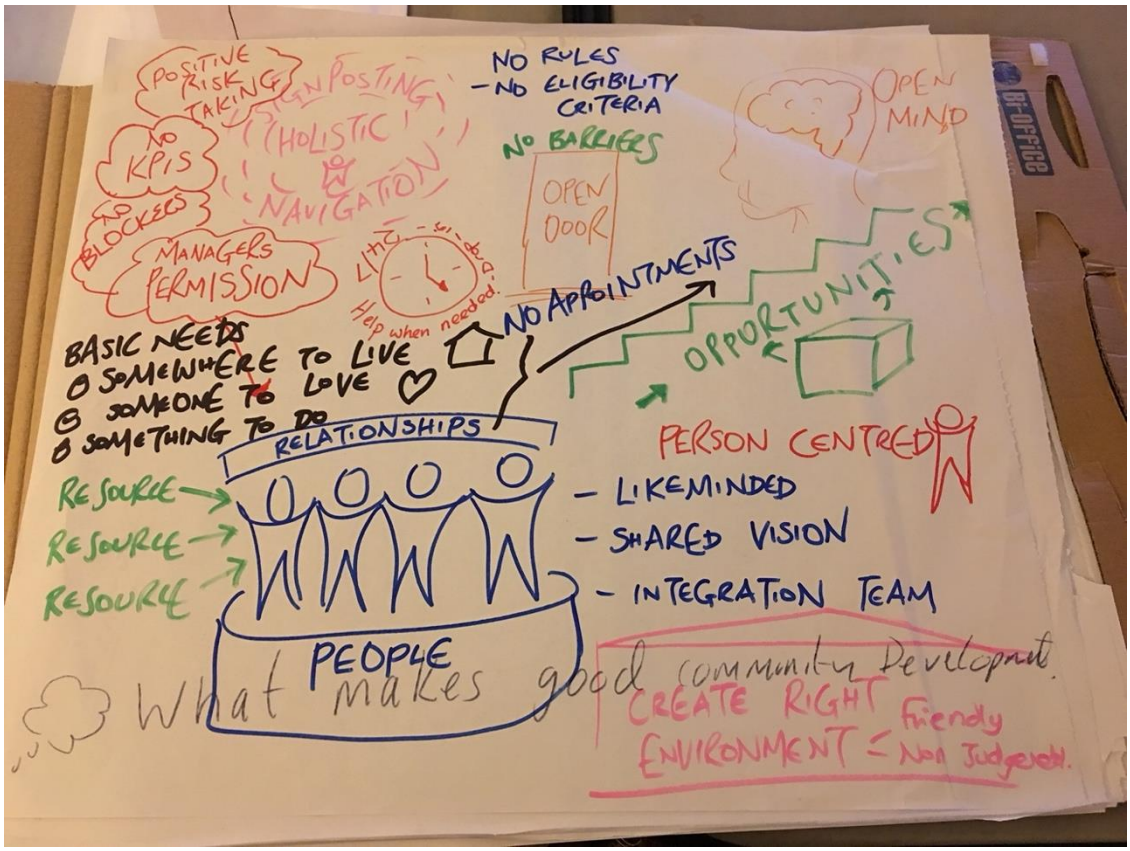


Figure 4.5: Wrexham Rich Picture

Key issues:

- Permission from organisations to work more holistically.
- Deliver each other's outcomes.
- Non-judgemental approach to people on the streets.
- Acting beyond authority and certainly outside professional role.
- It's about the people who get involved.
- Not about the range of skills, its mainly about their attitudes, and about their values and qualities as human beings.
- Essentially, they must be person centred.
- But they also must be able to work in a wider team with a shared perspective.
- A space is needed for people to be, which has the right environment where people can be supported, and it must be non-judgemental.
- Workers and organisations must be open minded and not bound by corporate objectives.
- Timing of interventions is crucial and giving people time.
- Small steps are important – in the Maslow sense, building when needs are met, but also that tiny steps and giving people feedback about their progress is important.
- A key issue was having an open-door policy and reducing organisational barriers.
- Linked to this is the joint approach in removing or ignoring silo working and KPIs.
- Bridging between the chaos around a person and the pathways into help – clarifying and empowering – belief from fatalism.

4.2.4.3. Youth Shedz Denbigh CATWOE and Rich Picture

Stakeholder Workshop One: Youth Shedz, Denbigh, 7 December 2018

Nine participants, including one Youth Co-ordinator/Educator and 5 young people over the age of 18.

The project is for young people aged 14-24 and is gaining national recognition, plus stimulating other areas to develop their own models, and forming a network of Youth Shedz projects.

It has been running 22 months.

The individual stories of the young people involved include a number who were subject to numerous ACES, including as a child buying heroin for a parent regularly and being involved in multiple statutory services throughout childhood and adolescence, the same young person has now undertaken school visits delivering education sessions for young people on drugs, has spoken of the community project in national conferences, and is working towards university study for a degree.

The Logo itself says a lot about the project as it was co designed between the young people and an artist, and it embodies all the main values of the project.

Rich picture and feedback

Figure 4.6: Youth Shedz Rich Picture

Key ideas:

- The original idea came about by sitting together eating pizza.
- Now we have pizza in every session and have that communication and speak to each other face to face (It's our trademark).
- Pizza has helped us to empathise (through listening) and it's also been an equaliser – brings everyone onto a level with each other – also has enabled more honest conversations.
- Acting Together.
- House – Home.
- Space (to do things, safe space, space to develop – given by Grwp Cynefin not restricting it to plans and outcomes).
- Inspiring innovation, ideas, and opportunities.
- Communities within communities.
- Changing perceptions (e.g., Tagging). Building understanding of this community.
- Inspiring others and raising Aspirations.
- Building confidence – empowerment.
- Empathising within and with community outside.
- Commitment.
- Bottom (ground) up.
- Doing things differently – not about plans – doing things differently.
- Developing trust and solidarity.

The biggest discussion that came through this was the pride expressed and demonstrated by participants as they explained the design process and result of the Youth Shedz logo. It had crystallised a lot of these key ideas within its design.

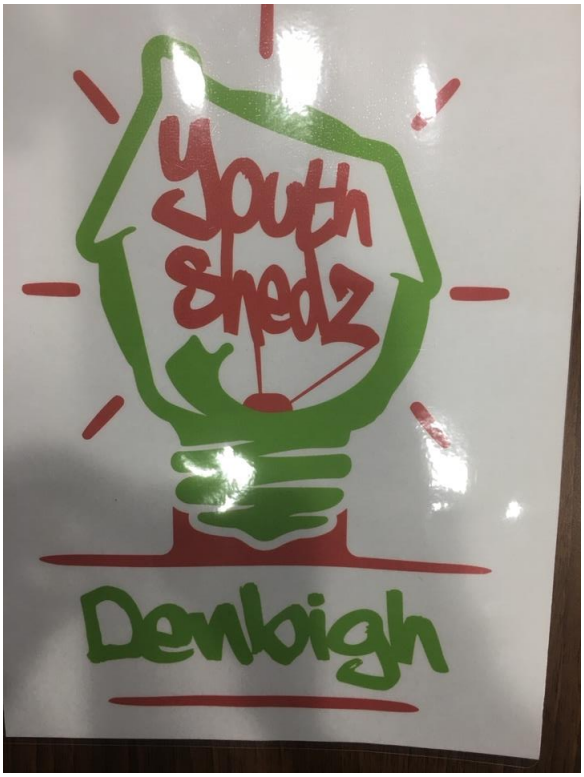


Figure 4.7: Youth Shedz Logo Incorporating Key Principles

Grwp Cynefin (the main commissioner) had previously brought in a graphic artist to work with the young people and had asked each person one word that Youth Shedz meant to them. This resulted in a chain of connected concepts:

"community/identity/safety/home/family/inspiration/ideas/creativity"

Each person had then drawn a picture of that word (like hand or home) which was then worked up into a draft logo. One of the members was prolific in 'tagging' and street art. She was asked to design the centre piece artwork. Elements of the Logo that are felt to be the most important by the young people are at the core of the programme and are therefore central to the logo:

- Light Bulb as a symbol for creativity and ideas.
- House, Home, Safety, security.
- The arm is about bringing people in, being a part of it, from the community – and "*doing stuff for the community and what not*".

- Tree for foundations and growth – acting from the ground up and out.
- The lines out are both inspiration and represent different Youth Shedz in other areas that are developing.
- Male and female symbols – It doesn't matter who we are – we are all accepted – inclusion and equality!

3.2.4.4. The Holway CATWOE and Rich Picture

The Holway Stakeholder Workshop: held 18 January 2019

The Holway is a recognised place-based community within Holywell, Flintshire. It consists of approximately 400 households.

It is a place of multiple challenges and high on the agenda of all public sector agencies, plus has a range of third sector input across all age ranges and wellbeing issues.

Community development programmes have been run on the estate since the early 1980s.

Participants in the workshop represented local authority departments, health, police, third sector, and independent consultants who are providing local input. One participant is also a resident of the estate, although was attending because of her job role.

Features of the community that were deemed to be important right at the start of the workshop by several participants were that there are 'criminal elements' at the heart of the housing estate who have a disproportionate impact on the rest of the community and, equally, some key families that have been in the community over numerous generations. It was also expressed strongly that the attention of public sector organisations is also disproportionately dealing with the impact these families have.

In addition to these specified communities, there are also the needs and potential assets of transient communities to consider.

Rich picture and feedback Group One

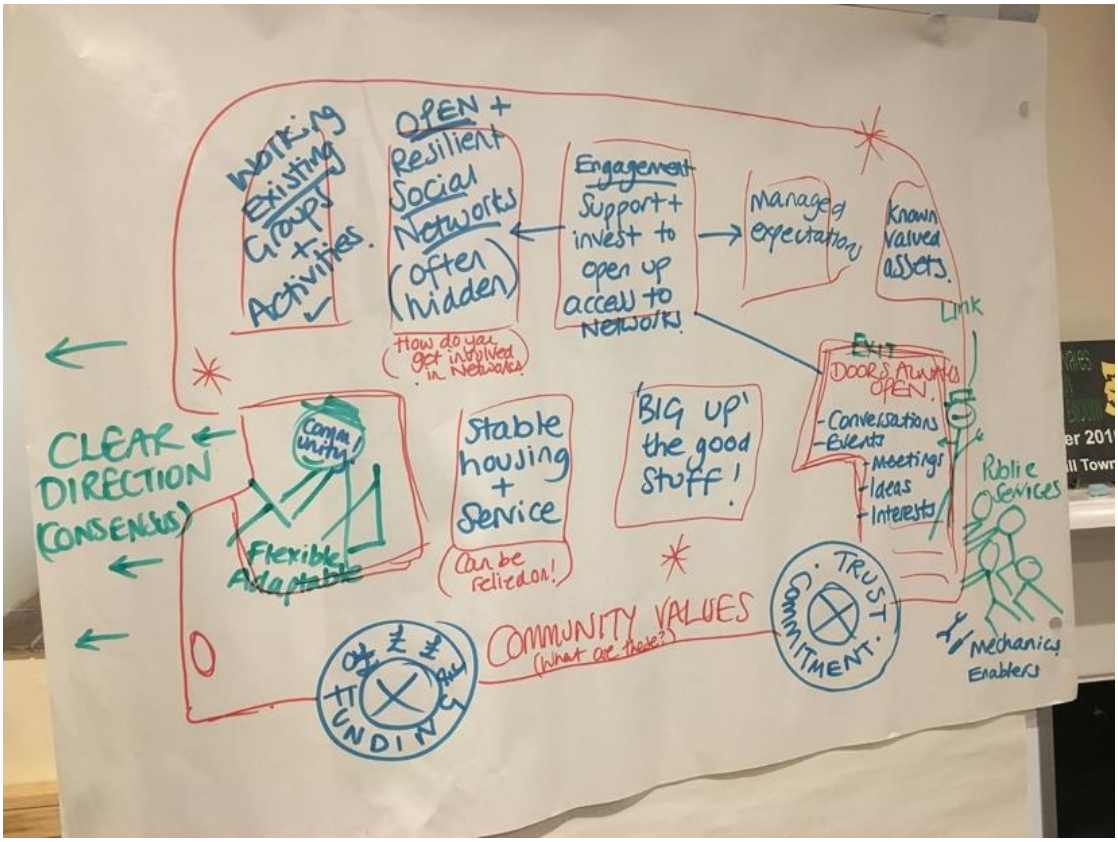


Figure 4.8: The Holway Rich Picture 1

Key Ideas:

- We needed some idea to organise our thoughts about how to represent the community, so this is it – it's a bus!
- It's a symbol that represents the challenge and the task ahead.
- It means the community driving change itself with public sector supporting/fixing/repairing to assist with the progress.
- Wheels to ease the progress are finance and trust/commitment (in equal measure).
- Both of which can stop the journey if they get punctured.
- Move towards assets approach and focus on what's strong not what's wrong.
- Create opportunities and networks.

- Key community empowerment is in creating flexible/adaptable skill set.
- Need to establish what the communities own value system is.

Rich picture and feedback (audio recorded) Group Two

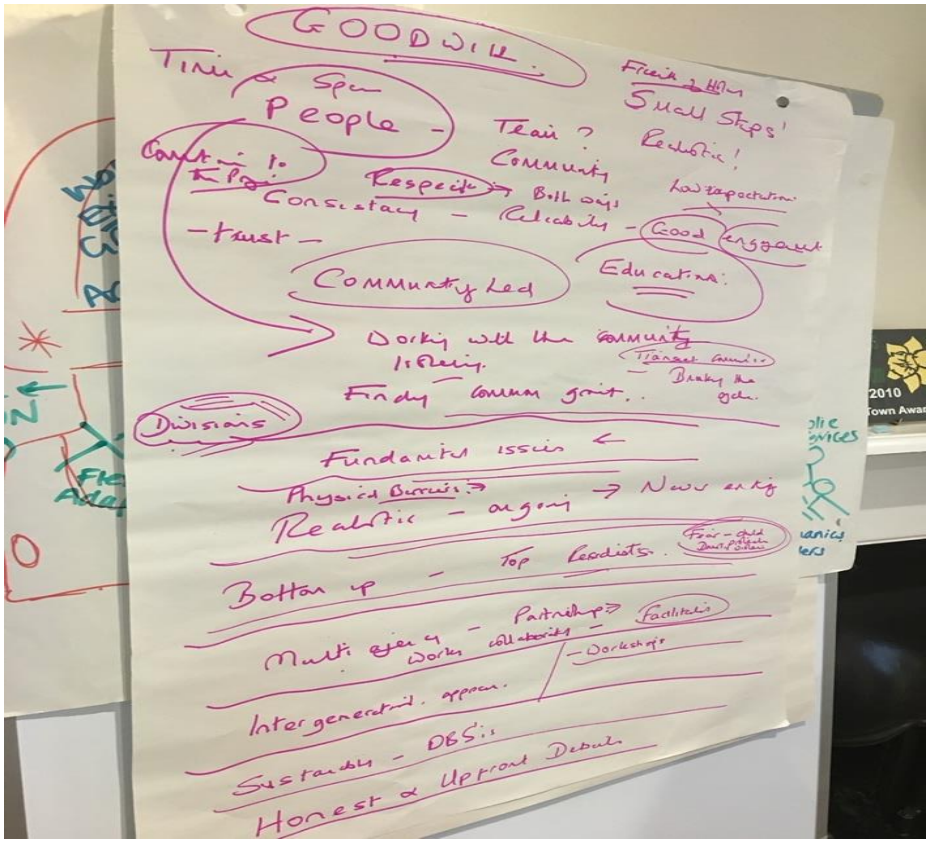


Figure 4.9: The Holway Rich Picture 2

Key Ideas:

- Even if you are a paid Officer, you don't get anywhere working with the community without good will – you've got to have that – you need to want to be there, you are interested, you can't be tokenistic, if you haven't anything to give, nothing to bring to the table, don't come, don't get involved from the start, don't do it.
- Very small steps are required.
- Don't raise expectations and then not act. That's what's happened here for thirty or forty years, don't do it.

- The challenge is how to get the residents to do the bottom-up bit aligned with the top-down bit.
- There is something about the Holway that is having a significant impact upon all public services in Flintshire – we all have an incentive to be here because there is a drain on your resource or service, or you recognise there are significant problems in this community that need to be solved BUT this work has been going on since the 1980s so, despite the fact we have been doing all this, something is still not quite hitting the mark.
- it is about how we use community development to help build the trust, relationships, to facilitate that, help them gain the ability to drive it themselves, but then also how the services can listen to what comes out of the community development work and say actually 'if these are the big problems coming out of this community, how can we deliver services differently, that you feel will be more helpful to you than previously'.

Rich picture and feedback Group Three

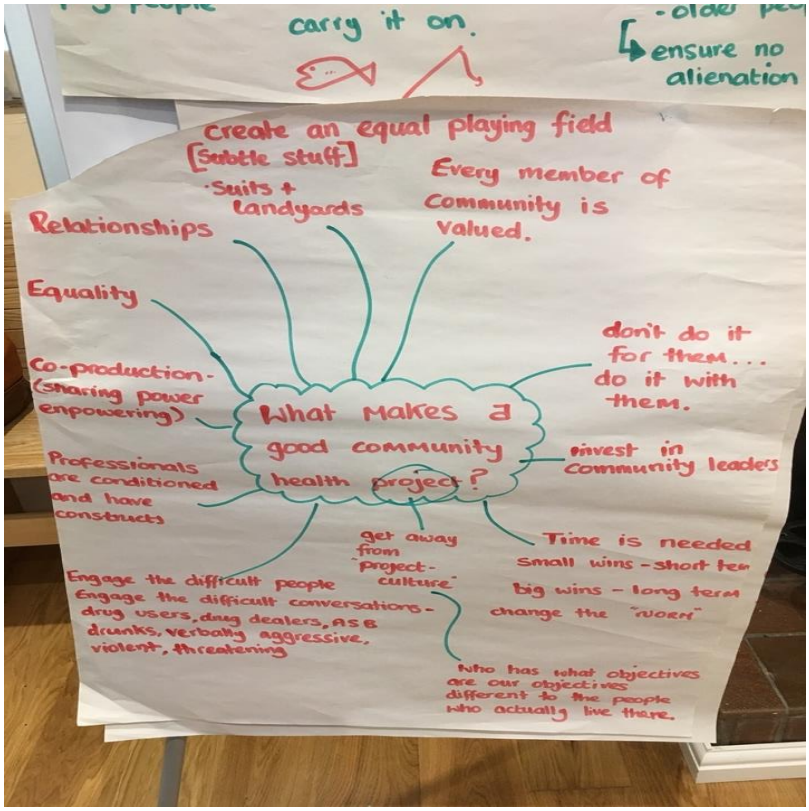


Figure 4.10: The Holway Rich Picture 3

Key Ideas:

- Give a man a fish, feed him for today, teach a man to fish, feed himself into the future – build in sustainability and build skills/empowerment.
- Remove professional distance, community barriers and hierarchy.
- Value each and every member of communities – equity and recognition.
- Basically, everything is here in words, but our vision is holding our hands outwards and trying to bring everyone together – so like 'stickle bricks' – attaching people together and we are looking for some small wins.
- Being realistic and not promising the world, because the small wins will breed confidence in the community that what we want to do from an expectation point of view.
- We need to invest in community leaders – that's the biggest thing. We need to change the norm – the norm being that we go in and do things **for** but that has to change, we need to flip that over to really facilitate and not do, we need to find facilitators for community leadership – to empower and to give confidence – if they are going to pick up the challenge of leadership, to make a difference and drive, we need to give them confidence that they can do that and they can make those relationships.
- And we need to ensure every member of that community is valid and they are valued community member, no matter what their background is or what trouble they may have caused, they all bring worth, and they are all valued.

Discussions between participants as they worked through the CATWOE exercise revealed three main positions held on community development for the Holway, some individuals holding more than one at once:

- Deficit based community development as bottom up (community) driven change.

- Asset based community development focussing on what's strong not wrong and empowering change building in what is already good.
- Joined up provision co-ordinating services with a shared perspective of the communities in Holway and integrated programme delivery to build wellbeing (involving communities in co-production).

4.3. Programme Theories Emerging from an Initial General Working Theory

Four potential programme theories, even though not yet fully formed or described, began to emerge from this initial Community Health Development Project engagement phase of the research.

The roughly drawn Initial Programme Theories are:

- **Space:** A place to be and to be me!
- **Identity:** A journey from 'me' to 'us' to 'ours'.
- **Coherence:** Building a personal understanding of challenges, the value and meaning of change, and a consequent belief in an outcome.
- **Reframing:** From what's wrong to what's strong.

The process that was used to build on the two main realist lenses utilised up to this point (capturing insight from a realist review of literature alongside insight from unpacking project participants' understanding of their experience) is as laid out below.

Each of these initial Programme Theories emerged from the way that programme's participants talked about the rich pictures they drew and the ideas that they had added to flipcharts under the CATWOE headings. These discussions had been recorded and then transcribed, the researchers coding any clusters of ideas, concepts, issues that were either frequently mentioned or strongly expressed as important.

Tables were produced to lay out these codes as they appeared to relate to the four emerging theory areas and whether they seemed to be mainly

connected to ideas about the person making the intervention, the people receiving the intervention (programme participants), or if they related to ideas about the intervention (programme architecture) itself or the organisational conditions within which each programme operates.

The 'codes' (outlined at high level in figure 4.11) used were developed from the literature and consisted as the most strongly supported concepts and those most often cited across papers as important in community health development.

These were linked in the table to the original reference they came from and to quotes from the workshops (verbal or written on flipcharts that seemed to be associated with each concept or 'code'.

The literature collated from searching and concept mapping was then reviewed again to find any further evidence to support each of the codes. The table here is an illustration of a much larger coding table that included 38 separate codes across the four working theories.

Code	References	Programme Participant's quotes	Working theory
Coproduction	Bovaird, 2007 Boyle et al., 2006 Cahn, 2000 Coote, 2002 Neeham and Carr ,2009 Realpe and Wallace, 2010 Wallace et al., 2010	At first people don't have the confidence to do it for themselves - **balance giving them support but no point doing things for them because by having a go and doing it themselves they learn by experience and build up their knowledge of support available**	C17 R13
Empowerment	Berry et al., 2014 Ersing, 2003 Thane, 2011 World Health Organisation, 2020	Shedz **helped me work out who I am and accepts that my past shaped me, but I can change** It's about **building their knowledge and skills**	S2 I6 I8 I9 R11 R13 C21

		and recognising what is already strong in the community - what they already have.	
Asset building	Antonovsky, 1979 Burns, 2014 Blickem et al., 2018 Foot and Hopkins, 2010 Kretzmann, McKnight , 1996	There **need to be a problem to solve or an asset to build on that is recognised by the** community. We did the deficit and needs based things first and then came the more strengths-based approaches. **To make any community project you have to have community members and you must have an understanding of what assets are there** in a community – the key people – like you know the best people in your community, and what they are interested in.. you can't go in and ..say, let's do hang gliding if no one is interested in doing hang gliding part of getting to understand the assets is also knowing the needs - if you look at communities that aren't already really resilient you can't expect them to respond – it adds too much stress.	C18 R11 R13 R14

Figure 4.11: Extract of the Coding table to support Working Theories and connection to peer reviewed evidence and observations of the programmes.

Whilst not yet in any way expressed as values, principles, or theories – let alone, constructed at Context, mechanism or outcomes – these ideas did seem to naturally corral around key elements of programmes, in that programme interventions and the programme structure supporting interventions seem to be mainly about context, whereas codes about those intervening or receiving the intervention appeared to be more about mechanisms.

A further point of note at this stage was that these ideas, elements, and concepts important to the Community Health Development Project participants were scrutinised and edited to be only recognised as part of the emerging programme theory if they were supported in at least two of the four case studies, plus, they could be supported by evidence from the literature collated in earlier phases.

These tables list the important elements related to each of the four emerging programme theories.

It is important to note that whilst not yet expressed as CMO configurations this is the point of their genesis within the research. The stage where potential C, M and Os and how they may interrelate started to emerge, and that emergence came about through the processes of abduction and retroduction applied by the researcher in thinking around and beneath the concepts, and then continuing that iterative process in presenting the emerging findings to the supervision team.

Table 4.3: Potential Programme Theory – Space/Place

Potential Programme Theory	**Space: A place to be and to be me! -** **Providing a space for people to easily access that is welcoming and where they feel welcomed and accepted, supported to explore their health determinants**.			
	Intervention	interventionist	Recipient	Organisational or structural factor
Code Idea/element	A) Create a home. B) Safe Space C) Open access space D) Place for conversation E) Non-threatening environment F) 'Everyone in the room' approach, wrapping services around people holistically	G) Develop a common non-threatening focus around which to bond (e.g., *pizza*) H) Non – judgmental acceptance of all I) Recognise professional and community boundaries/barriers	J) Confidence in self K) Tell their own stories.	L) Revolving open-door policy with reduced organisational barrier M) Relax demand for specific goals and outcomes.

Evidence from Case Studies **Links to quotes in transcripts**	A) 7 14 B) 9 80 C) 15 20 46 47 D) 16 48 49 E) 36 F) 53	A) 16 36 B) 51 75 83 52	A) 4 43	A) 13 14 B) 21 22
Evidence from Literature	Men's Shed Case Study June 2019 Compressing the Atom case Study (Blog)			Chappell et al 2006 Dale et al 2008 Neighbourhood Carers Soham Whitley Case Studies NCVO
Purposive Search: **Providing Safe Space**	**Space to explore personal ideas on wellbeing.** **Providing a place where people feel safe and able to express themselves and explore what wellbeing means to them**		Related Key words: place-based approach/place making/safe space/milieu/habitat/human ecology/ecological approach. Related ideas: Cynefin/Navajo health/Bao/Aboriginal	

Table 4.4: Potential Programme Theory – Identity

Potential Programme Theory	**Identity: A journey from 'me' to 'us' to 'ours'** **A skilled facilitator supports personal reflections and builds bridges between people around common issues**.			
	Intervention	interventionist	Recipient	Organisational or structural factor
Code **Idea/element**	A) Development of personal and shared identity B) Develop a sense of pride and achievement	C) Skilled facilitator with caring approach D) Role model E) Community connector F) Passion to change wider perceptions in the wider community/society.	G) Sense of ownership H) Active involvement I) Open to examining self and identity J) Recognise wider 'other' communities and the boundaries between them	K) Openness to full community involvement L) inclusive – all are recognised and valued

Evidence from Case Studies **Links to quotes in transcripts**	A) 5 7 24 B) 24	A) 1 2 3 4 B) 8 C) 12	A) 10 5 7 25 26 42 B) 11 18 39 54 C) 12 17 23	12 19 20
Evidence from Literature	Wetherall et al., 2010 McMillan, 1986 Wilson, 2009 Phillips and Pitman, 2009 CD and Health Network, 2018 Australian Government, 2004	South et al., 2015 Silk, 1999 CDAS – How Community Development Happens	Brown R, 2000 Zeldin, 2004 Puddifoot, 2003	Arnstein S 1969 ABCD in Ayrshire Blog Watertown and Watson 2011 Gilchrist, Bowles et al 2010 Campbell et al., 2000

Purposive Search: **Building/affirming identities within communities**	○ **Helping people to explore their connection to where they live and gain a sense of home** ○ **Helping people to re-connect to their environments** ○ **Helping people to find a common purpose and ownership**	Related key words: responsibility, accountability and capacity, citizenship, stewardship, connecting, bonding, a movement, Related ideas: *Community Engagement, Communitarianism, Positive Regard, Social Identity Theory, Intimacy Development, Isolastalgia, Heritage and community engagement, Social Connectedness, Identities and social action*

Table 4.5: Potential Programme Theory – Reframing

Potential Programme Theory	**Reframing: From what's wrong to what's strong** **Individuals and communities are encouraged and supported to focus on their strengths and assets and adopt a more positive perspective to their wellbeing challenges.** **(Relates to ABCD, What Matters Conversations, Appreciative Enquiry)**			
	Intervention	interventionist	Recipient	Organisational or structural factor
Code Idea/element	A) Develop boundary spanner's B) Workers deliver each other's objectives alongside their own	C) Recognition that wellbeing is socially not individually constructed. D) Undertake "what matters" conversations. E) Jump onto opportunities outside usual focus. F) Recognise each other's roles around the person/community	G) Develop community leaders	H) Permission to act beyond traditional role boundaries. I) Recognition of business as usual needs to change. J) Joint agreement across partners on core priorities K) Narratives of change valued over specific outcomes
Evidence from Case Studies	A) 37 38 B) 39	A) 30 31 32 33 B) 34 C) 50 D) 60	A) 54	A) 21 22 28 29 30 B) 27 41 44 55 C) 40 D) 43 45

Links to quotes in transcripts				
Evidence from Literature	Assets in Action (Glasgow Population Health)	Corbyn, Gormally, 2018 McKnight and Russell, 2018		Mittlemark, Bull et al., 2013 Blickem et al., 2018 Kings Fund Lessons from the Wigan deal Mathie and Cunningham, 2003
Purposive Search: How does taking a what's strong rather than what's wrong approach work?	Taking a positive asset rich approach or perspective		Related key words: Social capital, social networks, Related ideas: 7 Capitals of community wealth, appreciative enquiry, reframing (NLP?), assets approach, ABCD, appreciative enquiry	

Table 4.6: Potential Programme Theory – Coherence

Potential Programme Theory	**Coherence: Building a personal understanding of challenges, the value and meaning of change, and a consequent belief in an outcome** **People are facilitated to untangle the challenges in their life, understanding the meaning in those challenges for themselves, and, encouraged to make proportionate and achievable action plans for change**.			
	Intervention	interventionist	Recipient	Organisational or structural factor
Code Idea/element	A) Create a person focused problem identification and owned solution – finding approach B) Wellbeing is broken down into understandable components	C) Use a what matters conversation approach. D) Client focussed E) Supportive facilitation F) Co-production of change G) Provide positive feedback and reinforcement. H) Set small goals	I) Encouraged to explore/tell their own stories J) Understand their own assets K) Motivated to change L) Co-production of change M) Set small goals	N) Support early help hub approach. O) Accept service user goal setting over and over organisational goals
Evidence from Case Studies Links to quotes in transcripts	A) 56 57	A) 58 64 65 66 68 70 B) 61 63 75 C) 6 7 68 D) 74 75 E) 76 77 78	A) 62 64 B) 71 79 C) 72 73 D) 74 75 78	A) 59 B) 69 80 81 82

Evidence from Literature	Burns 2014	Tamarack Community - Hippocratic Oath for Community Workers blog Chad Renando Blog 7 Villages Parish Nurse	Mittlemark et al., 2016	Van Beurden et al., 2013
Purposive Search: Helping/supporting people to understand and address complex challenges	○ Finding wellbeing through balance and coherence ○ Helping people to untangle their complex challenges.		Related key words: Related ideas: salutogenesis/Maslow/Cynefin (Snowden)/What Matters Conversations/Helping People Change (Prochaska and Di Clemente)	

The process used by the researcher to go back and forth between the evidence from the literature and that from stakeholders in and across the project workshops demonstrates applying both ‘abduction’ and ‘retroduction’.

As outlined in chapter 2.8. (Realist Studies Reviewed to Inform the Methodology) abduction is the process of making an educated guess about the likely explanation for an observation, which can then be tested.

In ‘Retroduction in Realist Evaluation’ (Rameses II Project, 2022) it is also explained that within the term ‘retroduction’ using the Latin prefix ‘retro’, meaning “behind or beneath”, suggests that the researcher is attempting to reveal the causal forces lying in observed patterns or changes in patterns, they cite Sayer (2000)

> “*Merely knowing that ‘c’ has generally been followed by ‘e’ is not enough: we want to understand the continuous process by which ‘c’ produced ‘e’, if it did. This mode of inference in which events are explained by postulating (and identifying) mechanisms which are capable of producing them is called ‘retroduction’*” (p207)

A crucial factor in this process of retroduction is that it is more than observing patterns that can be seen and it involves a degree of invention (or use of ‘Informed imagination’, a combination of intuition and common sense) to conjure up and then test the theories about causation in later processes.

Hence the tables for each programme theory laid out here exhibit the application of abduction and retroduction as they are to some extent a product of invention with assumed or implied connection between observation of rich pictures, things expressed by programme stakeholders and seemingly related theories and evidence from the literature accessed but they have not just been observed at face value and the researcher has led a process of getting behind and underneath what was presented to uncover drivers of them.

The tables in this sense make no pretence to be anything other than full of possibilities of contexts, mechanisms, and causal pathways to be tested in

the next phase of this realist process, that phase offering the opportunity of testing them as potential programme theories in teach back sessions with stakeholders across the case studies.

Neither do they pretend to be the only time that the abduction and retroduction processes are used. The Rameses Guidelines clarify the iterative cycle of deductive reasoning thus.

> "*The process starts with deductive reasoning (seeking evidence to test the theory). Cases are examined, preferably to the point of saturation, checking that the patterns of success and failure, intended and unintended outcomes are consistent with the theory. Inconsistent cases may require the theory to be refined. That is, new theory is generated on the basis of observations, or inductive reasoning. That new theory is then put to the test in further cases (deductive reasoning again)*".
>
> (RAMESES II, 2017)

In other words, abduction and retroduction go back and forth drawing on inductive and deductive logic whilst theories are established, strengthened, refuted, discarded, or are refined.

4.4. The Impact of The Covid 19 Pandemic Upon Each Community Health Development Project and consequent amendments made to methodologies.

At this stage of the research process, beyond the conduction of the research methods themselves, became a more pressing and important issue, how were the programmes themselves responding to the pandemic challenges? Would it be possible to continue with the research process?

Whilst all four case studies faced the same overall conditions, they had responded in very different ways with two of them faltering and two finding new direction and momentum, evolving new ways of working very swiftly.

Wrexham Homelessness

Early in the outbreak, the Welsh Government made £10 million available to councils to quickly re-accommodate hundreds of people across Wales who were sleeping rough, or in communal temporary accommodation that was a public health risk during the pandemic.

This, at a time when face to face contact between people was restricted to those people living together in households, no worker to homelessness person to person contact was possible.

Whilst this action undoubtedly saved lives with infection rates and deaths from Covid 19 amongst people experiencing homelessness at extremely low levels when compared internationally, the impact on other aspects of health and wellbeing are less well known at this point.

What it meant for the “everyone in the room” approach in Wrexham is that the programme stalled, being so reliant upon the central intervention of wrapping services around people in a process that relied upon people being together in a single space at a single time – clearly an anathema to the social distancing Covid 19 prevention regulations of the time.

Nearly two thousand individuals in Wales were homeless during the pandemic (Bramley, 2021).

> “*A total of 1,717 individuals were flagged as homeless between January and July 2020 in Wales. Most of them were male (70%, 1,188/1,717) and in younger age groups, 16 to 34 years (42%, 721/1,717) and 35 to 54 years (43%, 744/1,717) of age’*.

Of these 31 per 1,000 tested positive for the virus causing COVID-19, 9 per 1,000 had COVID-19 related hospital admissions, and 3 per 1,000 died with COVID-19 listed as one of the causes of death, while the figures are 22 per 1,000 positives, 1 per 1,000 admission and 1 per 1,000 died within the general population comparison groups (Boobis, and Albanese, 2020).

The most significant intervention arising from this was that governments across all UK nations were directed to provide accommodation for everyone rough sleeping, at risk of rough sleeping, or in accommodation where they could not self-isolate throughout the pandemic.

The temporary nature of these changes and the impact these may have on homelessness in the future was not well thought through, and the existing programme in Wrexham and the factors that made its work (i.e., its underpinning programme theory) was ignored.

The ‘problem’ was framed as homelessness and the resources found to provide accommodation as the ‘solution’. The core of the Wrexham intervention, “the everyone in the room” approach was not attempted to be replicated (even virtually).

The result was that University accommodation was used following students being sent home, thus freeing up bed space, to provide temporary shelter.

The Wrexham Homelessness programme itself was simply halted in its tracks.

Youth Shedz

At a very early stage following the initial social distancing measures coming into force, the Youth Worker in the project pulled together an online meeting, by phoning or emailing all existing participants inviting them to meet virtually for the first time using an online platform (Zoom).

Prior to this all meetings had been face to face and that personal connection had been deemed to be a crucial part of how the Youth Shedz worked – developing a shared identity in a place that Shedderz’ felt comfortable in.

The Youth Worker only had the intention of checking in with the Shedderz and making sure they were okay; however, he was uncomfortable with the technology and asked the Shedderz themselves to conduct their own meeting.

The result was highly significant. The call was scheduled for one hour but eight hours later the group itself had worked through how it could maintain momentum of the programme, sticking to the original principles and main type of interventions but delivering it entirely online.

Recognizing that for some young people the place they did not feel comfortable or safe was their home environment (and hence coming to the programme was their refuge) a crowd funding project was initiated to buy wristbands for Shedderz to wear and share their identity.

The key within this was that the wristbands had sources of help and support printed on the inside (e.g. Childline, Samaritans etc.) and a system of use was devised that if a young person in an online meeting was in any way feeling under threat or needed help in some way, they would flick the wristband as a signal to tell others on the call that they a) needed help, or b) needed someone to call them to help them talk something through.

These were usual conversations in the programme when it was person to person (pre pandemic) and the participants had devised a way to replicate this at distance using online solutions.

One consequence of this shift was that some participants left the programme as they missed the personal connection, whilst others preferred this way of interacting, and still others then joined in as they too valued the online support.

The Holway

The pandemic revealed the fragility of the programme overall in the Holway due to it largely being led by key workers from different agencies, rather than the community itself. The intention may have been to transfer ownership and responsibility to community members themselves, but the programme had not reached that level of maturity by the stage of the pandemic.

Two other factors had also provided obstacles just prior to lockdown. Firstly, the main stakeholder left employment with Flintshire Council at the end of January and just weeks before the start of the first lock down.

Secondly, around the same time, there was a significant community safety issue within one of the main community programmes that had created disruption amongst the main partners.

Without the spectre of the pandemic this would have been a challenge, but combined with the prevention measures it had the effect of halting any programme momentum.

Seiriol/Medrwn Mon

The core of the programme in Seiriol was in neighbours looking out for neighbours and in developing and fully using local assets, and this, in a similar manner to Youth Shedz, managed to harness online and social media communication methods to continue, but at a social distance.

There were enough people in and around the programme with digital awareness and skills that existing activities could be moved largely online and be sustained, and new interventions were developed using technology to meet current and new technologies. A main example of this was the use of What's App and Facebook to develop and share local information about the community's response to the pandemic, and to organise help and support to those most vulnerable – organising a pharmacy collection 'round' for example to get medicines and necessities to those unable to leave the house. Similar interventions developed around food and essential household supplies.

In summary, early into the initial stages of the pandemic in the first quarter of 2020 two case studies folded, two developed in exciting new ways to transform, however the research secured a commitment from key stakeholders from all four case studies to stay involved and complete the research, taking part in the planned teach back and refinement of

programme theories, even without continued activity of the programmes themselves.

The implications for the next steps were that amendments for the research methodologies were required, but these were relatively minor.

It had always been the intention from the start of this research to eventually narrow the focus to complete the full four phases across just two Community Health Development Project areas, therefore reducing from four case studies to two would have happened at this stage if the initial plan was still deliverable.

However, the pandemic offered a great opportunity to understand not only what works when such changes in condition occur but, just as importantly, what does not work. It was therefore discussed and agreed with the supervision team that the remaining stages of the research would still continue to involve the stakeholders from the two programmes that had halted in order to understand the mechanisms that were constrained by context changes.

This line of enquiry with the two halted programmes was therefore treated with the same attention and care as that given to the two programmes with a transformation, or even acceleration, of their programmes.

4.5. Methodology For Teach Back and Theory Refinement

The main purpose of this stage is ‘field testing’ the Initial Programme Theories identified from the combination of soft systems workshops with stakeholders, concept mapping and realist synthesis of literature, it is still important to go back to those stakeholders to check out their recognition of those theories and allow them the opportunity to validate or to challenge them.

The ‘teacher- learner cycle’ (Nanninga & Glebbeek, 2011) employed at this stage is an important process within a realist evaluation as it allows the researcher to put the initial theories back to Community Health Development

Project stakeholders for them to confirm, deny, or suggest how to refine the theories. The cycle in the definition therefore starts with theories, tests theories, refines them and if necessary, tests them again.

‘Teach back’ in this sense is a process drawing on a similar method used within nursing and healthcare where it is used to check patient understanding of healthcare by requesting patients to repeat back their understanding of what they have been told by health professionals. However, here its’ meaning is extended further than this as it is not just recipients (participants) checking understanding of the developing theories but by the stakeholders fully debating the ideas offered they are essentially “teaching back” to the researchers if the proposed ideas are correct. When done effectively this adds nuanced understanding and greater specificity.

An important focus in this process is who is teaching and who learning? In realist methodology this relationship is fluid, and the researcher may ‘teach’ by presenting an element of programme theory and checking out if it stands up or is challenged, alternatively the researcher becomes learner as the stakeholders propose how it works or doesn’t work in their programme. In this way the process more closely represents a discussion as both parties assist each other to think through the complexities of the programme (RAMESES IIb, 2017).

The use of framing the discussions around potential CMO configurations in the style of “If – Then” statements also assist with this more natural conversation at this point.

This is the stage which progresses theories from “a relatively isolated, static, reified source” towards “developing, validating, modifying, and advancing conceptual knowledge in the field” (Kislov et al., 2019), in other words, when initial programme theories begin to be more strongly articulated as Mid-Range Theories (MTRs).

The initial rough working theory from Phase 2 suggested what is supposed to happen in community health development, the four programme theories emerging are beginning to be framed as mid- range in that they are close

enough to the data to test the hypothesis but also general enough to be applied in other situations. (Roodbari et al., 2021). They are not yet refined theories as the supporting evidence base is still too tentative and implied.

Middle Range Theories is an adjective that simply describes the level of abstraction of the theory at this stage, to a level that is specific enough to explain the phenomenon of what works in community health development in and across these cases, but general enough so that they may be tested and applied across cases of a similar type – in other words, other community health development programmes (RAMESES II, 2017).

These mid-range theories emerging from the testing cycle of teach back then may produce “an ordered set of assertions about a generic behaviour or structure assumed to hold throughout a significantly broad range of specific instances” (Weick, 1989).

A technique, which is also used within logic modelling, is used to help articulate this transition from Initial Programme Theory to a Refined Programme Theory that can fully meet the criteria of being ‘middle range’.

It is the use of “If – Then statements” to tease out into the open the key components of the programme theories. Although not yet Context-mechanism – Outcomes constructs, the use of ‘If-Then’ propositions is a step toward developing them.

The Initial Programme Theory illustrated at the end of Chapter Three proposed that community health development, through the use of a holistic understanding (perspective) of wellbeing, connects people to act jointly for positive change through combining both needs and assets-based methodologies.

That is quite challenging conceptually as it encompasses a host of different elements, but the application of “If – Then” construct as a step on the way to defining CMO configurations may help to illuminate which element does what and how they are related.

The WK Kellogg Foundation (2004) express it this way:

> "*At its simplest, this is the crucial link between components of any argument. If I do this…then I will get this. If this happens …...then that will happen* ".

The If-Then construct links together resources and activities and towards expected outcomes. It is not as refined or forensic as unpacking context and mechanisms but enables the start of conversations in that direction.

Discussing context and mechanisms and how they interact to produce outcomes can be quite complex for those unfamiliar with the realist approach and its language. Using the if – then phrasing is much more accessible and enables a richer conversation on the way to eventually construct the CMO constructs.

The process of constructing If – Then phrases to explain and support each programme theory began with a review of all the outputs to date and how they related to each other in the programme tables (Figures 4.13, 4.14, 4.15 and 4.16) and discussing emerging patterns across codes with members of the supervision team, peers in community wellbeing and public health, and a network of other researchers and students themselves also using realist lenses to their research.

4.6. Initial Programme Theory Supported by If – Then Statements

Table 4.7: Initial Programme Theory

Four connected Initial Programme Theories
Space: A Place to be and to be me! Good community health development happens when there is a space for people to easily access that is welcoming and where they feel welcomed and accepted, supported to explore their health determinants.
1. If a community space feels like a home, feelings of belonging and acceptance grow in members of that community, and they lower their barriers and open up to support. 2. If workers are regarded by community members primarily as people rather than professional representatives of organisations this more personal connection builds bridges between people and trusting relationship develop 3. If a place contains non-threatening focal points ('muses' or conversation pieces) around which to bond community members are able to discuss and test each other's views and express themselves in a safe way resulting in strengthened connections between each other and the development of trust (also known as 'BUMPING SPACES') If a community space has a 'revolving door' feel to access, it then enables people to enter and leave as they wish which then empowers them to have control over their own boundaries and feel safe which helps them to connect and work collaboratively with others 4. If community members can access a 'third space' (a place unlike the place they live in or the civic space they work or study in) can be supported to explore and express their own identity and simply be themselves facilitating a sense of acceptance, connection and belonging. 5. If the community's own culture and identity is reflected throughout a space participant then feel more comfortable, validated, recognised and valued resulting in feelings of acceptance, affirmation and empowerment.

6. If partner organisations appreciate and support local distinctiveness of place and communities tailored programmes can be built which enhance a sense of pride and belonging resulting in greater engagement and sustainable local support
7. If a project is embedded in a wider area that has latent social capital when usual ways of working are obstructed, community resourcefulness and neighbourliness can be harnessed to provide support and guidance to sustain activities.
8. If community members and workers can draw upon digital capital new ways of delivering programme activities can be designed evolving delivery from human centred platforms onto virtual and digital media sustaining engagement and programme delivery

Identity: A journey from 'me' to 'us' to 'ours'

Good community health development happens when a skilled facilitator supports personal reflections and builds bridges between people around common issues.

1. When community workers share similar socio-cultural attributes and characteristics of that community the recognition enables bonds and relationships to form resulting in the growth of trust, kinship and cooperation.
2. When a common cause or issue can be identified which has resonance across all community members a sense of joint purpose and ownership may be nurtured enabling the community to join in a shared and cooperative action
3. When there is a culture of validation and acceptance of all in the community people can open up to recognising themselves and others around them and form a spirit of appreciation, togetherness and trust.
4. When a culture of confidentiality, non –recrimination and respect is established people are enabled to tell their stories and be heard by others resulting in growth of trust and feelings of acceptance and validation.
5. When the community identity is congruent with personal values and goals relationship can be formed to echo a family or kinship and a sense of togetherness and inclusion can be built

6. When an understanding of varied and nested communities in an area is recognised exploration of difference and common factors can be undertaken helping community members to acknowledge and resolve the relationships and tensions between them
7. Coproducing **plans** with peers and project workers in a safe place allows people to develop agency encouraging them to take ownership for their own journey to wellbeing

Reframing: From what's wrong to what's strong

When individuals and communities are encouraged and supported to focus on their strengths and assets, they can adopt a more positive perspective to their wellbeing challenges.

1. If communities are enabled and supported to appreciate their strengths and assets a more positive and optimistic perspective and attitude can be developed towards wellbeing, and they are empowered to explore the foundations and small steps for change they can make.
2. If in conversation with peers or project workers in a community a person is encouraged to think about their own needs, strengths and aspirations they no longer feel on their own, consider life may have more meaning and are able to develop more positive ambitions.
3. When there is acknowledgement across stakeholder services and partnership that existing silo interventions are ineffective in supporting communities, it enables the testing of holistic wrap around service provision ensuring comprehensive attention to complex challenges.
4. If community facing workers roles are focussed more upon supporting people to express what matters to them rather than delivering a service goal, engagement and coproduction of a wellbeing solution are strengthened and faith, commitment and trust in positive actions and results are increased.

5. If community engagement begins with appreciative enquiry/ a ‘what matters’ conversation or focuses upon what is strong the community can define its own starting point and small steps to take for action with a sense of agency optimism and ownership for the intended change.
6. If communities remain fatalistic about their wellbeing the lack of confidence and diminished faith in possibilities for change provide obstacles to connecting with support and a lack of engagement.
7. Understanding the range and access options to helping services provides reassurance and confidence that support can be accessed when making life changes.
8. Creating a service map around community projects enables people to find the most appropriate support to the issues they are tackling increasing engagement and efficacy in changes they are implementing.

Coherence: Building a personal understanding of challenges, the value and meaning of change, and a consequent belief in an outcome

Good community health development happens when people are facilitated to untangle the challenges in their life, understanding the meaning in those challenges for themselves, and, encouraged to make proportionate and achievable action plans for change.

1. If a community project is rooted in a salutogenic approach participants are enabled to explore and compare personal understanding and beliefs of the challenges they face, the value and meaning of change, and their faith in achieving any outcomes which provide a sense of balance and opens options for action.
2. If workers and community members work together in co-production more accurate and attuned theories of change may be defined leading to proposed solutions that have wider support and commitment to be tested.
3. If a culture of achievable goal setting, positive change, reflection and small successes is built in a community, confidence and a sense of progress increase enabling more positive risks and opportunities to be taken and further and more ambitious goals to be developed.

4. If early intervention is valued and supported by stakeholders' communities can be engaged in an initiative before the drivers become too complex enabling a clearer understanding of the changes required and the testing and refinement of learning strategies.
5. If the organisational and cross partnership narrative changes from the importance of meeting silo based KPIs to prioritising a more holistic sense of success determined by communities themselves workers are able to focus on client aspirations as well as needs supporting self-determined change alongside success criteria valued by the community itself.
6. If self-determinism of communities is recognised and valued by all stakeholder organisations project workers are empowered to facilitate people in exploring their own challenges and solutions setting realistic and achievable steps for change.

4.7. Moving From Initial to Modified Programme Theory

As seen in earlier chapters the programme theories have been gradually developing through the phases of the research:

- Chapter 3.7 An initial broad Working Theory.
- Chapter 4.3 Emerging Elements of a Programme Theory from literature search, concept mapping and workshops.
- Chapter 4.6 Initial Programme Theory is established supported by If-Then constructs.
- Chapter 4.7 now describes how through a series of ‘teach back’ conversations this mid – range Initial Programme Theory is further modified and strengthened.

As covered in section 4.6 above, realist methodologies have often presented theories at this stage as constructs that lay out the functions of contexts (C) and mechanisms (M) that lead to a particular outcome or set of outcomes (O).

However, there is a danger in forcing this apportionment of a specific factor as either context or mechanism too soon. Whilst it may be intellectually stimulating to do so it can be a contorted process (Brocklehurst, Hoare et al., 2021) particularly at the outset where initial programme theories (IPTs) are being developed.

The simpler process of using IF-THEN propositions still captures a combination of context and mechanism interactions and their outcomes but is a much clearer way of presenting them to audiences in an immediately more understandable level, an approach that is more practical for using with stakeholders in programmes, certainly for those not familiar with the intricacies of the realist approaches to research.

“IF we do x Then y happens” is much more readily accessible and understandable to non-researchers than the specific meaning in realist research of the words “context”, “mechanism”, and “outcomes” and how they interrelated in a CMO construct.

It was therefore these IF THEN constructs, rather than CMO constructs, which were taken forward into the theory testing stage of Phase 3 in teach back workshops, as the priority was to enable engagement with the concept themselves over and above any need for research partners to understand the intricacies of the realist approaches.

Progression of CMO development in a research study such as this is a deeply iterative process involving, as previously outlined, applying retroduction and abduction at various stages to think around developing ideas and how they connect, plus continuous dialogue on these deliberations back and forth between researcher, supervisors, projects, stakeholders and research peers.

In this research concept mapping had provided a rich foundation of ideas from which to begin a realist exploration of practice. Some of the more well-known definitions, principles and values around community health development mapped well against the ideas of context mechanism and outcomes, although as already noted the exists a real lack of clarity by practitioners in whether the most strongly identified concepts (such as ‘empowerment) is any one of these or could be all three.

Once the workshops and literature searches had provided further data upon which to further build or reject specific C, M, O’s and their potential configurations the next step in the iterative process was to present these emerging CMO configurations (or if-then statements) and programme theories back to those involved in projects to test their recognition, accuracy and validity.

This original intention to present back the Initial Programme Theories in further face to face workshops to a set of stakeholders from each Community Health Development Project was primed ready (and teach back materials were already prepared) when the pandemic and lock down measures effectively paused the research.

This had two important implications. Firstly, two of the community projects folded and were unable to continue in their original form (the nature of this halt will be explored later in the chapter) however the main stakeholder in each of them committed to remain involved in the research and represent their case studies up to and including the impact of the pandemic. Secondly, a new opportunity opened for testing the case programme theories.

The unprecedented change in conditions brought about by the pandemic and the societal response was of such a scale that it was highly likely to have affected the resources available to the programmes and, in fact any other matters of 'context'. It was equally likely that reasoning within programme actors and, hence, 'mechanisms' themselves may fire differently (be enhanced or be restricted).

The teach back sessions were therefore re-structured to enable a dual level testing and refining process, concentrating on how things operated pre covid and then once Covid 19 had its major societal restriction impact. Hence, teach back was to now take place within each of two separate but linked conversations (using a semi structured interview schedule) conducted for each of the four case studies, two of which froze, but two of which continued with vigour.

The Wrexham and Holway projects were represented by just the original lead stakeholder within each. Both of whom, despite the folding of programmes, honoured their original commitment to the research and remained engaged in the research.

The Seiriol and Youth Shedz programmes both brought together a range of stakeholders including workers, programme recipients, statutory partners, and commissioning representatives from the original soft systems workshops, (Youth Shedz in addition also brought some new stakeholders from a new Youth Shed that they had developed during lockdown in a different location in Blaenau Ffestiniog).

Each online session per space study was undertaken in the same way, irrespective of whether it was with one stakeholder (as with Wrexham and

the Holway) or whether with ten to twelve participants, as with Youth Shedz and Seiriol, in that:

- A PowerPoint presentation which covered a review of the outputs from the Soft Systems Worksop, the Working and Initial Programme Theories with supporting IF Then statements.
- Three time periods were covered and discussed – as programmes operated before the pandemic, the lock down period, and thoughts on how programmes would run post pandemic (if the programmes would operate differently to pre-covid).
- All conversations were recorded and then transcribed.
- The style of presentation was purposefully crafted to present programme theories back to stakeholders not as findings, but as potential theories for their validation or challenge. A phrase used often for this was "*this is what seems to be emerging from the exploration of your programme work – do you recognise this, if it seems right can you tell me more about how it happens….".*

The first of the two conversations presented in each session covered the four Initial Programme Theories in turn together with underpinning IF-Then statements. To supplement the presentation a series of open-ended questions were also included to identify any new potential IPTs.

Participants discussed if and how these statements reflect or explain their programme as it was delivered up until the start of the pandemic (in other words as it was operating in the first phase of the research when the rich pictures and CATWOE were undertaken), whether anything important was missing, and if they were expressed in a way that was a comfortable 'fit' for the programme. In this way, the interviews were designed to support both 'theory gleaning' and 'theory refinement' (Manzano, 2016).

The second conversation with each group of stakeholders then repeated the process but with stakeholders reflecting upon whether the programme theories maintained their validity and significance during the pandemic, how

the programmes themselves were conducted, and whether they are continuing through subsequent phases of the pandemic as originally or if they have maintained a revised programme theory and operation.

This second conversation was therefore a unique opportunity to test whether:

1) Such a change in conditions affected the programme theories.
2) These changes in conditions may have impacted upon ‘If -then’ C-M-O configurations.
3) The programme theories themselves still stood up through such unprecedented events.
4) New programme theories may be defined.

4.8. Teach Back Results

The teach back workshops enabled the intended validation of initial programme theories to be carried out, but they also added texture to each statement (see figure 4.12 for key themes). This conversational approach also allowed for greater discussion on human qualities that in more usual times may not have been appreciated so much but was appreciated much more clearly during the pandemic, a strong theme of iterative and cyclical processes emerged as observations were made that rarely do the processes represented in ‘If–then’ statements operate in isolation, more often they are linked in some way and can be returned to at various stages in a project life, not merely repeating themselves, but layering and building, so that the repetition makes them stronger.

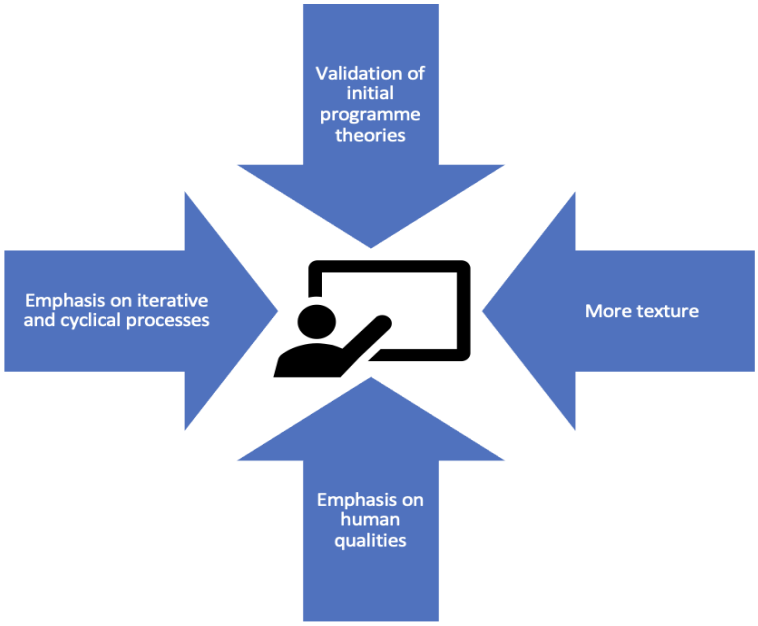


Figure 4.12: Key Themes Emerging from Teach Back

4.8.1. Place/Space

Creating the right Space: Building a place where people are welcome, feel safe to be and be themselves, opens doorways to change.

Across all four case studies the provision of a place where people could feel "at home" was a fundamental foundation, although the term "at home" turned out to be a proxy for a place where people could be themselves, a place where they felt safe and able to be the person that they felt themselves to be, rather than playing a role to fit within other people's expectations of them.

> *"… (within our logo) the house isn't hard like just a place, it's a home and the project is like a family, the community project has created its own family, but one I feel ok to be in. I don't feel ok in my family and that house, but I do here, this is my home*".
>
> (Youth Shedz participant)

Through teach back, the concept of whether it is "space" or "place" that matters were considered at length. The balance of the conversations favoured space as this denoted the connection with the second programme

theory on identity. When conjoined this became the place where each person's identity could be recognised and freely expressed. Therefore, not just about a venue where interactions could happen, the venue itself also needs to reflect or support the participants' identity.

This sense of 'place making' (Ellery et al., 2020) was a deliberate strategy in Seiriol and Youth Shedz but implicit across all case studies, and fits well with the definition of Placemaking from the Project for Public Places,

> "***Placemaking*** *inspires people to collectively reimagine and reinvent public spaces as the heart of every community. Strengthening the connection between people and the places they share, placemaking refers to a collaborative process by which we can shape our public realm in order to maximize shared value……. it is a crucial and deeply valued process for those who feel intimately connected to the places in their lives*".
>
> (Project for Public Spaces, n.d.)

This concept is most often applied to the level of the urban environment, often one that is impoverished, but can be applied at all levels, as in these case studies where it represents the space that is created where the communities in question meet in the programme (in Wrexham most often the Salvation Army café, the 'Shed in Wrexham, community centre in Holway and various community venues in Seiriol Ward).

The theory beneath place-shaping is that *places shape people and people shape places*. This is what ties idea of place and identity together, when people feel they fit in a place, that it somehow reflects them, they become empowered or simply more open, receptive, and relaxed. In short, more amenable to working with others (peers or workers).

Having a sense of place is suggested by Ellery et al., (2020) as a key mechanism in building social communication and social coherence among community members, community stewardship, and a sense of belonging

within the community (Antonovsky, 1987). It is this sense of connection to place that opens the possibility of connection to others in that place.

> "*We need **space** to find our **identities** – without this online we can get bullied, there are just so many factors that can affect members of society – mental health etc, so it's important that in projects like Youth Shedz young people can find a safe space and someone to talk to, to have support when they need it, about who they are and their mental health*".
>
> (Youth Shedz participant)

This quote in the teach back led to lengthy conversations about the need to recognise this is not just about a venue that has visual cues about the participants' demographic characteristics, it is more than that, in particular, access is a key factor,

> *"… let's have an open-door policy and anyone can come in that needs help and there are no eligibility criteria and we will support you in the best way that we can, and we won't judge…*
>
> *... it helps then that we have an open door, I guess when we first started the project, we did it in a place where there were lots of rules and it was erm it was almost quite intimidating*".
>
> (Wrexham Worker)
>
> "*... it's our Bus analogy in the Holway – 'It's an open back bus so people can just jump on and access it – the door is already open and conversation events ideas interests – that door being open allows all those things*".
>
> (Holway Stakeholder)
>
> "*I didn't want this to be about badges and uniforms – I wanted a place where people could come together, and it wasn't obvious who was a*

service user and who was a deliverer of services – it was very much that social space and that's what the guys really responded to".

(Wrexham main stakeholder)

"*Men in Shedz is a **safe and nurturing** environment where Men, who have time on their hands for whichever reason, can go to work on projects and activities which interest them*".

(Seiriol projects participant)

The theory of providing a place or space that people can relax and open up in and be 'themselves' draws upon a substantive theory called "third space", a sociocultural term which designate a communal space as distinct from the first space of a person's home (and the life lived there), or the second space where a functional life is played out (the workplace or in education, or where someone volunteers).

Third space theory exits in sociology and psychology with quite varied applications, but the exact meaning drawn upon here is that described in his book '*Celebrating the Third Space'* by the urban sociologist Ray Oldenburg (Oldenburg, 1991) who describes the third space as the place that allows people to put aside their concerns and simply enjoy the company and conversation around them. He further draws a contrast with a home, noting that:

"*The third place is remarkably similar to a good home in the psychological comfort and support that it extends...They are the heart of a community's social vitality*". And,

"*Life without community has produced, for many, a lifestyle consisting mainly of a home-to-work-and-back-again shuttle. Social well-being and psychological health depend upon community*".

This underlines once again the close connection between place and identity within community wellbeing, as noted by all stakeholders across the teach

back sessions, place alone doesn't build the community and in itself produce wellbeing outcomes, it is in the purposeful actions of home making and making connections between participants to build a joint identity that makes the provision of the place realise its full potential.

The elements of context (if this is in place, if this happens…) important for the place/space programme theory most prominent/acknowledged across case studies in teach back were:

- Welcoming – a place someone like me is able to be and is wanted by others to be there.
- Diversity is acknowledged.
- No barriers to entry.
- As easy to exit as it is to enter.
- Reflects the culture of its community.
- Workers in the space act in a complementary manner to consistently wrap attention around participants.
- People can feel at home.

Then the following elements of mechanism are triggered (or restricted) so that wellbeing outcomes result:

- Feelings of acceptance.
- Confidence raising.
- Relationship building.
- Trust and openness increase.
- Boundaries are broken down between participants and workers.
- Greater focus on people needs and assets.

The most significant expression of this programme theory, encompassing each of these elements comes from an evaluation by Hughes, Dubberley et al., (2012) of the Wrexham approach:

> "*The ethos of the Hub centres around the belief that participants needs are best served in an accessible, person centred and de-medicalised environment. Hub staff and volunteers take a relaxed, social approach to care provision, opting for mutual trust, respect, and cooperation rather than rues, restrictions and red tape. The Hubs staff and volunteers believe that if people accessing the service are afforded an opportunity to be listened to and in turn feel valued and respected, they will be more likely to remain engaged and therefore better able to achieve stability*.**"**

Great caution was expressed in the teach back, however, that this programme theory should not be considered alone as it is the way it interacts with other elements that is most important.

> "*The interaction between these four programme theories is best shown by considering **reframing** as actually this is the main thinking behind "community hubs". Community Hubs don't just need to be an accessible and comfortable **space** for people, they also need to be supported by each of the other theories. Taken together these support that sense of 'home making' in that it isn't just about a **place**, but it essentially includes elements of human connection and recognition that are distinctive for that community*".
>
> (Health Board Commissioner)

It was noted by several stakeholders that whilst it is a big step for statutory organisations to let go and allow communities build place and identity in community programme this can be challenging for services more used to keeping their users passive. This was best described by one stakeholder as:

> "*There was a feeling that if it was left to the community there wasn't trust that the community <u>would do it right</u>*".

(Holway stakeholder)

This perspective on usual public service delivery and its expectation that people present to them in a certain way to gain access and support was very significant across case studies.

> "*We forgive, we don't stick goals on people and then if they fail, we don't penalise them for it, we do let people dip in and out as it suits them – so it's about building relationship and trust I think*".

(Wrexham Stakeholder)

A further point considered at length by stakeholders in the teach back session was how the interaction between backdrop to the programme in terms of conditions, organisational cultures, traditional ways of delivering services, and user expectations, interacts with the programme resources and in particular personal qualities of the workers to create the positive space for wellbeing to flourish in.

It was strongly suggested that much depends upon the maturity of the vision and experience of the programme, not necessarily in evidence right from the start, but more emergent as the programme grows, and whether 'parent' organisations or commissioners actively support it.

This was expressed well in this extract from an independent evaluation report of the Wrexham Hub commissioned by the Community Care Collaborative:

> "*A small number of delivery partners cited their own internal governance and attitudes of other staff within their organisations (particularly those in middle management positions) as problematic when justifying their attendance at The Hub.*
>
> *For example, the open nature of the delivery space caused a manager from a prominent delivery partner to suggest the agency not attend The Hub. It was only once senior managers from the partner bought*

into the innovative nature of The Hub was the continued presence of this partner assured".

(CCC, 2019)

In summary, place or space building appears to be validated as a prime programme theory, although what is clearer following teach back is that it is entwined very much with the second programme theory of identity, which works on a number of levels to enable participants to feel they belong in a programme and allows them to relax any personal barriers to being supported by others (peers or workers).

4.8.2. Identify

Developing a route from "I" to "me" to "ours", creating a joint identity and ownership for health and wellbeing.

Programme Theory 2 is important in all four case studies but is absolutely fundamental in Wrexham and Youth Shedz as building identity even features as a process of, and a main feature within the logos for each programme.

In fact, both projects used the process of coproducing a logo for the programmes with participants as a way of bringing to the surface and expressing their individual and collective identity.

"*That logo production process has also enabled individuals to be seen within it – ME is in there (that's my identity) everyone's input is now seen and valued*".

(Youth Shedz founder member)

Similarly, within the Wrexham Programme,

"*We managed to set up a peer group that themselves wanted to take in their own programmes called 'clean up Wrexham' to change people's attitudes of the homeless.*

Part of this was being proud of their identity and they worked together to produce their own logo.

*The guys had put it all together and wanted to set up a social media presence to tell the community that "**we are ok people too – see us not the problem**".*

(Wrexham worker)

Within this explanation there is the expression of moving beyond merely forming an idea of personal identity, because it validates participants and shows them there are others just like them; that there is value in connecting with them in a shared identity.

"*I like that theory it is clear because its right it's not just about identity but how it is built from me to us to ours, and then to it being a shared purpose. It's all about the people, and the relationships, and then on to creating a culture to codesign a service*".

(Youth Shedz stakeholder)

"*… we absolutely need to **ensure every member of that community is valid and they are valued** community member no matter what their background is or what trouble they may have caused, they all bring worth, and they are all valued. So, it starts with being positive about their own identity but once that is done and bridges are built then it's the time to tell others about their identity*".

(Wrexham stakeholder)

It is interesting to observe that within these programmes the shared task itself also then became about identity, in respect of telling wider society and other communities about their identity and trying to reframe others' assumptions of them.

"*The tag has become the centre point of the logo the importance is that tagging is seen as antisocial but this has turned it around "it's sort*

of the essence of it coz people look at it as sort of an urban thing, look at it as sort of a bad thing, like a negative thing about young people and stuff but to be able to turn it around into a positive things is really good – like a positive contradiction".

"*The arm (in our logo) is about bringing people in, being a part of it, from the community and then doing stuff for the community and what not*".

(Youth Shedz participants)

"*This innovative service design took place under the motto, 'letting those who know tell those who don't'*".

(Wrexham Stakeholder)

Identity therefore wasn't just about trying to build positive identities, but about mediating sometimes between a personal and collective identity and the perspectives of others (services and wider society).

"*The Holway badge was a very negative thing, there were lots of anecdotal stories of people being bullied for coming from the estate. Whist there was an identity it wasn't an identity of pride. The Holway tag was a negative thing. It was expressed as a strong identity when negotiating with services but not when dealing with outside communities*".

(Holway Stakeholder)

The real importance of this within this community came from understanding how dominant identities could simply 'drown out' others and dominate service provision.

"*Two or three dominant families drove the wider relationship with services. When services were being delivered on the estate it was perceived to have high level of engagement, but it was the same two or three families, The same dominant characters. There were silent*

parts of the community who you didn't hear from, plus many transient communities who were not encouraged to stay there".

(Holway worker)

The last sentence here underlines the importance of identity building across communities, not just within individual communities as, on the Holway, if your identity didn't fit the dominant identity, it had profound consequences.

"*This building of identities within communities is quite important, at a granular level finding how communities see themselves is really important and it became even more significant during covid. Constructs from outside will not work, you can't make assumptions about how communities think and feel unless you understand how they see their own identity*".

(Seiriol Worker)

This caution that identity building can sometimes exclude too led to a strong recommendation that programmes always consider that strong identification of a common cause can push other priorities to the side and result in pockets of that community feeling they are not included.

"*The overall idea of me to us to ours needs constant (re)consideration, so that it is acknowledged that others can still be excluded and overshadowed by dominant voices*".

Identity and inclusion therefore need more than careful mediation, they might also require a stated ethos around this (and potentially all these programme theories) and for this to be a boilerplate for the programme.

"*… its making sure there is a stated ethos of inclusion - build the ethos and publicise that this is how our ethos works- it's like a having a Hippocratic oath for community development, for example our Seiriol Model says this is what we are and you are free to take part if you want to and we are accepting if you want to join us*".

(Seiriol Worker)

The most relevant conditions, local cultures, heritage, and organisational factors most important for building identity were agreed to be:

- Recognition of various communities by services,
- Acknowledgement of needs and assets in communities,
- Identification of common causes,
- Programme workers share features of identity with community participants,
- Culture of confidentiality, validation, and respect for all.
- Organisations encourage and promote coproduction.

Mapping the communities needs and assets and being ready to work in coproduction was agreed by all the stakeholders as a set of prerequisites for recognising and then building identity.

And the resources that were created or responded to that were most significant for identity building were:

- Relationship building.
- Self-reflection and recognition.
- Storytelling.
- Sense of purpose.
- Ownership and agency.
- Compassion.

Most of these resources locate around a shift in attitudes about the nature of helping, perspectives on who is helped, and what helping actually entails:

> "*I think ultimately what this comes down to is attitude. Yes, 100% it's about attitude, I could be a rubbish doctor but it's the fact that I am kind, it's definitely about attitude, it's all about people for me,*

massively it's about people and relationships….the biggest shift is when workers start to see the person, not the problem they present".

(Wrexham Stakeholder)

This particular statement was further evidenced from the independent evaluation of the Hub,

"… at The Hub I feel more respected, valued, and listened to than I have before.' 95% of respondents either agreed or strongly agreed, with 29% strongly agreeing with this statement".

(CCC 2019)

Across the case studies there was strong affirmation for this programme theory and its supporting constructs.

"*These sentences make sense to how we actually do the work, it is understandable to us who do and receive the work, laying them out like this does put into words what we do at an intuitive level*".

*(*Seiriol Stakeholder)

"*I like that way of putting it (from me to us to ours) I think it could be used by us further down the line in further Shedz - that's a really good visual representation of what we would like to see – we don't do things for people we help them do the things they want to do*".

(Youth Shedz Worker)

"*We are working on the toolkit – a manual to share this is how to do it – identity is exactly it, but we didn't know that's what we did*".

(Wrexham Stakeholder)

In summary, the building of identity seems as central in 'what works in community health development' as the creation of place and space.

In fact, the two appear to be intricately entwined, which is possibly not so surprising given that there is a uniquely Welsh cultural aspect which is so strong that it even has a term for it that does not have an English language direct translation.

‘Cynefin’ denotes a place where a person feels they ought to live and belong, it is where nature around you feels just right, where you feel right and welcomed. Its literal translation is the place of my multiple belongings, and this brings together a sense of being at home and in touch with the things that provide fulfilment now and, alongside this, also a sense of heritage.

It has given rise to a dominant framework that helps people make sense of complexity developed by David Snowden (The Cynefin Co., 2022). It was developed to help leaders in many different sectors work through complexity by understanding challenges within their contexts.

David Snowdon himself acknowledged his inspiration for considering a combination of identity in place came from the ideas of Sir. Kyffin Williams the renowned Anglesey born artist. It was Williams who noticed the connection between the Welsh landscape and the spirituality of its people:

> “*It describes that relationship: the place of your birth and of your upbringing, the environment in which you live and to which you are naturally acclimatised*”.
>
> (Sinclair, 1998).

Other cultures such as the Navajo, aboriginal peoples, have a similar concept but they are all slightly different. For example, there is a Japanese concept that denotes as shared space for emerging relationships called ‘Ba’ (Nonako and Conno, 1998) but this is about the current space rather than Cynefin which also denotes a more strongly cultural attachment to the past and a definite continuance of heritage.

The fact that both identity and place have so strongly been affirmed across the four case studies may then not be so surprising if this sense of Cynefin is still a strong part of the Welsh context.

4.8.3. Reframing

Reframing wellbeing challenges and appreciating strengths enables wider options to be considered and positive foundations for change to be agreed and owned.

Programme Theory 3 is the programme theory considered across the stakeholders to be most in synch with contemporary policy drivers across Wales, at least within health and social care.

Helping people to reframe their challenges and issues to a more positive and appreciative perspective of what they have to build upon is now widely referenced across social care, as well as public health. It is the elemental feature of the Assets Based Approach to Community Development (Kretzmann and McKnight, 1993).

Kretzmann and McKnights' basic idea was that concentrating on what was working as opposed to what was not working could help promote community development. By focusing on success stories, workers could support programme participants find their own solutions to things, residents defining change, instead of constantly providing them with the services they thought that residents needed but which seldom satisfies their needs in any sustainable manner.

This basic philosophy is also the core of the 'What Matters Approach', a targeted conversation relating to any type of wellbeing assessment process. It refers to a skilled way of working with individuals to establish their situation or specific contexts, their current well-being, what can be done to support them now and what can be done to promote their well-being and resilience for the better in the future.

It is expressed well by the Future Generations Commissioners Office as they compare it to the way that the majority of services currently operate:

> "*Organisations often seek people's opinions about key strategic issues such as budgets or specific decisions such as planning applications or service changes – this approach starts with the needs of the organisation…. An alternative approach is to have 'what matters' conversations which helps organisations understand people in the context of their own lives and that things that are most important to them*".
>
> (Future Generations Commissioner 2022)

Social Care Wales also promote a what matters approach and emphasise that it is not really a type of assessment but what is important is the way it is undertaken so that recipients are enabled to express:

- how they want to live their lives.
- what might be preventing that or getting in the way of their aspirations.
- what support might be required to overcome those barriers and achieve aspirations.

They suggest that the conversation needs specific competencies from those initiating the conversations, they need to fully understand the situation, the person in their context, and work with individuals as equals, coproducing a new more positive perspective in their wellbeing based on an appreciation of what they have to build upon (Social Care Wales, 2022).

This reframing is evident as a process and programme theory across the case studies.

> "*Scott has been a real role model teaching us how to take our negatives and turn them into positives*".
>
> (Youth Shedz participant)

> "*Some of the elements you really can't pull apart because in isolation they won't really work ..*
>
> *But where you should start is with a conversation about what really matters to people – because it then gives a grounding for everything else that then flows into it.*
>
> *… and then you can look at what assets are there that can make that happen…*
>
> *There needs to be a problem to solve or an asset to build on that it is recognised by the community*".
>
> (Seiriol Worker)

> *"…you know we always [have] start [ed] by looking at what's going wrong and we have to now start by looking at what's strong and build on that, Assets as starting points are what people in that community*

already thinks is working, these are invisible to us from outside, so what's good already so that it can be grown rather than what's wrong with it and what can we change with you!".

(Holway Worker)

"*These are invisible to us from outside – not that we and go and say 'there is a lovely park - don't forget you have a lovely park aren't you pleased you have a lovely park or whatever' it's more about what the community values about living there, we find out what's of value already to them living there – such as the neighbours are really good and reliable if they are stuck for child care etc whatever it might be.*

And the big thing is to look at assets – you know we always start by looking at what's going wrong, and we have to now start by looking at what's strong and build on that".

(Seiriol Stakeholder)

So much of this approach is about context itself as its key conversation between participant and worker is the exploration of the environment and determinants of wellbeing for the participant and how they fit within their world. Hence the conditions available in programmes explored in supporting the programme theory include:

- appreciative inquiry (a what matters conversation).
- recognition of strengths.
- personal reflection.
- silo thinking is challenged.
- fatalism is challenged.
- assets are mapped.
- self-determinism is recognised by stakeholders and commission organisations.

The resources these conditions are inter-related to include:

- identifying options for change optimism and positive aspects are developed.
- people feel connected.
- the development of meaning and agency for wellbeing.
- holistic service connections. Develop.
- reassurance and confidence.

Stakeholders emphasised that the absolute anchor for this programme theory is that what matters conversation, as by giving ownership back to people for their own wellbeing it starts a step change in the relationship between people and services.

> "*Once people 'get this' it redefines the whole relationships with statutory services*".
>
> (Health Board Commissioner)

It was also strongly emphasised that reframing isn't just a one step process but part of a wider set of actions and therefore programme theory 3 and each of its supporting constructs relate to each of the other programme theories and performs a vital connection between identity and the development of coherence for people (programme theory 4).

Teach back stakeholders however provided two caveats to the reframing programme theory:

Firstly, the empowerment of individuals and creation of agency can also be counterproductive if an individual isn't supported at the same pace by their wider community.

> "*... reframing assumes that services can respond to a more assertive community response and that services are keeping pace with community programmes and the emerging mechanisms and*

outcomes …. So, to sit alongside these in a practical sense requires organisational development, the wider system needs to be developed in readiness to respond to people more assertive about their assets".

(Health Board Commissioner)

It was noted and discussed across stakeholders that a further piece of realist research to match this one would investigate the organisational development across partnerships required to meet the challenge of asset literate communities and how organisation may support community ownership of their own wellbeing.

In other words, if service users have reframed their expectations, does it demand a similar reframing from services themselves to be in place to realise successful outcomes?

Secondly, those already with a sense of agency and control may also still benefit from reframing how they currently experience challenges, therefore it isn't a time limited intervention, but an ongoing process.

"*The construct on helping reverse fatalism may be much more flexible and situationally dependent than the others in this theory area, providing confidence and faith in possibilities for change should be an ongoing process supporting people to become more resilient no matter what new challenges face them*".

(Holway Stakeholder)

Whilst the programme theory itself was solidly supported and considered as the logical next step from a successful process of identity building, the size of the challenge to transform existing practice in this way was still emphasised, this programme theory may be enshrined in Welsh Policy but still the system across public sector provision appears locked around needing 'needs', service provision still expecting to respond to people expecting help and resources rather than a starting point of coproduction.

"*We need to change the norm, the norm being that we go in and do things for people but that has to change! If they (communities)are*

going to pick up the challenge of leadership, to make a difference and drive, we need to give them confidence that they can do that and they can make those relationships.

The relationship and engagement of people between the estate and changes was recognised as something that needed to change but this wasn't agreed system wide – not up and through the organisations. Workers get it, Directors get it, middle managers lose sight of it".

(Holway stakeholder)

"*But seriously don't patronise people, or pity them, don't judge them, again we all know that we to have treat people in the right manner whoever they are or have done – take the barriers down, from a professional point of view we have to open up, we have to forget we* ***have come in with certain aims and objectives and stuff – we do have to keep them at the back because we do have to work to them but we do have to somehow remove them when working here***".

(Wrexham Worker)

"… there's something about our ID badges and our lanyards that means they separate us from the communities, and we are seen immediately as from outside coming in, parachuting in and we need to get rid of that".

(Holway Worker)

"… the challenge has been that as a teacher I am so used to go in with a plan and an agenda – I am in charge and telling everyone what to do – the challenge in this was not to do that – to come in and keep it safe but...and motivate and what not ..but not give ideas but listen to the ideas and help them , facilitate them, making it happen".

(Youth Shedz Stakeholder)

In summary teach back revealed the reframing programme theory to be incontrovertible as an idea, fully supported in policy, theoretically sound, and strongly championed within the workshops, however all case studies work in the space between statutory services and people in their communities and it appears that, whilst the communities are responsive to working in this way, it is the services that are slower to reorientate and support their workers using reframing in practice.

This may be the reason that a blended approach around deficit and asset-based approaches in a pragmatic way of working is prevalent:

> "*We did the deficit and needs based things first and then came the more strengths-based approaches next, part of getting to understand the assets is also knowing the needs… if you look at communities that aren't already really resilient at first you can't expect them to respond to reframing things, it adds too much stress and if their needs are so pressing it seems like you aren't hearing and attending to what does really matter and they desperately want help to fix not just look at it in a different way*".
>
> (Seiriol Stakeholder)

After Covid – more working asset based? No in fact more likely to be pockets of people who understand the ways of working – it will probably be the same people who are always trying to drive change that will take up the opportunity to try new approaches.

> "*There need to be a problem to solve or an asset to build on that it is recognised by the community. To make any community project you have to have community members and you must have an understanding of what assets are there in a community, the key people, like you know the best people in your community, and what they are interested in****. you can't go in and ..say, let's do hang gliding if no one is interested in doing hang gliding*****".**

Whereas Space and Identity may stand alone as programme theories, but preferably work together, it is reframing that teach back stakeholders expressed is so dependent on them, and in fact may also in turn be the accelerant or amplifier for place, identity, and the final programme theory, coherence.

4.8.4. Coherence

Building Coherence through understanding wellbeing challenges and finding meaning in positive actions creates agency.

Whilst there are substantive theories contributing to each programme theory, it is the coherence programme theory that is most closely wedded to one specific substantive theory.

Rippon and Hopkins (2015) developed a theory of change for salutogenesis and this building of 'coherence' at its heart, based upon studying a range of case studies to find the causal mechanisms in how salutogenesis based programmes work.

> "*In developing action from evidence, we need to know much more than just 'what works' or even 'what works, for who, where and in what circumstances' we need to 'know about'…'Know why'.. and 'know how'?".*
>
> (p21)

In other words, they suggest what is needed following reframing is another range of processes to happen. Their theory of change suggests four elements:

- recognising assets
- reframing assets
- mobilising assets
- coproducing assets and outcomes

Programme Theory 3 'Reframing wellbeing challenges and appreciating strengths enables wider options to be considered and positive foundations for change to be agreed and owned' relates to the first two of these elements, whereas it is the second two elements that **programme theory 4 expresses** as these are the processes **facilitating coherence.**

Rippon and Hopkins propose that reframing is stage one of their theory of change and that once assets have been recognised and been mapped, other sequences are required for the assets to be:

> "*Connected, mobilised, and put to work towards an agreed purpose*".
>
> (p25)

This needs a very different way of working with people and they suggest it is mainly through the application of community development workers' skills in brokering, facilitation, and active listening plus, most importantly, that these are brought together in a co-production approach.

Teach back on programme theory 4 completely validated this set of skills and the coproduction approach, however it was the illustration of the programme theory that seemed to explain it better than any narrative explanation.

> *"… that complex knot of strands is where our conversations start, people are dealing with such complex challenges that they can't see a way forward, we simply stand with then and help to tease out strand that can be understood, then we help them develop any plans they want to develop for each strand, supporting them as they start to act…. The steps show how once they are successful, they get confidence to tackle other strands, but they are acting, we just nudge, support or give them a mirror on how they are doing*".
>
> (Wrexham Worker)

> "*We need to change the norm – the norm being that we go in and do thing for- but that has to change we need to flip that over to really facilitate and not do … and then being realistic and not promising the*

world, because the small wins will breed confidence in the community that what we want to do from an expectation point of view".

(Holway Stakeholder)

The conditions proposed as important for this process of unravelling complexity and empowering motivation and meaning with communities include:

- Assets are recognised and appreciated (possibly as a result of reframing).
- Self-determinism is respected.
- Early intervention and prevention are recognised and supported.
- A Salutogenic approach is recognised and understood by community workers and service providers.
- Coproduction is actively encouraged.
- Partners understand the limits of existing silo-based working.
- Facilitation of change through coaching and mentorship.

The resources created through a coproduction and coherence building approach include.

- Community confidence.
- Sense of progress.
- Solution generation.
- Increased motivation improves engagement.
- Faith in self and community driven change.
- Theories of change generated.
- client focussed working.

Whilst these aspects of the If Then constructs were generally supported, in teach back the strongest elements were agreed to be related to small

changes in communities growing confidence, and the primacy of services recognising self-determinism (that people and communities have a right to make their own decisions).

> "*… the increased confidence in communities that had previously achieved small changes really came to the fore in the pandemic, they knew that there were things they could take control of themselves*".
>
> (Seiriol Stakeholder)

> "*Recognising communities' self-determinism really depends on the maturity of organisations in being able to deal with this, without organisational development it's hard to see how organisations get the confidence to respond*".
>
> (Health Board Commissioner)

Across all the IF Then constructs for coherence building it was noted there is an assumption that agencies know how to do this hand holding at an early stage and can respond. It was suggested that it's just not the case as the dominant culture is still against it:

> "*You almost need lessons coming out from greenfield projects to provide confidence for organisations to carry on in this direction*".
>
> (Holway Stakeholder)

In particular:

> *"… you will only get organisational support for early intervention and prevention at community level when that culture of small successes and respect for self-determined change are fully endorsed by statutory bodies*".
>
> (Seiriol Worker)

The implication of how to change organisational culture then was discussed at length, and whilst noting that case studies alone are insufficient:

"… you can borrow our approach but not the conditions that shaped our approach".

(Seiriol Stakeholder)

Rich narratives that capture both contexts and the mechanism that lead to change were also strongly supported:

"*Prevention approaches will give the biggest outcomes, but you need to prove that with stories…that's what's needed to give confidence to funders to invest, they need to understand what it is that makes the change, and yes, its complex but a good story can capture that*".

(Wrexham Stakeholder)

4.9. Links Between Programme Theories

A few further comments were made about the relationship across and between the programme theories and the model of a programme theories escalator relating loosely to Maslow's hierarchy of needs was strongly supported.

It became evident early in the process of revising Programme Theories that there seemed to be an obvious and logical order to them, almost a sequence in the way they fit together and flow as ideas and actions within programmes.

The initial order that the programme theories were presented in teach back had been.

1. identity.
2. space/place.
3. coherence.
4. reframing.

It was soon pointed out that this isn't how the different programme theories happen in practice as an anchor point seems to be space/place, and in these case studies at least not only is it a consistent pattern that the programme

theories flow in the order below, but also that each programme theory also relies to some extent upon the preceding one.

Space/place ⟶ Identity ⟶ Reframing ⟶ Coherence

Not only was this sequenced relationship agreed across stakeholders, but there was also a common agreement that the programme theories may also relate to an underlying substantive theory, originally described as the 'Hierarchy of Needs' in his work on human motivation by Maslow (Maslow,1943).

As with other elements of common theories and ideologies that were emerging across case studies (such as the affinity with salutogenesis or strong elements of Cynefin), neither through observations, soft systems workshops, interviews, and documentation review was there any indication of a deliberate building of programmes around a theory. On the contrary, the programmes were all quite organic and a blend of ideas coming together from workers and participants, assumingly any reference and evidence of an underpinning theory such as Maslow's therefore comes from the previous education and experience of those involved.

The alternative is that each Community Health Development Project has been inspired by an exemplar or Community Health Development Project elsewhere that has deliberately underpinned its model, yet all four case studies claimed no such exemplar was used and they were all "home grown".

This was surprising as through each set of teach back conversations a sense of underlying alignment with the Maslow 'pyramid' came through either implicitly or explicitly.

> "*It was almost that Maslow's hierarchy of needs, led by the service users as we met each need, they would express what they wanted more. They often said that what they ultimately wanted to do was help people themselves and it really was very much led by the community, and I had never really experienced that before*".

(Wrexham Stakeholder)

"*We can rock up, do the basic health provision, benefits, housing and actually I have just written that old Maslow stuff down its about giving someone somewhere to live, somewhere to love, new relationship, something to do, a new purpose, so actually that's where we are up to now – we have done the basic bits but it's not enough*".

(Holway Worker)

"*We started with basic needs but then we moved on from the basic needs to asking about their self-belief, asking about help with confidence, and they were ahead of us and saying we are bored we want to do things. Yes, it was almost that Maslow's motivation hierarchy thing of as soon as we have met initial safety needs, we moved on to other needs, we asked them what do you need and they started with the basics and then it built quickly from that. Truly led by them*".

(Youth Shedz worker)

A basic presentation (figure 4.13) was then roughly constructed to test with all stakeholders how these middle range theories, explaining the underlying logic of community health development programmes, work synergistically when in a certain order to move people towards wellbeing in a manner modelled by Maslow (1943).

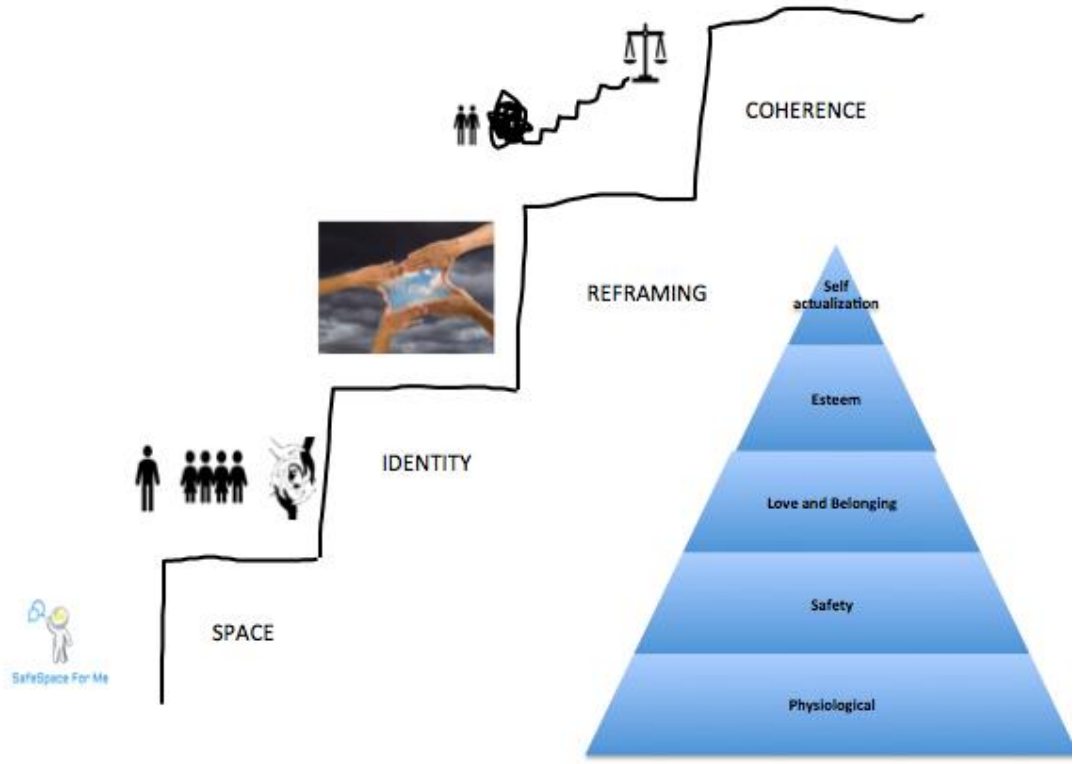


Figure 4.13: Visual Representation of the Programme Theory

When regarded in this way an overarching narrative binding the revised programmes together in a sequence took shape. The resulting sentence then formed the overall programme theory.

> If a **space** is provided allowing people to feel at home and express their real self, then building **identity** helps relationships form with others to create joint ownership of a cause or task; **reframing** helps them individually and collectively to address complex issues and through increasing understanding, motivation and meaning (agency) a sense of balance, **coherence** and wellbeing may be attained.

The term '*synergistically'* is used to describe this relationship between middle range theories as it suggests that it isn't just about the existence of the four programme theories in a programme that is important, but how they work together to produce a combined effect greater than the simple summation of adding them together.

Maslow may give some insight into why this may be the case, space/place aligning with meeting the needs at physiological and safety levels; which means new needs relating to love and belonging, when they emerge, can be attended to through identity building; once people feel they are in a place and with people that they feel comfortable with issues of esteem and even self -actualisation may then emerge and be addressed through reframing perspectives on needs and assets and through learning, reflections, and trying small experiments for change in safety may then result in coherence and articulation to others of their collective self.

This basic step model was agreed but with the caveat that, certainly during the first phases of covid, it was not so sequential.

.

> *"… so, you had to go back and rerun processes again, the identities and belief in communities changed so much during that time, processes usually paid attention to at an early stage and then moved off from were 'checked in again*".
>
> (Seiriol Worker)

With this amendment, that it should not be taken so literally that a programme must use it as a step ladder to build a programme starting with finding a place first before undertaking the other 'steps', teach back stakeholders gave firm affirmation that it provided a useful model and that it helped to illustrate important aspects of how programmes work.

It also provided a useful device to explore where the major traditions of community development may fit within it. Because the realist lens was

chosen to undertake the study, throughout the realist evaluation phases it had been carefully managed that reference to specific underlying community development theories had been minimal.

Asking simply, what works for whom, why and in what contexts? had meant that underlying elements of theories came through but were not constrained, or framed within, constructions. The only exception to this was that the apparent dichotomy of community development primarily dealing with deficits and those which took the approach of appreciating assets regularly cut through in workshops, documentary review and in interviews (see figure 4.14).

It was therefore important to test how these relate to the emerging model of synergistic programme theories.

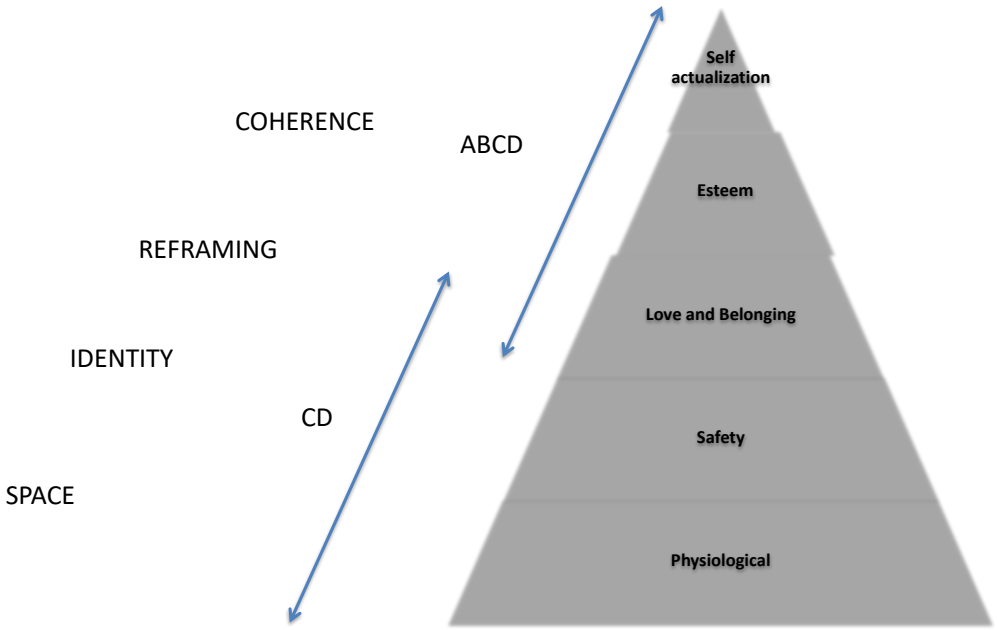


Figure 4.14: Visual Model of the Relationship to Community Development and Asset Based Community Development

There is an obvious alignment with deficits approaches essentially implemented before asset-based community approaches that does tend to reflect the Hierarchy of needs. As the study of the Wrexham Hub study from Glyndwr University (Hughes et al., 2012) found, the Ethos of the Hub centres on the belief that participants needs are best served initially in an accessible, person-centred and de-medicalised environment, but then there is a step change in intervention from meeting shelter needs to using the inclusive empathetic and helpful attitudes of front line staff to then connect people, affirm identities, and begin the processes of reframing and coherence building using appreciative inquiry methods.

> "*Hub staff and volunteers believe that if people accessing the service are afforded an opportunity to be listened to and in turn feel valued and respected they will be more likely to be engaged and therefore better able to achieve stability…The whole homeless services previously was built on deficits – we tried to turn that around by bringing services to the hub and then developing ownership – so with hepatitis C which is a deficit model really we brought services to the hub and then after treatment one of the participants then became a hepatitis C champion and went on to do peer education – with greater impact than we could do." Also, the way we developed the strengths-based approach was through the resilience and wellness programme, what do you really love doing and if your life could be really good what would it look like? What would you be doing? And they would say help other people or set up a yoga group – everyone has a skill and it's just getting a way of finding what that skill is.*
>
> *So, the fact we start with that deficit-based approach doesn't mean we stop there – we build as soon as we can onto that by asking more about their strengths and interests – from deficits to assets as soon as we can*".
>
> (Wrexham Stakeholder)

This was quite deliberative, and she went further to explain that, even without a specific theory and model for it to work from, the workers simply kept focussing on the same question to drive interactions with the participants "what do you need now and what's next?" This expressed their ambition to try to develop a progression pathway so that each participant could become part of the delivery team themselves and ultimately then help others.

> "*Led by the service users as we met each need, they would express what they wanted more. They often said that what they wanted to do was help people and it really was very much led by the community and I had never really experienced that before*".

In other words, a journey through needs to assets, and then actualised participants sharing their journey with others and facilitating their journeys, a progression through both the hierarchy of needs and demonstrating the synergy of the programme theories.

This is remarkably like the experience in Seiriol:

> "*For us the basic step model is agreed, and certainly using ways to initially tackle deficits through community development but then to empower people you have to bring in assets approaches, there is an element of work you have to do before you get to the assets work otherwise people can't tune in to it!....what's important is that if you don't understand the challenges in communities you can't then understand the assets - when you get to ABCD there is an element of negotiating how those assets are prioritised – homeless issues and older people's issues are very different – you can't compare those assets without understanding the underlying difference in deficits – not seeing kids for two weeks versus having your lawn cut by social services aren't things easy to equate*".
>
> (Seiriol Stakeholder)

Within Seiriol a much more cyclical process was developed:

> "*It doesn't stop you have to keep remember that you can't keep stripping assets from communities you can't just leave it that the communities assets are just the people that are left – resilience is not about breaking them down so far that they have to bounce back – we should keep building the strengths at the first opportunity but all those processes we usually paid attention to at an early stage and then moved off from need to be regularly 'checked in again*'".
>
> (Seiriol Stakeholder)

This apparent synergy and progression in programme theory prompted a further consideration of whether what was being expressed by stakeholders and participants also demonstrates a 'ripple effect' (Chazdon et al., 2017).

The ripple effect idea is based upon a belief that a series of events within a system may lead to the evolution of new structures of interaction and shared meanings (Jagosh et al., 2015). Here, the ripple effect combined with the underpinnings of context, mechanisms, and outcomes (described at this stage as If -Then constructs) may account for how the outcomes of one programme theory may form (or at least influence the development of) the context or mechanism of the next programme theory and so on.

If this was found to be the case, it would significantly strengthen the argument that the programme theories do operate in the stepped way that the draft model indicates.

- All stakeholder confirmed a very strong view that it is essential to avoid diminishing the complexity of community health development practice.
- Due to this, simply trimming back CMOs in number is counterproductive, as it risks losing the richness of each programme theory.
- However, there are in each programme theory certain CMOCs that may be considered prime and others that are supporting CMOCs.

- These supporting CMOCs are still essential to consider in understanding what works for whom and in which circumstances in community health development.

Chapter Five covers the final phase of this research and accounts for the presentation of the final programme theory in a joint interpretive forum (and, opportunistically, other forums that offered the chance of engaging with development practitioners and researchers) to gain further feedback and make any final amendments.

This provided an opportunity for these unforeseen aspects of ripple effects to be, not only be acknowledged, but further developed as part of the heuristic.

There certainly appeared to be a strong case at this teach back stage for thinking about the ripple effect within each programme theory, however, what also started to emerge from the discussions with stakeholders was an idea that the programme theories themselves demonstrated a ripple effect between them, suggesting that it should be explored whether at another ontological level - above that primarily focussed upon - there exists a 'meta programme theory' connecting space/place to identity and reframing influencing the development of coherence.

The positive reaction to presenting them together in teach back as connected and dependent had been strong, and more than one person had talked about them as 'ripples in a pool' in that:

> "*... you start with the big splash of ensuring the space encourages people to want to be there and once that is in place and having an effect almost inevitably the other stuff here like the connecting and working on reframing their situation, like ripples in a pond, they will flow*".
>
> (Wrexham Worker)

4.10. Emerging or New Elements Brought into View by Considering the Impact of the Pandemic Upon Case Studies

As suggested throughout this chapter, the impact of the pandemic and consequent public health measures restricting social contacts was profound upon case studies as Wrexham and the Holway programmes both folded (at least in the way that programmes had been operating) whilst Youth Shedz and the Seiriol case studies found new expression and continued with great strength, particularly through embracing digital and social media.

The unprecedented change in conditions brought about by the pandemic and societal response was of such a scale that it was highly likely to have affected the resources available to the programmes and in fact any other matters of 'context'.

It was equally likely that the reasoning within programme actors themselves, and hence programme 'mechanisms', may fire differently (be enhanced or be restricted) as participants, workers, funders, and commissioners all were challenged to think and behave differently.

This will be explored further in chapter 5 'Discussions'.

The pandemic's impact at its very minimum appears to have surfaced some previously unrecognised or unacknowledged aspects of context, such as social capital - "*the social rules, norms, trust, in-short the glue that binds communities together*") (World Bank, 2000), and digital capital – *the available technology plus skills and literacy in using social media and online technology within communities* (Ragnedda, 2018).

It also changed the nature of the relationship between programmes and their funding bodies and commissioners, partly due to the latter not being able to function in the usual manner, but also because there was a shift in attitude towards expected outcomes and a dramatic relaxation in terms of monitoring and evaluation.

The programme in the Holway didn't necessarily halt, it would be more accurate to describe that it faded away during this period.

The research had engaged with The Holway project when its programme theory was being built but was only tentatively in operation. Most of the ideas and approaches described in soft systems workshops and interviews therefore proved to be aspirational.

These may have been carried further in the first phases of the pandemic had the main stakeholder still been in post to progress them, but she left her post at the start of 2020. This coincided with (although in no way was connected to) the community safety issue and a temporary (initially) withdrawal of many services from the community projects. However, this was just before the first lockdown so, there was no opportunity to pick these interventions up for at least the next two years.

A similar scenario of a programme halting occurred with The Wrexham Homeless Hub, however it was much more of a dramatic dead stop as the change in national policy drove the Council to act and implement a new and very different programme theory swamping the Hub programme in one fell swoop.

As previously outlined in section 4.4, the ‘problem’ was conceptualised by the Council Officers charged to act as simply one of shelter and the provision of a roof and bed, consequently homeless people were given accommodation in student halls, but with no other aspects of the Wrexham Homelessness programmes being provided and, most significantly, no wrap around services provision.

In both programmes a series of connected elements was observed

- Despite good understanding and commitment to the programme theory by front line workers across organisations, and it being reflected in policy drivers, middle and senior managers were not in tune and actively championing the programmes.
- Transfer of ownership and commitment to build wellbeing to communities themselves was still at too early a stage for it to be continued without significant services organisational input.

- The social capital around programmes was not yet strong enough to respond to support programmes alone.
- Human to human contact and communication was so central to the programmes it could not be supplemented by any digital means when social distancing measures stopped services operating as usual.
- Ultimately at that point in time both programmes still were very much reliant upon the funding bodies and provision of workers skill, talents and resources to function without their input, despite that transfer of ownership being a key goal.

As the other two case studies not only progressed. but accelerated it is important to understand whether any of these resources and mechanisms operate differently in those programmes in the initial Covid 19 pandemic.

4.11. Summary of Phases 3 and 4 Results

Chapter Four has reported on how four programme theories were tested, revised and a set of proposals for an overall programme theory and model for community health development emerged.

Whilst, due to the necessary research method amendments made, it has relied heavily upon the voices of those involved in each programme, this was always intended as an essential process of testing and validating the programme theories and working with those involved in programmes to refine them further.

The initial research plan had proposed that, alongside teach back sessions, observations following Spradley's methodologies would be undertaken of programmes to capture data on outcomes. This was simply not possible during lockdown restrictions, even within programmes that continued online.

The activities of Seiriol and Youth Shedz could be partially observed online, for example, Medrwn Mon collated stories and case studies from all activities through the pandemic on Anglesey, although many of the digital solutions found to sustain programmes ('What's App' Groups, 'Zoom' calls etc) were not recorded or open to an external observer at the time.

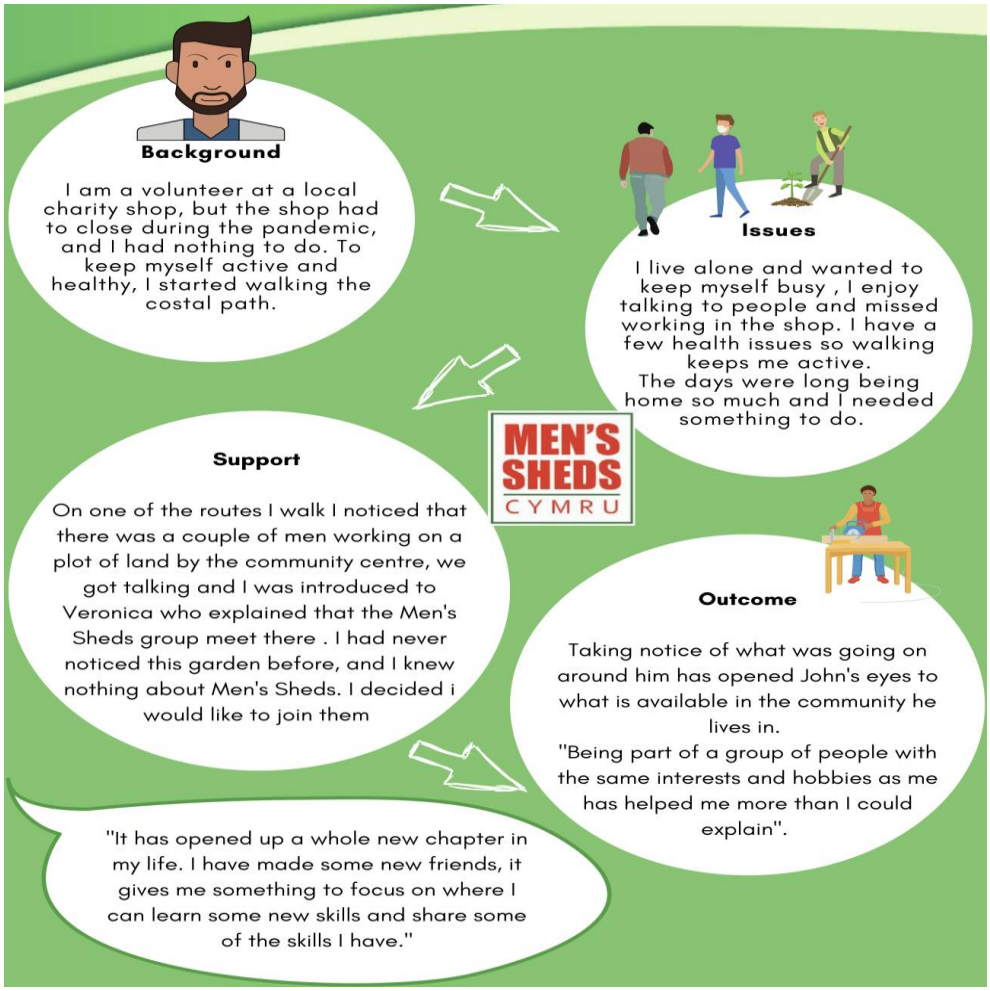


Figure 4.15: Medrwn Mon, 2022

The teach back enabled a validation of those programme theories and supporting If-Then statements commonly supported across programmes, plus it identified which of those underpinning constructs were unique to specific programmes.

The ‘if–then’ statements provided a useful way of structuring the researcher’s thinking. They also helped to focus the process of taking ideas and assumptions about how interventions work, allowed a pragmatic way of testing them against the evidence that was found, plus enabled a consideration of how constructs stood up during the condition shifting pandemic, which new constructs emerged, or were further strengthened.

The teach back phase then ended with a suggestion that the programme theories themselves may each be but one part of a meta programme theory connecting them in a ripple effect.

Chapter Five will now assimilate this learning, reporting on the actions taken in Phase 4 of the research, developing the final programme theories after they have been presented to, and refined by a Joint Interpretive Forum.

The Joint Interpretive Forum (JIF) combines experience and representation of the research sponsor as well as the Community Health Development Project lead stakeholders from across all four case studies jointly considering the programme theories and to what extent they answer the initial question.

"***What works in community (health) development, how, for whom and in which circumstances?***"

It presents the high-level programme theory alongside a visual model which articulates how the four individual programme theories relate to each other in a sequence for further scrutiny.

The Joint Interpretive Forum was also asked to consider two issues suggested in teach back sessions, how supporting Context- Mechanism – Outcomes constructs are related and may exhibit ripple effects between them, and, if there is anything specifically pertinent for programme theories about the North Wales context for these programmes.

CHAPTER FIVE:

CONSOLIDATION: PHASE 4, JOINT INTERPRETIVE FORUM AND THE FINAL PROGRAMME THEORY

5.1. Introduction to the Consolidation Phase

This chapter will end with presenting the final programme theory developed from the processes reported through the chapter, which were a combination of concept mapping, realist synthesis and realist evaluation, consisting of several soft systems workshops across four case studies, teach back sessions with stakeholders, and from a final presentation to a Joint Interpretive Forum specifically outlined in this chapter.

Whilst not originally built into the methodology, delays due to the pandemic also provided some new opportunities for further engagement with the community health field to test emerging theories and refine them.

It also became possible to extend the reach of engagement with a wider group of expertise through presenting and capturing feedback from presenting the research at several conferences, research networks, and online workshops during the later stage of the research to test the findings and gain further feedback on the programme theories and draft model, these had included:

- Rural Health and Care Wales Conference 2021 (Student Poster Award)
- KESS Annual Event (Sustainability Research Winner)
- WHO/Centre for Urban Health Online Conference- Covid 19 Public Health Solutions (Paper Presentation and Workshop) (2021)
- Manchester Festival of Public Health (Poster Presentation) (2021)

- KESS International Summer School in Pardubice (Paper and Poster Presentation)

Additionally, posters were presented at several internal Bangor University Conferences and Research Summer Schools.

These were not initially planned into the methodology, but became an option to exploit when, due to the pandemic, many conferences and workshops moved online. Apart from the two KESS funded events, the other opportunities fortuitously were available at the point that the programme theories had been formed and supporting configurations were at a stage that their recognition and validity could be soft tested with audiences that may add some insight.

The feedback from these events was captured by the primary researcher in note form and key messages collated for presentation to stakeholders in the Joint Interpretive Forum.

Chapter Five covers the final amendments following feedback from the JIF, the next steps relating to this research topic, and reflections upon what using a realist lens offers to the community health development field.

It also discusses an issue not foreseen at the initiation of the research, the emergence of a potential ripple effect as outcomes from each programme theory may form new contexts and these contexts may themselves become new mechanisms. Working this through with the JIF was an important stage of the whole research process as previous phases had been effective in using the realist lens to explicate Middle Range Theories to reveal the underlying logic of programmes, test them against the evidence from literature, and practice case studies using ‘if – then ‘constructs and then set out ‘Context- Mechanism- Outcome configurations’ (CMOCs)

What further emerged from this was a connection and logical flow through the four programme theories which is not necessarily linear but, stakeholders proposed, cyclical and can build within a programme as it is progresses and grows.

This ‘ripple effect’ builds programme synergy as each individual programme theory is strengthened by its interaction with the others.

This final phase of the study, presenting the programme theories to wider audiences, enabled these initially unforeseen aspect of ripple effects to be, not only acknowledged, but further developed and with a greater consideration as to whether context-mechanism-outcome configurations can themselves be linked to each other - with the outcome of one phase of a project becoming an aspect of context for the next phase.

This chapter then accounts for the further development of the programme theory modified following teach back with Community Health Development Project leaders into a final programme theory and visual model, together with an initial exploration of potential ripple effects between programme theories and how the programme theories are linked and supported by substantive theories.

5.2. The Development of a Modified (Final) Programme Theory

The process of developing an initial broad working theory into realist Programme Theories is illustrated below in figure 5.1. Previous chapters have accounted for its development through concept mapping, establishing an evidence base through searching the literature, workshops with case studies, and teach back sessions.

The final transition of the Initial programme theory to modify it into Final Programme Theories is to work with a reference group such as a ‘Joint Interpretive Forum’ to interrogate established ‘If – Then’ statements, corroborate, refute them, prioritise them if deemed necessary, and overall provide a final rigorous test upon whether the programme theory is sound and defensible.

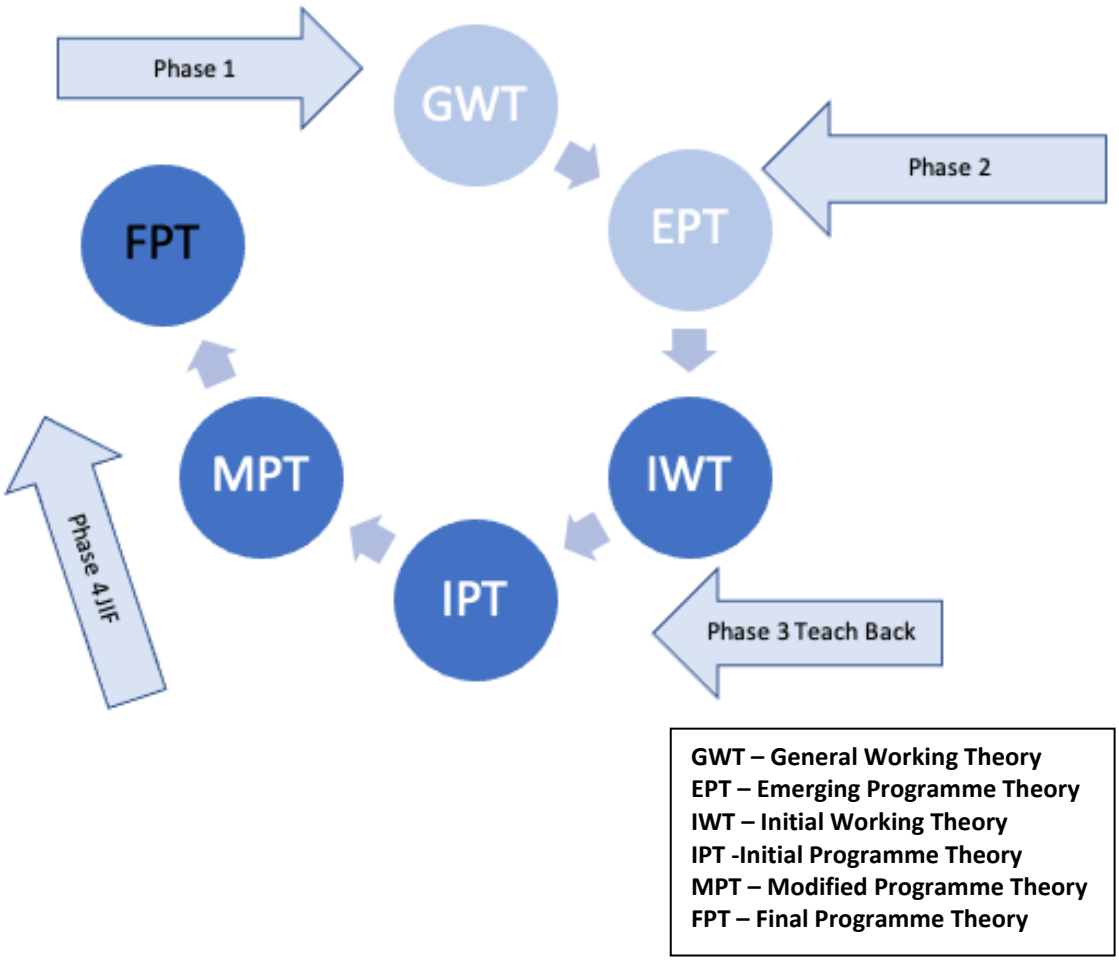


Figure 5.1: Actual Process of Developing the Programme Theory

The Joint Interpretive Forum closed a loop begun in Phase 1 as the North Wales Wellbeing Network, who were involved at the start in concept mapping, was returned to with their involvement in consultation through an online workshop on the Initial Programme Theories.

The purpose of the JIF in completing the realist evaluation cycle, was to further test and refine the programme theories, to validate them, and provide opportunity to reflect on and interpret information from the emerging results of the study (Bartunek, Trullen, Bonet & Sauquet, 2003). It also brought a new opportunity to go beyond what was originally envisaged and to assess what seemed to be emerging as a 'Meta Programme Theory'.

The lead stakeholder from each Community Health Development Project was once again a participatory member of this Forum, as was the representative of the Health Board from the Supervision Team.

As with the Teach Back Sessions in the previous stage, the process for the JIF was a presentation of the steps taken to date, feedback on the basic programme theories as presented in various conferences/workshop to field of expertise in either public health or community wellbeing, and then each programme theory plus supporting CMO constructs was discussed in depth.

The validated IF then constructs from teach-back had been translated into potential CMOs by members of the supervision team in preparation for the Forum.

This was another example of the iterative process and involved lengthy deliberations between team members about the precise application of terms that are in common parlance, terms like “space” and “identity”, but how they applied in these projects specifically as enablers or resources, contexts, or mechanisms.

Once the thirty if then statements, containing potential CMO elements had been crafted they could then be presented to the wider Joint Interpretive Forum for appraisal and scrutiny (figure 5.2). JIF participants were asked to confirm if these constructs make sense, are correctly attributed, and if they add any value to existing understanding of community health development.

As with the Teach- back stage in Phase 3, there was also a process of ranking the importance of each CMO as well as discarding those not recognised or supported by the expert group.

The slides illustrated here show this process at a mid-stage between MPT to FPT, with script in blue denoting those elements the Forum suggested needed be deleted or amended.

The slides of a potential visual model were also shown and discussed.

Creating the right Space: Building a place where people are welcome, feel safe to be and be themselves, opens doorways to change

1. If a community space feels like a home, (C) feelings of belonging and acceptance grow in members of that community (M) and they lower their barriers and open up to support (O)
2. If workers are regarded by community members primarily as people rather than professional representatives of organisations (C) this more- human connection builds bridges between people (M) and trusting relationship develop (O)
3. If a place contains non-threatening focal points ('muses' or conversation pieces) around which to bond (C) community members are able to discuss and test each other's views and express themselves in a safe way (M) resulting in strengthened connections between each other and the development of trust (O) BUMPING SPACES
4. A community space with a revolving door enabling people to enter and leave as they wish (C) empowers them to have control over their own boundaries (M) and feel safe (M) which helps them to connect and work collaboratively with others (O)
5. If community members can access a 'third space' – a place unlike the place they live in or the civic space they work or study in (C) – they can be supported to explore and express their own identity and simply be themselves (M) facilitating a sense of acceptance, connection and belonging
6. If the community's own culture and identity is reflected throughout a space (C) participants feel more comfortable, validated, recognised and valued (M) resulting in feelings of acceptance, affirmation and empowerment (O)
7. If partner organisations appreciate and support local distinctiveness of place and communities (C) tailored programmes can be built which enhance a sense of pride and belonging (M) resulting In greater engagement and sustainable local support (O)
8. If a project is embedded in a wider area that has latent social capital (C) when usual ways of working are obstructed, community resourcefulness and neighbourliness (M) can be harnessed to provide support and guidance to sustain activities (O)
9. If community members and workers can draw upon digital capital (C) new ways of delivering programme activities can be designed evolving delivery from human centred platforms onto virtual and digital media (M) sustaining engagement and programme delivery (O)

Developing a route from "I" to "me" to "ours", creating a joint identity and ownership for health and wellbeing

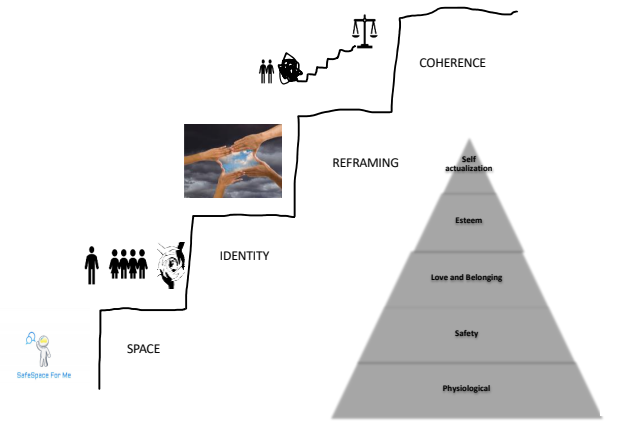
1. When community workers share similar socio-cultural attributes and characteristics of that community (C) the recognition enables bonds and relationships to form (M) resulting in the growth of trust, kinship and cooperation (O)
2. When a common cause or issue can be identified which has resonance across all community members (C) a sense of joint purpose and ownership may be nurtured (M) enabling the community to join in a shared and cooperative action (O)
3. When there is a culture of validation and acceptance of all in the community (C) people can open up to recognising themselves and others around them (M) and form a spirit of appreciation, togetherness and trust
4. When a culture of confidentiality, non –recrimination and respect is established (C) people are enabled to tell their stories and be heard by others (M) resulting in growth of trust and feelings of acceptance and validation
5. When the community identity is congruent with personal values and goals (C) relationship can be formed to echo a family or kinship (M) and a sense of togetherness and inclusion can be built (O)
6. When an understanding of varied and nested communities in an area is recognised (O) exploration of difference and common factors can be undertaken (M) helping community members to acknowledge and resolve the relationships and tensions between them (O)
7. Coproducing plans with peers and project workers in a safe place (C) allows people to develop agency (M) encouraging them to take ownership for their own journey to wellbeing (O)

Reframing wellbeing challenges and appreciating strengths enables wider options to be considered and positive foundations for change to be agreed and owned

1. When communities are enabled and supported to appreciate their strengths and assets (C) a more positive and optimistic perspective and attitude can be developed towards wellbeing (M) and they are empowered to explore the foundations and small steps for change they can make (O)
2. If in conversations with peers or project workers in a community a person is encouraged to think about their own needs, strengths and aspirations (C) they no long feel on their own (M) consider life may have more meaning (M) and are able to develop more positive ambitions (O)
3. If there is acknowledgement across stakeholder services and partnership that existing silo interventions are ineffective in supporting communities (C) it enables the testing of holistic wrap around service provision (M) ensuring comprehensive attention to complex challenges (O)
4. If community facing workers, roles are focussed more upon supporting people to express what matters to them rather than delivering a service goal (C) engagement and coproduction of a wellbeing solution are strengthened (M) and faith, commitment and trust in positive actions and results are increased (O)
5. If community engagement begins with appreciative enquiry/ a 'what matters' conversation or focuses upon what is strong (C) the community can define its own starting point and small steps to take for action (M) with a sense of agency, optimism and ownership for the intended change (O)
6. If communities remain fatalistic about their wellbeing (C) the lack of confidence and diminished faith in possibilities for change (M) provide obstacles to connecting with support and a lack of engagement (0)
7. Understanding the range and access options to helping services (C) provides reassurance and confidenc (M) that support can be accessed when making life changes (O)
8. Creating a services map around community projects (C) enables people to find the most appropriate support to the issues they are tackling (M) increasing engagement and efficacy in changes they are implementing (O)

Building Coherence through understanding wellbeing challenges and finding meaning in positive actions creates agency

1. If a community project is rooted in a salutogenic approach (C) participants are enabled to explore and compare personal understanding and beliefs of the challenges they face, the value and meaning of change, and their faith in achieving any outcomes (M) which provide a sense of balance and opens up options for action (O)
2. If workers and community members work together in co-production (C) more accurate and attuned theories of change may be defined (M) leading to proposed solutions that have wider support and commitment to be tested (O)
3. If a culture of achievable goal setting, positive change, reflection and small successes is built in a community (C) community confidence and a sense of progress increase (M) enabling more positive risks and opportunities to be taken and further and more ambitious goals to be developed (O)
4. If early intervention is valued and supported by stakeholders (C) communities can be engaged in an initiative before the drivers become too complex enabling a clearer understanding of the changes required (M) and the testing and refinement of learning strategies (O)
5. If the organisational and cross partnership narrative changes from the importance of meeting silo based KPIs to prioritising a more holistic sense of success determined by communities themselves(C) workers are able to focus on client aspirations as well as needs(M) supporting self-determined change alongside success criteria valued by the community itself (O)
6. If self-determinism of communities is recognised and valued by all stakeholder organisations (C) project workers are empowered to facilitate people in exploring their own challenges and solutions (M) setting realistic and achievable steps for change (O)



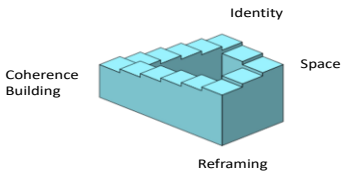


Figure 5.2: Slides presented to The Joint Interpretive Forum

5.3. Modifying the Programme Theory (MPT)

At this stage the thirty CMOC configurations resulting from teach back were presented and JIF participants largely approved them, but after considerable discussion trimmed them slightly discarding some (from 30 to 25 CMOCs), with only minor amendments in language and emphasis to the rest, however,

- All stakeholders confirmed a very strong view that it is essential to avoid diminishing the complexity of community health development practice by oversimplification or reducing only to essential elements.
- Due to this, further trimming back CMOs in number is counterproductive, as it risks losing the richness of each programme theory.
- However, there are within each programme theory certain CMOCs that may be considered prime and others that are supporting CMOCs.
- The idea that each programme theory is connected to the others in a series of ripples is persuasive and one that should be developed further to illustrate their generative causation (Pawson, 2008).

It was affirmed by the JIF that Initial Programme Theories appear to meet the criteria of 'mid-range' theoretical positions, which unpacked both the contexts and mechanisms that led to the outcomes seen across community health development programmes across North Wales.

Middle range theory as it is used here accords with the definition from Jagosh et al. (2015, p3):

> *"... an implicit or explicit explanatory theory that can be used to explain specific elements of programs or how program logic manifests in implementation. "Middle range" means that it can be tested with the observable data and is not abstract to the point of addressing larger social or cultural forces (i.e., grand theories)*".

Each final programme theory is illustrated below (figure 5.3) with the prime CMOCs presented in **bold** and the supporting CMOCs in normal script. This

stage may have only resulted in minor amendments or ‘tweaks’ to the theories however it was after robust debate and challenge by a knowledgeable and experienced group of people with broad based expertise and knowledge across community health and wellbeing.

A realist evaluation of geographically distinct community (health) development projects: what works in Wales, for whom, how, why, and in what circumstances?

If a **space** is provided allowing people to feel at home and express their real self, then building **identity** helps relationships form with others to create joint ownership of a cause or task; **reframing** helps them individually and collectively to address complex issues and through increasing understanding, motivation and meaning (agency) a sense of balance, **coherence** and wellbeing may be attained.

FPT1 Space: A Place to be and to be me!

Good community health development happens when there is a space for people to easily access that is welcoming (C) and where they feel actively welcomed and accepted (M), supported to explore their health determinants (O

- When a community space feels like a home, (C) members of that community lower their barriers (M) and open up to support (M) leading to feelings of belonging and acceptance (O)
- When a place contains non-threatening focal points ('muses' or conversation pieces) around which to bond (C) community members are enabled (M) to discuss and test each other's views and express themselves in a safe way (M) resulting in strengthened connections between each other (O) and the development of trust (O)
- A community space with a revolving door enabling people to enter and leave as they wish (C) empowers them to have control over their own boundaries (M) and feel safe (M) which helps them to connect (O), and to work collaboratively with others (O)
- If community members can access a 'third space' – a place unlike the place they live in or the civic space they work or study in (C) – they can be supported to explore and express their own identity (M) and be themselves (M) facilitating a sense of acceptance, connection and belonging (O)

- If diversity of culture and identity is reflected throughout a space (C) participants feel more comfortable, validated, recognised and valued (M) resulting in feelings of acceptance, affirmation and empowerment (O)

FPT2 Identity: A journey from 'me' to 'us' to 'ours'

Good community health development happens when skilled facilitators support personal reflections (C) to builds bridges between and forms bonds (C) with other people around common issues(O)

- When community workers share similar socio-cultural attributes and characteristics of that community (C) the recognition enables bonds and relationships to form (M) resulting in the growth of trust, kinship and cooperation (O)
- When a common cause or issue can be identified which has resonance across all community members (C) a sense of joint purpose may be nurtured (M) enabling the community to join together in a shared and cooperative action (O)
- When there is a culture of validation and acceptance of all in the community (C) people are enabled to open up to recognising themselves and others around them (M) and form a spirit of appreciation, togetherness and trust (O)
- When a culture of confidentiality, non –recrimination and respect is established (C) people are enabled to tell their stories and be heard by others (M) resulting in growth of trust and feelings of acceptance and validation.
- When the community identity is congruent with personal values and goals (C) relationship can be formed to echo a family or kinship (M) and a sense of togetherness and inclusion can be built (O)

FPT3 Reframing: From what's wrong to what's strong.

Good community health development happens when individuals and communities are encouraged and supported to focus on their strengths and assets (C), and they can adopt a more positive perspective (M) taking control of their wellbeing challenges(O).

- When communities are enabled and supported to appreciate their strengths and assets (C) a more positive and optimistic perspective and attitude can be developed towards wellbeing (M), and they are empowered to explore the foundations and small steps for change they can make (O)
- When there is acknowledgement across stakeholder services and partnership that existing silo interventions are ineffective in supporting communities (C) it enables the testing of holistic wrap around service provision (M) ensuring comprehensive attention to complex challenges (O)
- When community facing workers, roles are focussed more upon supporting people to express what matters to them rather than delivering a service goal (C) engagement and coproduction of a wellbeing solution are strengthened (M) and faith, commitment and trust in positive actions and results are increased.
- When community engagement begins with appreciative enquiry/ a 'what matters' conversation or focuses upon what is strong (C) the community is able to define its own starting point and small steps to take for action (M) with a sense of optimism and ownership for the intended change (O)
- When communities remain fatalistic about their wellbeing (C) the lack of confidence and diminished faith in possibilities for change (M) provide obstacles to connecting with support and a lack of engagement (O)

FPT4 Coherence: Building a personal understanding of challenges, the value and meaning of change, and a consequent belief in an outcome.

Good community health development happens when people are facilitated to untangle the challenges in their life (C), understanding the meaning in those challenges for themselves, (M) and, encouraged to make proportionate and achievable action plans for change (O)

- When a community project is rooted in a salutogenic approach (C) it is enabled to explore and compare personal understanding of challenges to wellbeing, the value and meaning of change, and the faith and beliefs in any outcomes (M) which provides a sense of balance and opens up options for action (O)
- When workers and community members work together in coproduction (C) more accurate and attuned theories of change may be defined (M) leading to proposed solutions with wider support and commitment to be tested (O)
- If a culture of achievable goal setting, positive change, reflection and small successes is built in a community (C) community confidence and a sense of progress (M) enables more positive risks and opportunities to be taken and further ambitious goals to be developed (O)
- If early intervention is valued and supported by stakeholders (C) communities are able to be engaged in an initiative before the drivers become too complex enabling a clearer understanding of the changes required (M) and the testing and refinement of learning strategies (O)
- When the organisational and cross partnership narrative changes from the importance of meeting silo based KPIs to prioritising a more holistic sense of success, then workers are able to focus on client needs and aspirations (M) supporting self-determined change and success criteria valued by the community itself (O)
- When self-determinism is respected and valued by stakeholders (C) communities are able to be supported to make their own choices and decisions (M) increasing commitment to change and a strengthened partnership approach (O)

A series of initially unrecognised or un- triggered CMO configurations also became important when the pandemic meant a huge change in societal conditions, the most obvious of which was the restriction upon social contact outside of household arrangements for long periods of times
○ If a project is embedded in a wider area that has latent social capital (C) when usual ways of working are obstructed, community resourcefulness and neighbourliness (M) can be harnessed to provide support and guidance to sustain activities (O) ○ If community members and workers can draw upon digital capital (C) new ways of delivering programme activities can be designed evolving delivery from human centred platforms onto virtual and digital media (M) sustaining engagement and programme delivery (O)

Figure 5.3: Modified Programme Theory

5.4. Modified (Refined) Programme Theory as a Visual Model

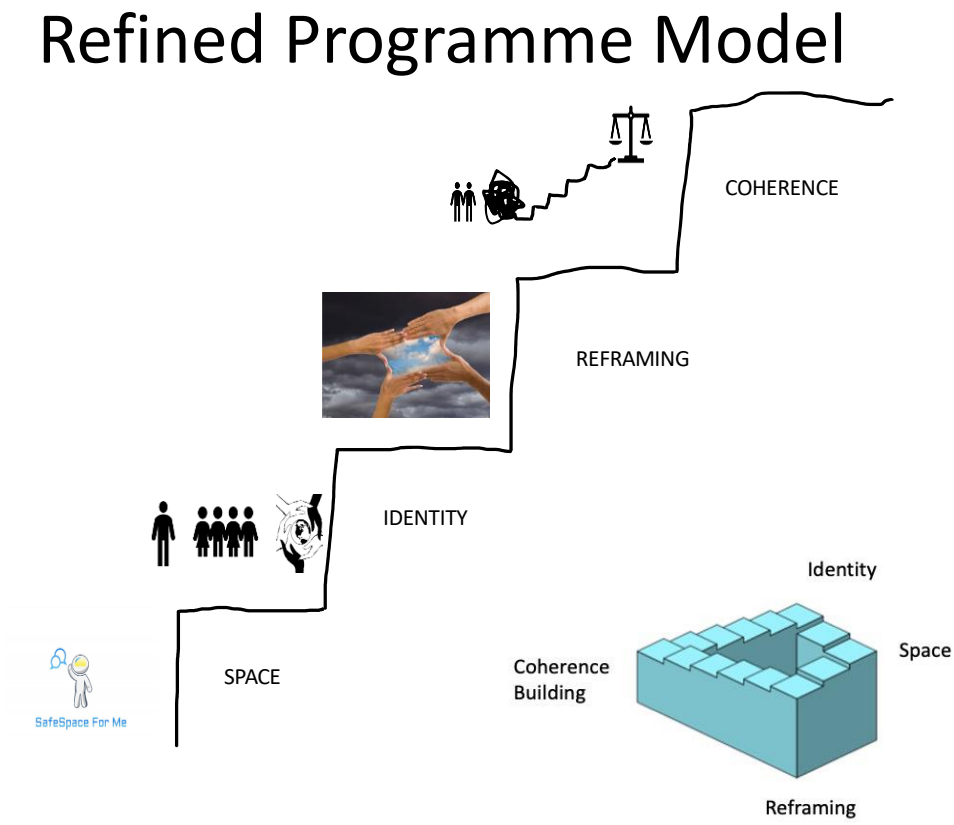


Figure 5.4: Modified Visual Model

5.4.1. The Modified Model Explained: A Stepped and Synergistic Model

This visual model illustrated in figure 5.4, which was built gradually throughout the research phases, illustrates concepts discussed in soft systems workshops, tested in teach – back conversations, and validated by the JIF. It represents the four theories and the interrelationships between them.

Space, Identity, Reframing, and **Coherence** are all appropriate and are each internally valid programme theories. Singly they may be used within approaches to building wellbeing as an individual component, however, their real power comes from how they build upon each other as part of a wellbeing

journey for a community or community participant, or as Hawe et al., describe it:

> "*Events in the history of a system, leading to the evolution of new structures of interaction and new shared meanings*.
>
> (2009, p267)

Foundational in this was the provision of **space** where people can relax and become more open and ready to connect with others through building identity (personal identity and connecting people to others) so they can work on joint interests. Both need to be in a place to enable the effective reframing of challenges to assets and facilitating people to gain a sense of coherence.

However, as teach back sessions explored, people may become engaged at different parts of this sequence and it may need to be a sequence which is regularly repeated (for example through a continuous process of reflection on programme space and identity with participants to ensure its continued acceptance and 'fit').

In this case, it may be more analogous to Rowling's fictitious moving staircases from the Harry Potter novels (Rowling, 2014). Taking this idea one step further is therefore presenting the sequence in the style of the famous Escher lithographic print "Relativity" (Escher, 1953) as a stairway that builds but can be still continuous meaning that the journey doesn't just reach a concluding step but may then lead onto further explorations in a journey towards wellbeing.

Whilst this model does present a persuasive summative narrative of the overarching programme theory that was endorsed and fully supported by each Community Health Development Project and its stakeholders, it nevertheless requires greater scrutiny and testing to find whether it is a convenient juxtaposition of complementary theories or if it is a true ripple effect of outcomes from one stage or programme theory forming some essential part of context for the next stage or programme theory and so on.

Hence, inspired from the work of Jagosh et al. (2015), the ripple effect illustrated by figure 5.5 might be observed:

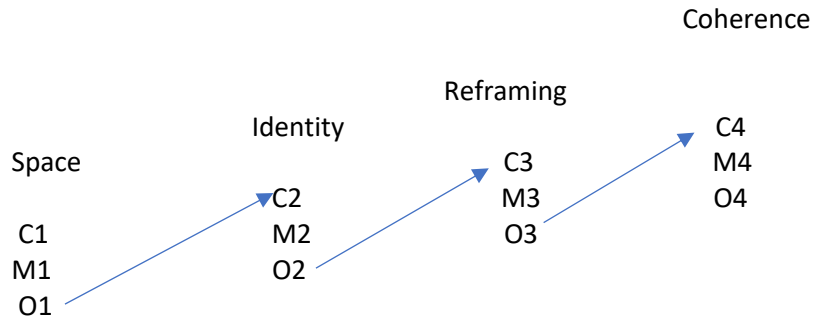


Figure 5.5: Potential Ripple Effect Across Programme Theories

One such candidate identified early in the research at the concept mapping stage is '*empowerment*' as even without looking at it through a realist lens, it was variously referred to across community development and practice as a key ingredient, but was variably described as a guiding principle, a method or an outcome by the experts and those community field workers engaged in the workshops.

5.4.2. Concepts For a Ripple Effect

On reviewing the final CMOCs across the four programme theories two further elements became clear candidates for such a fluid movement and multi-positioning as either or all of context, mechanism, or outcome, depending upon the stage of the overall programme. These are.

- Self Determination and affirmation of the self.
- Social Capital.

Each of these three will now be further considered.

Self Determination and affirmation of the self emerged through Community Health Development Project workshops and was affirmed in teach back sessions and discussions with the Joint Interpretive Forum as a fundamental element of programme theory 4. Respect for self-determination

of communities to set their own outcomes has been shown to be vital in how community health development works.

It is identified as a main element in each programme theory, but does it link and ripple across CMO constructs?

Certainly, if the outcomes from previous programmes have proven that respect for self-determination is a component that works, it sets a supportive context for further programmes to be built specifically to appeal to participants' sense of self through building a space that reflects them and their aspirations.

Central to the theory of self-determination (Deci and Ryan, 1985) is the idea that there are competing forces shaping human motivation and behaviour, those that originate within the self and those that are external from the social environment. Many theories of human behaviour concentrate on the direction of behaviour change but not on how it is energised. External forces impacting upon motivation include social acceptance and congruence between personal values and behaviours (Williams and Williams, 2010).

Most of the contextual factors in the space/place programme theory are about providing a place where people could feel at home and supported to open up and recognise or express their own self. This is very closely related to the idea of facilitating self-determinism. The opposite of this is when people go from service to service to service not recognising their 'self' in any of the access criteria or services offered.

If the space supports expression of self, this directly leads to identity building in programme theory 2, and to establishing the connection and common cause with others in that community.

That joint appreciation of individuals and collective 'selves' and aspirations are then the essential context for reframing and, in turn, the positive framing of self becomes the main mechanism within coherence building as individuals are supported to make their own choices and decisions.

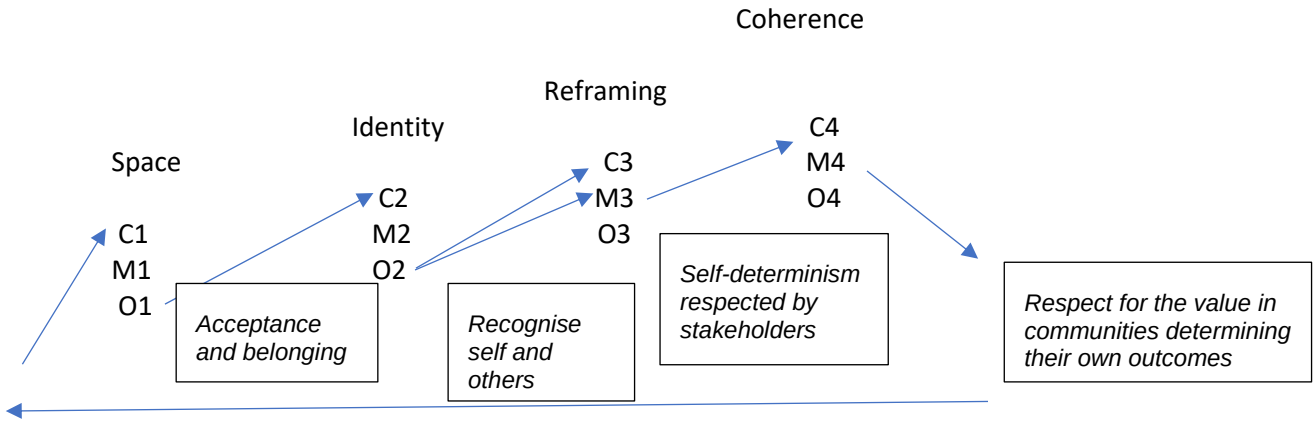


Figure 5.6: Ripple Effect of 'Self Determinism'

The two arrows here between 'identity' and 'reframing' illustrate that this may still be an oversimplification.

Self-determination resulting from feeling in a comfortable place and working on self and joint identity both sets the context for taking a more asset-based frame on health and wellbeing issues, but it also becomes the mechanism by which options and small steps for change are defined.

The mechanism triggered in reframing of "the community is able to define its own starting point and small steps to take for action" is the context required in coherence. It is essential that commissioners and stakeholders recognise and honour this so that all the mechanisms required for building action plans for change in the programme can fire.

Social Capital may be also considered in this manner, particularly during the pandemic societal lockdown phase.

Whilst not recognised initially in programme theory building, it became very significant for programmes when social distancing and service restrictions were implemented. Within programmes the building, bridging, and bonding rippling across each of the programme theories overall builds social capital

within the programmes. However, it also became evident that the culmination of building identity and a community spirit was also to express that community identity externally and to change wider perceptions of society about it, expressed in another way, bridging, bonding, and shaping other communities too.

The importance of latent social capital in the Seiriol and Youth Shedz programmes has been emphasised, and the lack of it in the Holway and Wrexham case studies in programmes that stalled also noted.

On a global level this has also been evidenced with Wong and Kohler (2020) noting that social capital that '*recognises the needs of vulnerable in communities and ensures that they are connected with and not ignored*' has been crucial in tackling the pandemic across countries and communities. In particular, they note that it has played a main role in linking those people with low risk of loss of life from infection (especially those who are motivated and able to help) to those with high risk who are vulnerable and need that help.

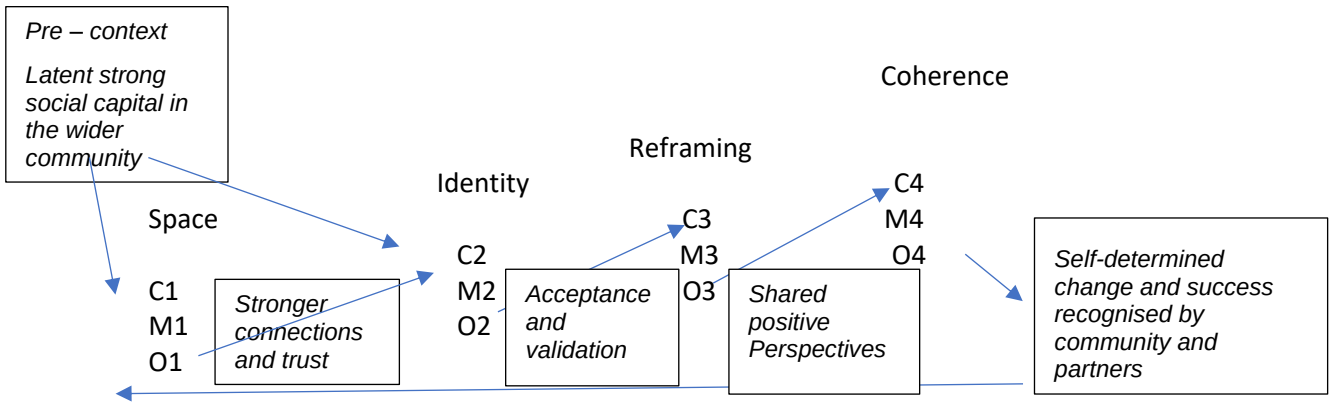


Figure 5.7: Ripple Effect of 'Social Capital'

Lockdown meant that Space/place became inoperable in a physical sense, yet the availability of **social capital** combined with **digital capital** was able to supplant it and enable the continuation of programmes through support for programme theories 2, 3 and 4 to be sustained.

Both Seiriol and Youth Shedz had achieved wider recognition in their nested communities and support was available for them to transform their delivery using digital solutions to organise support. It would be easy to concentrate upon the digital solution as the main factor in this as the platforms enabled projects to run in a different way, however the driving force to make the change came from a joint desire by people bonding together to look out for and provide support to their neighbours and particularly to the most vulnerable.

It is the mechanisms of bridging, bonding, and building identity and connection between participants across the programme theories that ultimately results in internal social capital within programmes and a contribution to it in wider communities, and this may be drawn upon to sustain programmes when the conditions for programmes are altered. Therefore, a virtuous cycle of social capital building whereby outcomes become contexts become mechanisms become outcomes etc.

Empowerment is the third underpinning concept that may be framed as context mechanism or outcome. It is this idea that in the concept mapping phase of the research workshop participants consistently rated as one of the most important elements in community health development, despite great variation in whether they believe it is a principle, a method, or an expected outcome of good community health development programmes.

Empowerment means enabling the individual (or collective such as a formed community) to take control, in other words have the power to make some change.

One of the fundamental mechanisms within space making is enabling participants to have control over their boundaries and feel more in control (for example a revolving door idea means they can decide for themselves to be there or not). This basic sense of control in being in a place on their own terms is an outcome fundamental to them connecting to others in exploring identity.

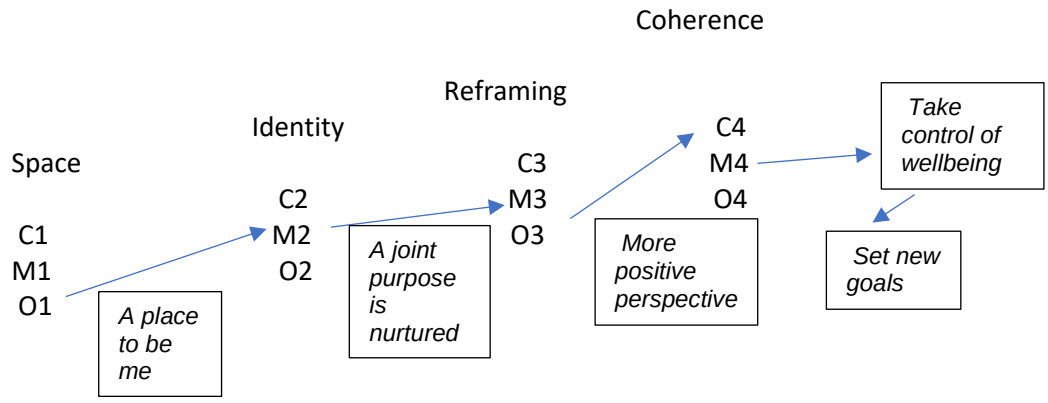


Figure 5.8: Ripple Effect of 'Empowerment'

These three examples of elements that 'ripple' across programme theories

i) self-determination (and respect for it),
ii) social capital, and
iii) empowerment

support the hypothesis that the four programme theories do work sequentially and synergistically within an overall meta programme theory. Although it should be noted that the potential ripple effects across CMOCs here are still oversimplifications and further research into this would be valuable.

The illustrations here have remained at a relatively high level and considered the ripple from groups of CMOs to groups of CMOs across the four theory areas. It would be possible to go further than this in analysis to consider in much greater detail how each CMO within each programme theory demonstrated a ripple effect.

However, to do so would require further steps to be added at a late stage to this research process and to employ the specific techniques for 'Ripple Effect Mapping' (REM).

REM is a specific method of capturing the wider impacts of system changes in complex programmes, particularly useful in Public Health (Nobles et al., 2022). It uses.

- appreciative inquiry.
- participatory group work approaches for reflection.
- uses visual and drawing techniques to explore impacts.

As a process therefore it is very similar in operation to the methods that have been utilised in this research to establish and explicate the programme theories.

However, such a lens wasn't employed at that time and the opportunity was missed to map potential ripple factors across context, mechanism, and outcomes, apart from a rear-view consideration of workshop outputs.

At the end point of section 4, the idea that emerged from teach back was presented, that the four programme theories themselves could be considered as a Meta Programme Theory.

The observation from stakeholders at that point had been that the visualisation of the four programme theories as connected was a sound one and the stepped visualisation of a staircase worked well, however in practice it didn't feel as linear and predictable as that and a more organic visualisation of ripples in a pool had been offered.

The ripple effects illustrated here in 5.6, 5.7 and 5.8 do support the notion of a 'Meta Programme Theory' for community health development as the outcomes from one programme theory become the context for the next, but how may this be presented best in a realist sense?

The JIF had already helped to hone an overall statement of the shape of the programme theory, but without attribution of the C, M, and O's.

> '*If a **space** is provided allowing people to feel at home and express their real self, then building **identity** helps relationships form with others to create joint ownership of a cause or task; **reframing** helps them individually and collectively to address complex issues and through increasing understanding, motivation and meaning (agency) a sense of balance, **coherence** and wellbeing may be attained.*'

The JIF then considered this against the basic generative causation model underpinning the classic realist evaluation and synthesis approaches according to Pawson (2008) outlined here in figure 5.9.

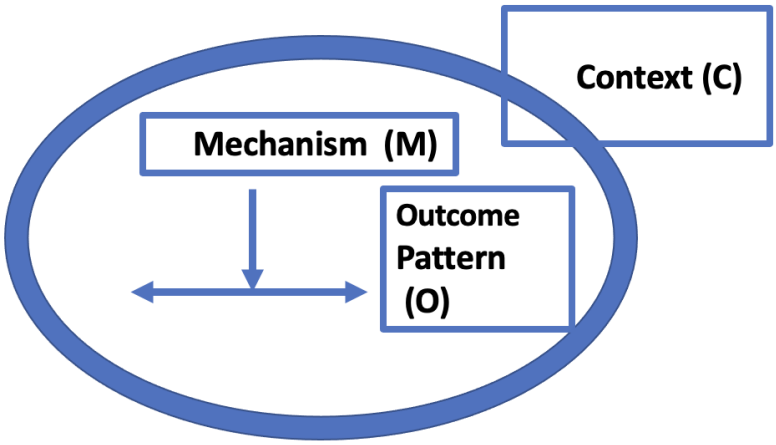


Figure 5.9: Basic Generative causation model

They asserted a preference for retaining a much more visual element of the programme theory that remained true to how they experienced it working across their four case studies and, hence, Pawson's figure was harnessed as a muse to present the "Meta Programme Theory for Community Health Development" (figure 5.10) thus:

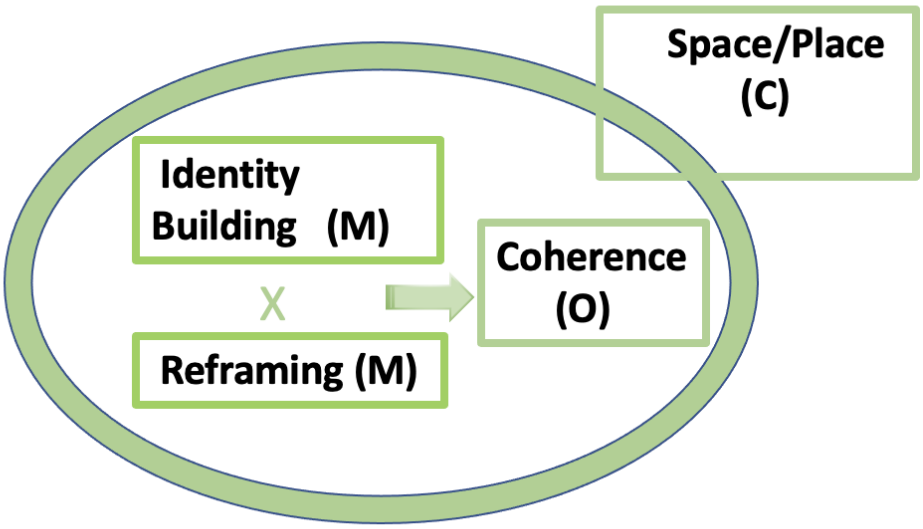


Figure 5.10: Meta programme Theory for community health development

In word format this strengthened Meta Programme Theory, complete with CMO's now reads as:

> **"*When a community health development programme creates a space in which members of the community can be and feel able to 'be themselves' (C) identity building (M)and reframing (M) processes can be ignited resulting in individual and community wide experience of balanced wellbeing and a state of coherence (O).*"**

5.4.3. Relationship To Substantive Theories

Throughout the workshops and interview stages of the research a keen scrutiny had been maintained to capture for reference any acknowledgement or deliberate adherence of programmes to underlying substantive theories.

It was important to recognise and capture whether any underpinning model was being worked to which may shape the programme theories. Principally,

whether there was alignment with any grand theories pertaining to specific community health traditions.

As discussed earlier in Chapter Four, there was one substantive theory referenced numerous times during teach back, Maslow's Theory of Human Motivation (Maslow, 1943), and its relevance to the programme theories has already been covered in some depth.

The other two substantive theories or ideas that, whilst not directly referenced in original workshops, or specifically named, but were constantly in the frame of conversations because of the ideas that they influence (and kept recurring), are the concept of Cynefin - which inspired David Snowden's work in helping leaders understand decision making in context, and Salutogenesis - Antonovsky's ideas underpinning the drive towards asset-based approaches to wellbeing (Antonovsky, 1979).

The ideas and conversations around these two substantive theories arose time and again through workshops and interviews, yet neither was mentioned by name at any point.

Despite this, both remain as central and important to the programme theories as Maslow's theory on motivation.

Cynefin, as the word that sums up that connection for people on a very personal level between their sense of self and how it is dynamically interrelated to their habitat, home, heritage, and national or community identity is the idea underpinning and connecting the space and identity programme theories. Another Welsh word with no direct English translation 'Hiraeth' sits alongside it. Hiraeth denotes a grief or sadness, almost a nostalgia for a Wales of the past, or communities as they might have been.

It does not have to have a sense of reality to it, as in it doesn't have to be an accurate depiction of a Wales and communities that once were. In fact, it is almost always an idealised notion.

Its importance, as with Cynefin, is that both drive a preference for communities that give succour to that longing for 'home'. In the 'Hiraeth Book' Helen Iles (Iles, 2019) describes how being away from Wales but in a community that she was enjoying being a part of, stimulated a need for her to reconnect and form new meaningful bonds with herself, who she was with and where she was – her place and her context. This is the essence of Space and Identity programme theories together.

> "*Cymraeg – this ancient language of poetry and myth – lends hiraeth a more mystical significance than a mere longing for one's country. As well as a longing for land, I sense that it points to a disconnection of spirit…let us look again at the way we live our lives and make time and* ***space*** *for the knowing that comes via the felt senses…. We need to find a way to discover what that the Buddhists might call refuge, a sense of safety found not only in land and community, though they surely support it. A refuge is a place where we can truly rest****. Where we can be ourselves and feel accepted and loved for who we already are***".
>
> (Iles, 2019 *promotional excerpt*)

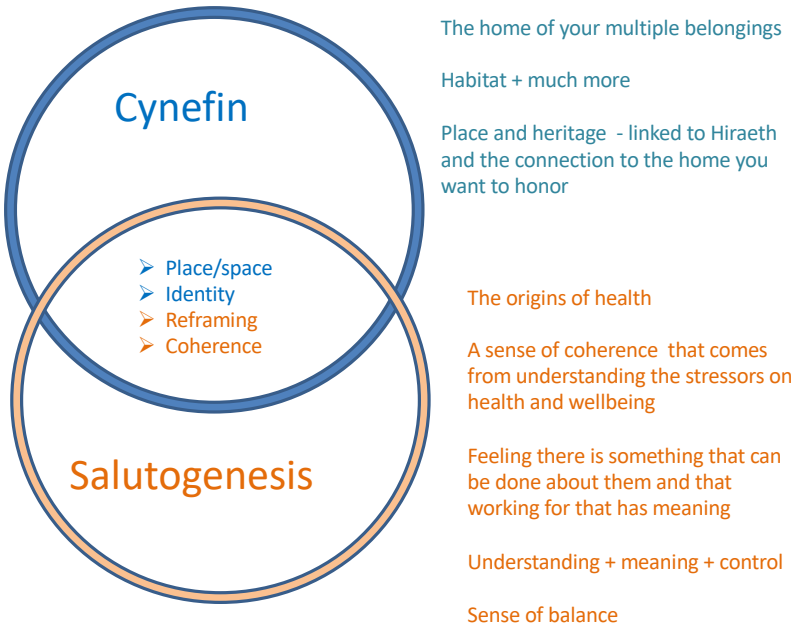


Figure 5.11: The Potential Relationship Between Programme Theories, Cynefin and Salutogenesis

In a similar fashion, that Cynefin supports and connected space with identity, so salutogenesis binds reframing and coherence building. Harry Burns, then the Chief Medical Officer for Scotland explained it most succinctly in a Ted x Talk in 2014 when he outlined that:

> "*In the salutogenic paradigm we also tend to avoid hysteria about stressors and move away from the traditional question of: 'How can we eradicate this or that stressor?' towards* ***a new way of thinking*** *where we ask: 'How can we learn to live, and live well, with stressors, and, possibly even turn their existence to our advantage?' The aim thus of this new perspective is to explain health, rather than disease*."
>
> (Burns H, 2014)

Hence it is about reframing health as wellbeing, not just the avoidance of disease, but it is moreover about achieving a more balanced life which has a more nuanced understanding of wellbeing, meaning, and motivation,

> "*Antonovsky posed the insightful question: 'Given that all people living in poor socioeconomic conditions have broadly the same experiences, why do some stay healthy while others don't?'. he concluded that a healthy outcome depended on the extent to which an individual had acquired a '****sense of coherence'*** *- Unless the individual had confidence that the world round about him was comprehensible, manageable and meaningful, Antonovsky said, the individual would experience a state of chronic stress*."
>
> (Burns H, 2014)

Again, throughout workshops, despite the methodological expressions of these reframing and coherence ideas being regularly discussed as an

'assets approach' or What Matters? Methods were acclaimed, the underpinning substantive theories were unreferenced.

Across programme theories as a whole, a forensic thread from the ideas expressed in workshops and interviews to an array of associated substantive theories can be drawn.

Many of these are contributors to the salutogenesis theory itself as Monica Eriksson has mapped, however, Freire's theories on critical conscious raising and empowerment (Freire, 1973, 2000), Bandura's Self `efficacy theory (Bandura,1977), and, Putnam's on Social Capital (Putnam 2001) all closely relate to the programme theories of place and identity as well as reframing and coherence.

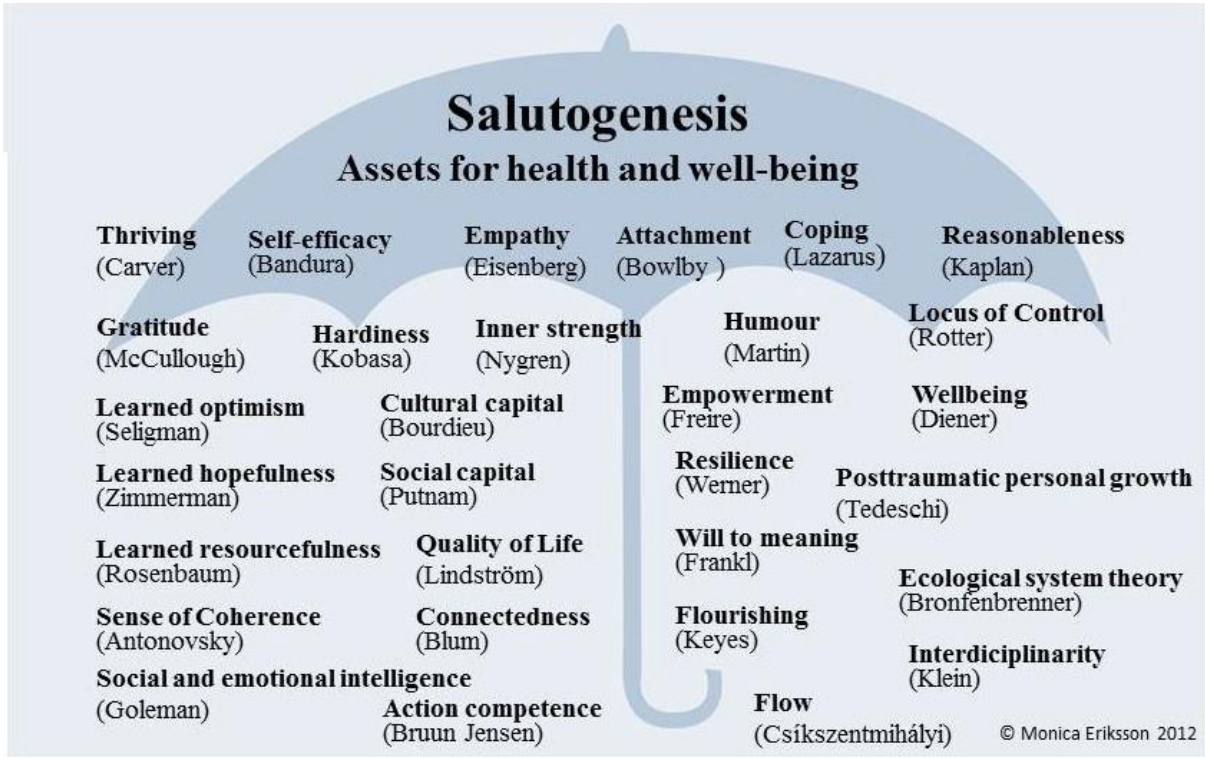


Figure 5.12: Substantive Theories Relating to Salutogenesis (Lindstrom & Eriksson, 2005)

5.5 Further core themes emerging from the results that are vital for good community health development.

5.5.1. Social Capital

One of the most important emerging findings from this research is that if a project is embedded in a wider area that has latent social capital it provides a protective factor, or at least a solid foundation for resilience. When usual ways of working are obstructed, community resourcefulness and neighbourliness can be harnessed through social capital to provide support and guidance to sustain activities.

Furthermore, if community members and workers themselves can draw upon digital capital. new ways of delivering programme activities can be designed evolving delivery from human centred platforms onto virtual and digital media, sustaining engagement and programme delivery.

All four case studies intended to achieve social capital as a main goal within their programmes, this was significantly what the identity programme theory purports to build through the journey ‘from me to us to ours’. If that is achieved, it equates to the most popular definition of social capital that eloquently describes it as the ‘glue that binds communities together’ (Haldane, 2021).

Andy Haldane, Chief Economist at the Bank of England, suggests that past pandemics have tended to collapse many of the capitals on which capitalism itself is built; physical capital, like machines and factories; human capital, like jobs and skills; and financial capital, like debt and equity, whereas social capital may actually be enriched in the face of pandemic pressures on societies and systems.

He suggests that the Covid-19 crisis may have reinforced the values of community purpose and social solidarity on which social capital thrives, allowing it to grow at the same time that other capitals were frozen.

If programmes themselves were able to continue to build that social capital between its participants that might well have been the case. but the Wrexham and Holway programmes suggest that it isn't just social capital creation inside a programme that is required when the context shifts so radically, it is the latent social capital around and able to support a programme in its wider community setting.

In just this manner, the existence of a latent social capital in and around community health development programmes on Anglesey, including Seiriol, was significant.

The Programme Manager described how the previous work in building a general approach across all communities on the Island to be 'neighbourly' and seek to find 'good turns' to do, rather than any formal sense of 'volunteering' was what seemed to spark into action as soon as the lockdown started.

> "*We didn't just have communities as a construct, we had built real networks, people feeling part of a wider movement with joint benefits and support for each other, People didn't see it as volunteering, it was just people doing a good turn, it is the nuance of whether you want the formality of being a volunteer, the volunteering in Seiriol is only about 5% of the good turns taken*".
>
> (Seiriol Stakeholder)

This advantage for the area was picked up by other stakeholders.

> "*What covid has done quicker is that it has stimulated that community knowledge – the neighbourliness – those networks that notice when something different in your neighbours*".
>
> (Seiriol Worker)

> "*Expanding the networks happened as well as – 'I can't bring your shopping, but this person will' -we will lose volunteers but those*

people that have connected are not going to be lost – those people that are connected don't think of themselves as volunteers, just people enjoying their community more, finding and recognising those connections. People don't always want to be volunteers they just want to be more connected neighbours".

(Seiriol Worker 2)

The programme manager noted that this development of social capital had always been the ultimate goal for the programme, however the mechanics of programme delivery had somehow stopped all of that functioning and it took the shock of the pandemic to bring it to its realisation once more.

"*When we started in 2013 with building communities what we wanted to happen was what we have now seen during Covid – people discovering their community rather than the emphasis that did develop which was about projects and bids for things and so on*".

(Seiriol Stakeholder)

This is described as latent social capital as what was witnessed wasn't even necessarily those people inside projects continuing their involvement through the pandemic, it was people around the projects who were inspired to make sure that the projects continued. Hence this was not a formal process of volunteering triggered into action by the pandemic and lockdown measures, but merely a firing of the glue that binds people within their communities across the Island, those unique bonds that people feel about the people and place they call their home.

Whilst this element of social capital surrounding projects springing into action around programmes wasn't evident in any of the other case studies, the increased emphasis on the social capital that had developed within the programme was a significant factor in Youth Shedz programme and specifically enabled the step change to a digital programme almost immediately.

> "*All it took was a simple zoom call that got people into that space again and we said we can't just stop this we've got to find a way to carry on and for some it worked, and they felt easier online but for others it didn't work as well… A good example is" xxxxx" she very rarely comes to the physical shed, but she is very engaged and engaging in the virtual stuff.*
>
> *But yet "yyyyy", who you would have thought would be as she is always in the shed, I thought would be all over it but she's not, she's quite happy to come to the in-person stuff but not this, it works for some but not everyone, but however we do it its ours no one is going to do it for us*".
>
> (Youth Shedz Participant

What isn't clear from these experiences across cases is whether social capital is **context** in that it is an essential part of the backdrop to a programme working, or if it is a **mechanism**, a resource that needs to fire to produce joint engagement and change in a programme.

Furthermore, whether it's lower profile in programmes pre pandemic suggests that social capital was an unrecognised context or if it was an untriggered mechanism?

Whilst this could be largely a semantic issue as Programme Theory 1, the building of identity, the journey from me to us to ours, is a close description of social capital. It still stands that latent social capital around programmes did make a big difference when other aspects of context shifted so rapidly. This then may favour the argument that latent social capital around a programme was an untriggered mechanism.

There is also an argument for considering social capital as an intended outcome within all the four case studies.

In which case social capital may well be one of those ripple factors that changes its nature from context to mechanism to outcome throughout the history of a programme.

5.5.2. Digital Capital

The other form of capital revealed as very significant by the pandemic is digital capital, and here too there is a dilemma of whether this was also unrecognised context or untriggered mechanism.

Digital capital is the accumulation of digital competencies such as skills and literacy in using virtual, often web-based and electronic platforms for information, communication, safety, content-creation and problem-solving, and access to digital technology (Ragnedda, 2018). In short whether a person is able (have the interest, understanding and skills) to engage in the digital and social media world around them effectively and if there is easy access to technology such as Wi-Fi or good mobile phone access.

Youth Shedz clearly had both and there were sufficient young people with good digital capital, supported by their social capital, which drove their joint purpose, to continue their community health development project.

In Wrexham, not only was digital capital not considered essential in the pandemic restructuring, the WIFI in Halls of Residence was also turned off, limiting the options for the programme communications to continue.

This was another indication that the authorities acting had no real understanding of the basics of the community concerned, a community who relied upon mobile phones to keep connected whilst they lived on the streets (Spink, 2020).

Poor digital capital, or at least an underutilisation of it, was also evident in the Holway,

> "*There was some level of digital capital on the Estate, at least people had devices, phones and iPads and stuff but use was limited by pay*

as you go data and poverty levels plus a general literacy issue. `some people helped each other out with online form filming and such but nothing formal, and there were the usual informal Facebook pages about the estate but nothing really linked to services or about health and wellbeing".

(Holway worker)

Without this digital tradition working across the community, any withdrawal of physical support from services to the community programme could not then be digitally supplanted.

The Seiriol experience was very different, and the social networks supporting communities not only existed physically across neighbourhoods but digitally also. Rapid development of 'Facebook' and 'WhatsApp' groups to co-ordinate support for vulnerable and isolated people proliferated, shopping for people organised and co-ordinated virtually, pharmacy deliveries arranged, and simple checking in on neighbours' mental and emotional needs.

This initial response rapidly became more organised and loans of iPads and teaching people how to use them became a new strand of programme development. This relied upon both social capital and digital capital to work.

Within only a few weeks a project had developed whereby young people were filming walks around the Island on phones and iPads so that people who could not get out of their Care Homes, or simply their own homes, could share the experience on iPad or Virtual Reality headsets loaned to them.

5.5.3. Social Digital Capital

Ragnedda (2018) proposes that this blend of social and digital capital is already tightly entwined, and that social digital capital is perhaps a key mechanism to be considered in contemporary community health programmes as it reinforces or mitigates existing social inequalities.

Certainly, across the case studies the significant change in context brought about by social distancing and restricting any person to person contact in the

first phase of the pandemic meant that if a strong social digital environment existed it had a significant impact upon the sustainability of programme activities. Seiriol and Youth Shedz both had strong social digital capital to draw upon, in the Holway it was limited, and in Wrexham any available social digital capital was obstructed.

5.5.4. Expectations on Outcomes

Pre -the pandemic expectations upon outcomes by funders and commissioners was a significant factor for all case studies and respect for the ability of programmes to self-determine them a key issue.

It was evident that if the organisational and cross partnership narrative changes from the importance of meeting silo based KPIs to prioritising a more holistic sense of success determined by communities themselves, workers are able to focus on client aspirations as well as needs supporting self-determined change alongside success criteria valued by the community itself.

If self-determinism of communities is recognised and valued by all stakeholder organisations, project workers are empowered to facilitate people in exploring their own challenges and solutions setting realistic and achievable steps for change.

Throughout each and all the case studies this fundamental tension around outcomes, which is totemic of community health development programmes, relaxed significantly during the lockdown period. However, whether this shift is sustained in a post pandemic environment is unclear.

Within this research the focus that has been maintained has been to work with case studies to tease out the theory behind the mechanisms used in an intervention and this is in particular relation to health and wellbeing outcomes:

> "*Realistic evaluators examine outcome patterns in a "theory testing" role.* ***Outcomes*** *are not inspected simply in order to see if*

programmes work but are analysed to discover if the conjectured mechanisms/ context theories are confirmed".

(Pawson and Tilley, 1997, p. 215)

It came through very clearly in rich pictures, soft systems CATWOE exercises and subsequent teach back interviews that within programmes themselves there was a consistent adherence to a belief / principle of self – determinism (usually a 'context' but potentially also a 'mechanism') meaning that the wellbeing outcomes that were expected were elements of growth, empowerment, and coherence determined by participants themselves (individually or collectively).

The overarching programme theory uniting the case studies was based on facilitating people to journey towards empowerment and wellbeing in whatever sense it meant to them – not to the workers supporting them, stakeholder organisations, funders, or commissioners – but themselves. However, this is not necessarily how funders resource or monitor programmes for outputs and outcomes (figure 5.13).

Wrexham	**The Holway**	**Youth Shedz**	**Seiriol**
At the start, even when we had the data – I thought if we can get data it will help gain resources so we did our own broad impact assessment but even then we couldn't attract funding – everyone avoiding	From a professional point of view, **we have to open up, we have to forget we have come in with certain aims and objectives and stuff** – we do have to keep them at the back because we do have to	Grwp Cynefin have not swamped it with expected outcomes? It wouldn't have worked – none of this would it have happened – but Grwp Cynefin took a risk – gave us the space and trusted us to work something	What really matters in measuring is the journey that people go on rather than measuring what they get out of it and can we count any quality as a result. The 'what matters

responsibility as it wasn't "their" problem alone So we made it a principle - we don't accept any funding with lots of targets and outcomes attached to it so therefore we don't have to keep changing our project to fit this and that… allows us to be natural and free and develop it as we like! We still survive and get funding …funding ties us and kills creativity …. So, what we do is take lots of photos and tell the stories of what we achieve with accessible real-life stories not tied into detailed numbers. Positive images, and actually now we find funders like those stories too !	work to them but we do have to somehow remove them when working here	up without specific outcomes for the investment being set out. But yet it has produced outcomes – including three other Shedz being set up – and it has now become a charity – this wouldn't have happened if it had been more 'Plan' led at the start. Once the formalities come in it somehow stops the community connecting and building itself. It's a big issue for sustainability.	conversation' is central for keeping the project sustainable.eg men in sheds you can count the number of people turning up over a series of weeks and it might not look so good but just listen to the two or three stories and they journey that is reflected in those stories and it's really powerful – transformed lives are much more than a stat that says ten men meet for two hours each Thursday! That old Communities first approach changed – ten years ago programme funding meant that you were trying to get public services to change their delivery based upon the evidence that you were getting from communities, and then, they changed the focus and new

One danger for the future is that people may think this is a usual scenario – not used to having to fight for funding – and actually in the future its will be harder – less money and it will become rules based again. Outcomes – are you trusted to just deliver the programmes based on belief you have done it before. There is now an understanding that resilience will bring wide outcomes social initially but then economic outcomes will follow			priorities were imposed .. but it does seems as though we are in danger now of going full circle back to those days again Let's hope the What Matters approach survives -It's a casual conversation approach that brings this out – was just being used more by health and social care workers now and is well received – it shies away from the formal and any recording is done outside of the casual conversation NO FORM FILLING!

Figure 5.13: Community Health Development Project Stakeholders expressed views on Outcomes.

These statements from across case studies articulate the firmly held beliefs from within programmes that when there is a strong element of trust from funders and commissioners (**Contex**t) together with a relaxed approach to monitoring for any specific outcomes **(Mechanism)** self- defined goals can be identified and supported to flourish **(Outcomes).**

It clearly takes a lot of faith from commissioners and a requirement that they acknowledge self-determinism, but such a position is still rare in practice, and it is against the way that most commissions from statutory bodies have been undertaken. Despite policy drivers like social value and the Wellbeing of Future generations Act, it is clear that changing decades of ways of working so they become more wellbeing focussed and sustainable is proving to be a difficult challenge. The Welsh Audit Office in 2020 commented upon system progress toward the Wellbeing of Future Generations:

> *"… we have found that public bodies can demonstrate that they are applying the sustainable development principle. But it is also clear that they must improve how they apply each of the five ways of working if they are going to affect genuine cultural change – the very essence of the Act. In the next five-year reporting period, public bodies across Wales will need to work together in taking a more system-wide approach to improving well-being if they are to take their work to the next level*".
>
> (Auditor General for Wales, 2020)

It was also clear from this research that this did cause tensions in stakeholder organisations at local level, specifically within middle management:

> "*I've got a good boss behind me who gives me that free reign, if he goes that could change you know…… it's that permission from above, and a lot of people have had to fight (and are still fighting) to be there and it's really quite tragic when the project is so successful… its constantly arguing back against KPIs that don't fit and won't ever capture growth and transformation*".
>
> (Wrexham Worker)

It was in the Seiriol Programme (and across the programmes on Anglesey), that the impact upon how outcomes were valued changed quite dramatically during the pandemic:

"*Covid was just an accelerator for what we were trying to do – the barriers melted away and there was a freedom to act and an equality – its already though starting to get boxed off again – " back in your box" we heard you and you did well, thanks you, but now we need to organise things again*".

(Seiriol Worker)

"*In the Pandemic local trust from the Council and organisations became very evident based upon the faith that they have worked well in the past you have delivered and suddenly much less paperwork than in the past, hardly any, for example, we had the networks and structures in place so we could hit the ground running …*

The money wasn't the issue, it was more the permission to act and approval that made the difference, and although the red tape didn't totally disappear its grip lessened, and trust became the key thing driving change not monitoring and machinery …

Each local community was allocated £300 but by the time it got down to communities we had already developed the relationships and the connectors – trust came from just asking people to look out for their neighbours – by the time the money got down to them they were acting anyway and for funding organisations it seemed a risk worth taking…

In a perverse way it was the perfect storm as it accelerated all our volunteer and good turn schemes doubled".

(Seiriol Stakeholder)

With Youth Shedz and Seiriol it was this trust, flexibility around indicators and outcomes, and respect for the programmes to self-determine their programme direction that allowed them to respond to the major **context** shifts brought by the pandemic. These **mechanisms** of trust, flexibility, and

faith in self-determinism had also been key elements of the Wrexham Hub pre pandemic and, in theory at least, The Holway ambitions too.

It wasn't any shift in theses mechanisms that halted the Wrexham programme, more that the programme was simply overlooked as a new set of actors followed unprecedented new drivers.

The similar withdrawal of support in The Holway for the emerging programme was also responding to an inability to continue face to face service provision but, in both cases, it must be questioned whether there was a stronger sense of these three mechanisms plus a commitment all the way through from fieldworkers to the strategic leaders in the respective stakeholder organisations, that programme would have been supported to find their own new directions and way to respond to the pandemic.

Looking to the future, as communities emerge into a post pandemic set of conditions, even in the surviving case studies, there isn't so much optimism that the valuable lessons about mechanisms have been really learned across all partners. As the final teach back session was concluded by the programme manager for Seiriol:

> "*The pace of change was the most significant and it was due to the conditions in which we work changing so quickly everything just melted away – all the hindrances and the "can we do this" can we do that" just melted away and enabled this enabling environment to blossom …but I am already afraid it's starting to be boxed up again and pushed back to remember your place, remember your role and what you are funded to do – go back into your box – it will be dire if that goes back to how it was before covid.*
>
> *It is a risk that we* ***undo the good of the flexibility that covid brings*** *– We already see the slips backwards– back to the "new normal" active volunteers is dropping off but that's not actually bad if Covid acerated the networks and reconnecting in communities under a common threat as more threats will come following Brexit…*

We couldn't have done this prior to covid – it is this common threat that did that...it would have taken a long time for us to achieve that".

It is this last line that is the most significant as Covid 19 combined with the public health social distancing measures was such a major condition change that it impacted upon so many of the contexts for programmes, in some maximising the reaction of mechanisms, but in other programmes snuffing them out.

In Youth Shedz, it is significant that self-determinism and the right to shape their own outcomes flexibly is so central to their approach that it is threaded through their published "Shedder Principles" (Youth Shedz, 2022)

> "*Once the formalities come in it somehow stops the community connecting and building itself. It's a big issue for sustainability. It was a very conscious decision not to have a defined plan – with a successful project let it organically grow and if it is right, it will attract like-minded people. If you get people together with a shared vision, it will emerge Ground up starting from scratch starting with nothing and allow it to grow".*
>
> (Youth Shedz participant)

This principle allowed them to flex the way the programme operated, and its shift to a virtual programme, partly because no one was able to tell them 'Not to' because it was outside any set goals, targets, or performance indicators.

5.6 Summary - The Process of Modifying Programme Theories to Arrive at Final Programme Theories with Supporting CMO Constructs Through the Use of a JIF

This chapter has brought the various strands of the research together and consolidated them through reflection with the members of the Joint Interpretive Forum.

The main point of this stage was to transform the programme theories into a Final Refined Programme Theory, which has emerged as a Meta

Programme Theory well supported by substantive theory but offering some new areas of insight to the field, both in relation to CMOs but also in terms of the ripple effects of programme theories and core elements within them.

The consideration and scrutiny of the JIF was a very valuable part of the overall research process and although the overall shape of each of the Initial Programme Theories remained unchanged, the apparently minor alterations and changes in emphasis are important and not merely cosmetic changes.

The JIF challenged, rationalised, and prioritised the programme theories and considered at length new elements of programme theory to be considered when such a change in conditions affected contexts and mechanisms in ways that are still emerging two years on from when they emerged.

The JIF were also able to consider the pattern between demi-regularities that appeared consistent across case studies and proposed that another lens of ripple effect mapping might be usefully applied to consider how outcomes from one programme theory might directly relate to context or mechanisms in another.

In doing so, the overall meta programme theory came into stark relief with the programme theory around space/place making proposed as the essential context that enables the mechanisms of identity building and reframing to fire with the resulting outcomes of wellbeing through greater understanding of health, motivation to work towards better wellbeing, and a sense of meaning in the journey – in other words, the sense of coherence so well described by Antonovsky's ideas around salutogenesis.

This meta programme theory was illustrated with three of the key components of community health development that had emerged from the research – social capital, empowerment, and respect for self-determinism. The initial results from this were encouraging and are recommended as a potential area for future research.

An initial idea by the researcher that substantive theories, from psychology (Maslow's Hierarchy of needs) and sociology (Antonovsky's salutogenesis)

plus the philosophy of Cynefin, all have resonance in the Welsh expression of community health development was strongly supported by the JIF and they urged the development of the connected ideas into a visual model more dynamic than the one they were initially presented with.

The basic step model gained approval but with the caveat that, certainly during the first phases of covid, it was not sequential “so you had to go back and rerun processes again, the identities and belief in communities changed so much during that time”, processes usually paid attention to at an early stage and then moved off from were ‘checked in again’.

The proposed amendment to the model was to make it less linear and more cyclical with multiple joining opportunities and to present how the four programme theories themselves operate as a meta programme theory. This resulted in the simple final model (Figure 5.10) illustrating generative causation and the description “*When a community health development programme creates a space in which members of the community can be and feel able to ‘be themselves’ (C) identity building (M)and reframing (M) processes can be ignited resulting in individual and community wide experience of balanced wellbeing and a state of coherence (O).*

Despite the challenges of the pandemic and its impact upon the research methods and Case studies themselves, an adjusted methodology had been able, though teach back, to challenge and refine the programme theories and transform if then statements to a series of CMO configurations to support each programme theory.

This final stage as described within this Chapter Five has shown that through testing with a wider expert audience the programme theory held firm and the final programme theories remained coherent viewed through both a pre-pandemic and peri-pandemic set of lenses.

CHAPTER SIX: DISCUSSION

Despite challenges to its original plan, this research managed to complete its investigation satisfactorily given it had to operate within new parameters and to amended timelines to reflect the social and methodological restrictions on the research methodology during the period 2020 to 2022.

The key findings from this research are four processes, or programme theories, which became apparent at a relatively early stage, and they withstood repeated scrutiny and tests to their validity through repeated analysis by researchers, programme participants themselves and a wider group of experts in community health development.

1) giving people **space** to “be” and “to be me”.

2) building a sense of **identity** through connecting people in “a journey from **me to us to ours”.**

3) helping people to unpick chaos in their life and develop a sense of **coherence**.

4) **reframing** people perspective to wellbeing and what influences it on a personal level.

Running through and connecting these four processes are two complementary ideas that had already been separately recognised as important in community wellbeing circles, but their marriage into one approach has emerged as a significant lesson from the Community Health Development Project exploration in this research.

Cynefin combined with salutogenesis emerged from the research as the key to good community health development, without attention to it initiatives are likely to fail and supporting its active development may well be transformative for people in their communities (Russel, 2022).

These concepts are both quite challenging as they stand out against the orthodoxy of existing ways that public health has dealt with communities over the last five decades.

The individual programme theories of space, identity, reframing and coherence building can certainly be traced within modern approaches to community health development. The ideas of space being very present in place shaping models, connecting people via recognising and celebrating common identity is found in many approaches and reframing and working towards coherence are the anchor points in asset-based community health development.

Yet it is how these work together as part of a meta programme theory that brings something new to the field from this research.

Using a realist approach and mapping the CMO configurations assists in demonstrating exactly how these important sets of ideas work synergistically in practice to produce positive wellbeing outcomes.

Community, and promoting it, became such an attractive proposition across public policy because few can argue with its core concept of community as *where people come together to exchange gifts,* (Nurture Development, 2022) as a positive notion and something that is worthwhile as a social policy goal. However, when questions are then inevitably asked which go beyond the simple definition about what alternative (and more evidence based) approaches such a noble activity may displace or distract attention from, for example focussing on individual communities instead of undertaking system wide approaches such as Health in All Policies, (WHO, 2014) the bubble of positivity around community health can be burst very easily.

Major debates arise when community is being championed in the face of withdrawal of societal support for health and wellbeing essentials at local level and when there is a lack of resources transferred to communities to go alongside shifts in responsibility and accountability. It is in these situations that the ideas of community and community wellbeing become much more contentious.

The tendency to buy into community health development for ideological reasons rather than evidence of how it works has kept the field alive for many years, but it has also struggled to attract long term funding streams and consistent societal and governmental support, an example of this is that none of the four case studies had a funding commitment beyond one or two years and more searching questions have increasingly been asked by commissioners and potential funders of programmes.

The time when doxa (common sense) was sufficient to support investment in a community health programme ended some time prior to the new commissioning environment of austere public finance and the need to prove wider social value of programmes and the contribution to Wellbeing of Future Generations Goals.

The theory driven approach to programme evaluation therefore has proven to be justified for this study as it helps to penetrate the complexities of interventions, unpacking what is really working in such projects to enable a more granular learning to be applied and uniquely reconstructed in other contexts. Often communities look at programmes and interventions successful elsewhere and try to replicate them within in their own different local contexts, but with limited results. The great strength of this research is that it provides them with the tools to build their own success not merely patents to copy.

The importance of this for the Health Board funding partners is that this understanding may then be used to drive future partnership arrangements and investment decisions across the diverse communities whose health and care needs it is responsible for addressing. It also has wider relevance across the Future Generations Act and may provide vital lessons for community health development programmes nationally and globally.

The fear that the impact of a global pandemic would weaken or even halt the research was not realised as the major change in conditions brought new depth to the study and allowed mechanisms to be tested even further.

This discussion chapter will also reflect further on the main themes that emerged from the results.

- social and digital capital and the pandemics trigger for both of these capitals.
- changing expectations on community health development outcomes.
- reflections on the contribution of realist lenses in this research.
- researcher reflexivity.

6.5. The Contribution of a Realist Lens to Understanding Community (Health) Development

The “realist constructed around the lens” theory-driven evaluation framework developed by Pawson and Tilley (1997) that had emerged from the realist traditions in sociology (Outhwaite, 1987; Sayer, 1992; Bhaskar, 1975), has been used in this research to identify, develop, test, and refine programme theories. Programme theories are the discrete hypotheses about what is happening within interventions, or ‘units of explanatory potential’ (Fletcher, 2017). Programme deliverers themselves may be very aware of those hypotheses, but often are not, and the value of bringing them to the surface is that they can become purposeful and consciously fine-tuned and applied.

Maintaining this lens or framework, even when due to the Covid 19 Pandemic the interventions themselves were amended, proved to be beneficial as it enabled vigilance on how the programme theories were impacted and, in particular how, as contexts were significantly impacted, it had an effect upon mechanisms firing in different ways, not firing at all, or new mechanisms firing. It also enabled oversight on outcomes and whether expected outcomes from programmes could still be relied upon.

The Initial programme theories were derived from a range of sources including academic literature, policy documents, and grey literature, which was particularly important given that much of the interest and debate in

community health development is now shared through websites of case studies, opinion pieces, blogs, and twitter.

These insights were then tested against the anticipated programme outputs, observation and elicitation of the case studies and programme theories then supported and developed, or refuted, through the iterative accrual of data (even if the methods for doing so altered in order to navigate the restrictions of the pandemic).

It was always anticipated that programme theories might emerge more strongly than anticipated, meriting further investigation, while others might be discarded because they are not triggered within that programme. This would not render the latter invalid but may just as likely be that they were not actualised in the context being studied as, in another context, they might be observed and pursued. In the same manner, any unexpected outcomes might lead to new programme theories being developed and explored within the evaluation.

However, within this study, it was found that the programme theories held firm even with a fundamental shift in conditions brought about by the pandemic (certainly in two of the programmes). Despite changes to the interventions themselves, the underpinning theories in two programmes flexed and were able to draw upon different capitals or resources (social and digital capital) whereas in the two programmes that halted, it was not the failure of the programme theories themselves, but the fact that how they were delivered was so reliant upon person-to-person interaction that they in effect were frozen.

The strength of using a broad research frame drawing realist evaluation together with realist synthesis and supported using soft systems methods to work with case studies to explore their understanding of programme theory has proven to have had its merits during a turbulent period.

This is both in a very practical sense in that enforced periods of inactivity working directly with programmes and stakeholders still allowed for work to progress on realist synthesis.

From a research methods perspective, a broad realist lens accepts both positivist and interpretivist evidence (treating formalised programme outputs and participants' experiences equally), allowing for the development of programme theories to illuminate the complex systems inherent within social programmes.

By permitting a range of data and data collection techniques, realist research is recognised to be more accessible to non-specialist evaluators.

> '*The data used to develop, and test explanations, can be either quantitative or qualitative. Realist evaluators are generally agnostic with respect to types of data'*
>
> (Mathison, 2005, p. 361).

Another strength is that programme theories are fluid models describing fluid situations. They are refined by combining multiple data 'snapshots' and iteratively amending the theory to develop a sharper image through the application of abductive reasoning.

The success of any intervention in a social context depends on the extent to which the programme theory/theories predicted or controlled the spiral of ideas and changes that occurred because of that intervention. Predictability indicates a level of consistency and therefore a successful intervention design. Therefore, enough data snapshots must be taken so that the programme theory can describe 'demi-regularities', or 'semi-predictable patterns or pathways of programme functioning' (Dieleman et al., 2011, p. 27).

This is particularly important when it comes to community health development as it is at its roots so conceptually fluid and methodologically permissive. Therefore, the data snapshots are required to be broad and long, as elongated along a process or period of observation to create more robust and appliable demi regularities which enable the likelihood of a programme theory being useable in a different intervention, although it always remains open to further refinement.

The use of the CMO heuristic that marshals theories into relatively standardised units is a way of addressing the consistency problem that has historically dogged social sciences.

Their use increases the ‘portability’ of theories, enabling deeper understandings of the links between context and outcome and how the resources available to programmes are triggered to produce those outcomes. The mechanisms being the illusive ingredient so often missing when community programmes look for inspiration at other programmes, and they attempt to simply replicate the contexts and resources but miss what the magic ingredients are that change these resources into wellbeing outcomes.

Realist lenses are increasingly popular methodological frameworks in social sciences research, yet there are many ongoing debates around their nature and application. Many of these are explored within the Realist and Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES, 2020) projects, whose website and mailing lists are a popular resource for discussing realist theory and study designs. Some of the central concerns are transferability, portability, and how to refine programme theories.

Transferability of findings is vital to ensure that research carried out in one context can have a beneficial impact in similar contexts. In our example, how do we know that a wellbeing mechanism triggered by community health development in one place will be triggered in the same way elsewhere? Or even in the same place when the resources available to the programme (the context) has been radically altered (as with the pandemic).

While generalisability remains an ever present and intractable problem in health and social sciences, strangled by the restricted range of ’recognised’ data and data collection methods available, the CMOC heuristic enables a certain degree of standardisation and so, the portability of findings across and between programmes.

In this research CMOCs enabled specific findings and programme theories to be articulated in a way that brough both an ontological depth (consistent with Bhaskar’s ‘stratified’ model (2008, p. 13)) and a pragmatic reliability, in the

sense of being portable and able to be tested in various programmes and contexts.

It is because programmes work differently in different contexts and through different change mechanism that we cannot assume that programmes can be replicated from one context to another or that they will automatically achieve the same outcomes if they are.

However, a good understanding and clearly expressed heuristic of ‘what works for whom, in which contexts, and how’ (Westhorp, 2014, p. 7 - quoting Pawson and Tilley, 1997) provides portability.

That these heuristics could also be framed as a result of this research within a visual model that illustrates how the programme theories connect and work with each other synergistically merely adds to this portability.

The CMOCs themselves tend to represent ‘middle-range theories’ as they are neither too narrow (only applying in very specific contexts) nor too general (providing overarching ‘grand’ theories).

It was Pawson and Tilley themselves who deemed that middle-range theories.

> ‘*… provide analytic frameworks to interpret similarities and differences between families of programmes*’
>
> (1997, p. 217)

In other words, they are useful in guiding the level of similarity at which contexts might be usefully compared. In our example, that means organised community development programmes which aim to build the community itself and support them to create their own wellbeing outcomes or changes to external factors that impact their wellbeing, these are more general than designed to bring about wellbeing-related changes; these are more general than a specific health issue centred programme like obesity or HIV prevention, and more specific than everyday health education interventions delivered at local community level.

The use of abductive reasoning underpinning the use of realist lenses does not claim any absolute truth, merely that it provides ‘inference to the best explanation’ (Sober, 2001, p. 28). Individual theories are still open to ongoing refinement and multiple programme theories might be active and interacting to varying degrees dependent upon the context.

Contexts, mechanisms, and outcomes themselves exist in dynamic configurations and so if one changes, rather like the faces on a rubrics cube, so do the others. Such dynamism means that outcomes are not necessarily replicable in identical ways in different contexts. On the contrary, rather than replicate interventions in anticipation of the same results, using realist lenses enables the researcher to regard subsequent cases as just presenting opportunities for further testing and ‘CMO configuration focusing’ (Pawson and Tilley, 1997, p. 217).

This explains the essence of programme theory refinement in that even small changes in C, M or O revealed by the data give rise to configuration changes in the programme theory. This may evolve further in relation to the programme it is tested in and therefore the realist researcher does not become obsessed with establishing and tying down outcome regularities to be replicable across contexts, but is much more interested in examining the outcome patterns in order to develop a more complete understanding of the generative causal mechanisms (Salter and Kothari, 2014).

This research has taken a very pragmatic approach to the explanation of the programme theories established and has taken the epistemological standpoint of ‘Empirical Realism’, acknowledging the need to ‘draw a line’ and select explanations although further potential explanatory mechanisms may be uncovered (Pawson, 2006). This standpoint differs from ‘Critical Realisms’ assumptions of an ‘overabundance of explanatory possibilities’ (Pawson, 2006, p. 19), which can embroil the researcher in an endless pursuit of potentially false or mistaken explanations (Bhaskar, 2008) in a drive to chase down ever more refined and tightly defined theories.

The research has ambitions to be useful to its funders as commissioners of wellbeing community programmes and to the field of community health development itself who need evidence of what works, that is useable and can be applied situationally.

A (possible) weakness of the research is that despite in depth work with four projects it still does not provide definitive proof of return on the investment to encourage the Health Board to continue or increase funding. The programme theories are suggestive of sound processes and great value to participants and stakeholders of the projects, but the amount of wellbeing created against the resource invested has not been possible.

Rather the main recommendation is to further test the programme theories in other projects, therefore, to expend more resource to validate what works for whom in what circumstances.

There is also a danger in framing the programme theories as part of a visual model that the illustration takes over from the heuristics themselves, however using it to present a broad set of flexible and commonly observed CMOCs for community health development that can be used in a range of contexts helps practitioners and policymakers to navigate and organise the dense evidence landscape. It offers not foundations or restrictive instructions to follow, but a set of hooks and runners along which approaches may be tested.

Each programme theory resulting from this research is unremarkable in the field of community health development and, as already noted, each has a connection and relationship to one or other already existing substantial theories. These theories are found in different places, come from different perspectives ideologically and epistemologically, and there are few examples where they come together as they do here.

Whilst it may seem that the realist lens has, in a utilitarian manner, been unquestionably useful in producing programme theories and CMO constructs supporting them for further consideration by community health development commissioners and deliverers, it must be recognised that untangling specific elements has not been easy, specifically untangling context from mechanism

was not always possible. It is still debateable, for example, whether the existence of digital social capital surrounding programmes was an unrecognised context or an untriggered mechanism.

Having digital competence plus an available IT/digital platform in terms of Wi-Fi connectivity and mobile phone coverage as resources to fall back on when face to face working and meeting was not possible was clearly a major factor that assisted the sustainability of the Youth Shedz and Anglesey programmes, their absence severely hindering Wrexham Homeless and The Holway.

Clearly, in one sense, this suggests digital social capital is a ‘context’ available to two case studies, but not the other two. However, this may be oversimplifying it as ‘mechanisms’ are the 'engines of explanation' or forces that lead to an outcome (Jagosh et al., 2015; Parlour & McCormack, 2012; Pawson, 2006; Rycroft-Malone et al., 2015) and there can be no doubt that during the pandemic the speed and impact of the development community health response in Youth Shedz and Anglesey programmes was not just the availability of resources, but a force and reaction that was certainly fired and drove new actions with a force and energy more akin to a mechanism!

Dalkin et al., (2015, p. 3) describe Pawson and Tilly’s original conceptualisation of mechanisms as ‘a combination of resources offered by the social programme under study and stakeholders’ reasoning in response’. They develop the theory further by disaggregating resources and reasoning – but retaining their causal relationship – within mechanisms. This helps to tease out and draw a firmer distinction between context and mechanism (Dalkin et al., 2015), making programme theories more refined, sensitive, and useful.

While these concerns about whether forces are mechanisms or contexts are worth debating, they do not necessarily diminish the useful products of using the realist lens. Even Pawson argues against becoming overly philosophical and abstract about whether a C is an M (Pawson, 2016) and hence,

arguments about using realist enquiry and if it is robust or merely a pragmatic approach will inevitably continue to rumble on (Porter et al., 2017).

In a policy and research environment where ‘impact’ has dominance, particularly in the world emerging from the pandemic, the ability to develop easy to implement and portable models that improve understanding of the deliverability and impact of community health development through sharing and collating empirical data, is both apposite and valuable.

In a field that seems to be so obsessed with presenting the values and principles of practice, it is useful to reflect upon what the research findings here may add.

Substantive theories already abound, so do myriad sources of values-based practice and ideology (The Community Toolbox, 2022) they play a vital part in creating the focus for action and grounding programmes in the most important foundations.

As with any other concept, theory, or method, there are certain basic fundamentals that determine its very nature. These are often referred to as principles and they act as the key identifiers for a concept down to its simplest state. They may be compared to the materials that are used in the construction of a building - building blocks that individually play a foundational role in the overall structure and function of the final product.

Analysis of these principles can offer a person further insight into the concept they are trying to understand. Value is closely connected to principles, and as principles serve the role as the most important foundations upon which to build, values allow us to move ahead with confidence in creating a sound structure on those foundations.

However, where they fall short most often is in informing what actions may then be taken to ensure the intended wellbeing outcomes, or to stretch the analogy further, how the building is created from its essential foundations. When you have the resources (bricks, a plan, builders etc. what mechanisms change this into an actual physical building).

This is because the field of community health development is one that is so extremely context dependent and very conscious of the unique situation of each community. Its principles rely upon very accurate and nuanced observations of context, but it leads to a tendency then to simply suggest all-encompassing descriptions of values and principles to work by.

Programme theories and their CMO constructions may direct not only what works (which should be familiar from values and principles) but how it works in specific contexts, whom it works for, and how. In other words, an essential guide to constructing a community health development programme than can be applied to different starting contexts.

This highlights the amendment to the visual model suggested by the JIF, that the programme theories should not be regarded as a linear process that starts with creating a safe space for people to be and be themselves, and when that is satisfactorily completed the baton may be passed to building identity, and then on to reframing and coherence.

The variability of contexts across community health development and variance in mechanisms being ready to fire implies that programme theories must be flexible and adaptable in a way that the original visualisation of a ladder or stairway increasing the strength and impact of the programme theories as they built was far too simplistic. That they work synergistically was proven in the case studies themselves, and that they are needed as a complete composite set was also strongly articulated. It was however the emphasis made by the JIF that the programme theories should, and do, support an iterative process because that is exactly what is needed by programmes.

Some community programmes form when there is already a strong identity in place, and it operates in an appropriate and sustaining space. This enables to building of coherence through reframing health challenges and assets for that community. Yet it will still be necessary as the programmes change and grow to revisit those aspects and identity and space to ensure they are all still contributing to the effective overarching operating of the programme.

Whether this research manages to resolve any of the elements of contested ness which abounds in community health development is doubtful. From the very beginning it was necessary to tie down concepts of ‘community’,’ health’ and ‘development’ to begin working on the research and these have not really become any more solid in form. However, the programme theories do have the effect of providing focus for the concepts and the very process of working through the programme theories and supporting CMOs does sharpen the mind about what form of health and wellbeing is being created and through which changes to community recognition, form, and structure.

6.6 A Realist Contribution to Understanding the Impact of The Pandemic and Its Management on Communities and Community Health Projects

On one level it is obvious that such a seismic event of a global pandemic and the shock and awe at its scale and devastating impacts would affect both context and mechanisms. All manner of resources initially available to programmes halted so, context initially was very restrained.

As social programmes, the almost immediate impact of restricting human contact and engagement as part of the initial public health population measures struck right at the heart of the way they worked. This universal component of human interaction was so obvious and ubiquitous that it was missed in the initial analysis and phases of research pre pandemic when any thought that humans would be kept apart in such a way would have been regarded as fanciful.

Similarly, mechanisms that are also so universal they were also missed is an important finding. The availability and interaction of social and digital capitals around programmes became a key signifier of the ability of programmes to flex delivery of their approach and still express their underlying programme theories.

Irrespective of whether the programme aimed to build social and digital capital, or not, it was its availability to stakeholders, workers, participants,

and new supporters of the programme activated by their own reaction to the pandemic.

Using the realist lens helped to identify and draw some learning from this, however further research in this is still required to fully understand and test if:

- latent social capital in communities around programmes was an unrecognised context or an unfired mechanism?
- Digital capital is a separate capital operating in a similar way to digital capital in being unrecognised and unfired?
- Or whether it's more appropriate to consider the two together as social-digital capital recognising within that the rapid growth of the field during the pandemic as 'WhatsApp' and 'Facebook' groups proliferated alongside the use of video conferencing platforms to connect people socially as well as enabling work lives to transition online.

The realist lens was also invaluable in discovering potential ripple effects as contexts become mechanisms become outcomes across a programme theories operation (empowerment, social capital, self-determinism).

6.7. Problematic Areas and The Darker Side of Community Health Development

Undertaking this research has unearthed numerous challenges and questions about community health development beyond 'what works for whom, how, and in which circumstances.

They are not resolved in this investigation as they require further research and investigations to be developed to do them justice, along with amended approaches.

The prime issue is that creating communities purposefully uses place and identity building to establish an "us". However, almost inevitably, doing so will also define a "Them", the "other" and exclude some people or communities.

This may be justified if a community health programme is attempting to protect and strengthen a particular community, particularly if the members of it are similarly excluded from wider communities.

Fortunately, this issue is a familiar one for community health development programmes and why inclusion, respect, and anti-discrimination are so often expressed within a programmes' values and mission statements, in for example Youth Shedz' Shedderz Principles (Youth Shedz, 2022b)

However even with these principles, in the face of the pandemic Youth Shedz, in flexing their approach to harness social and digital capital to move online did end up with an us and them in the same programme as some participants left the programme because they had a strong preference for face to face, whilst others joined because it was no longer face to face. The same programme but dividing into an online community overlapping with a face-to-face community.

The second issue deserving further research emerged in terms of whose outcomes are most valid and how can they be negotiated to the satisfaction of all programme partners. At the heart of this is the centrality of the concept of self-determination.

This research has barely done this core issue justice, beyond recognising it as another concept that acts variably as context, mechanism, and outcome depending on the programme stage and maturity.

Here again the recommendation is for further research into how self-determinism operates as a ripple effect through a programme theory, possibly through a combined research methodology of ripple effect mapping combined with constructing a theory of change.

6.8. Reflexivity

Throughout this thesis, I have reflected upon the potential congruence between my preference for a socio- ecological perspective on health (or more accurately a human ecology perspective upon health promotion) and

the use of a realist lens and its core construct that it is the interaction between contexts and mechanisms that leads to health outcomes.

Whilst it is the mechanism that attracts a lot of focus because they are regarded as the 'engines of explanation' or forces that lead to an outcome (Jagosh et al., 2015; Parlour & McCormack, 2012; Pawson, 2006; Rycroft-Malone et al., 2016), without a relationship with context they may remain inert or hidden and only triggered when context changes are an altered dynamic with context causes them to ‘fire’ (Jagosh et al., 2014; Pawson et al, 2004; Westhorp, 2018).

My own career long frustration has been that taking a human ecology approach inevitably ends up in hard to unpick layers of complexity and the options for change become obscured. When the cause of issues is so multi-layered and co-dependent, finding recommendations for interventions that can be confidently presented as effective can be very challenging.

My ambition in this research was to test for myself whether uncovering mechanisms and their relationships to context was a reliable way to address this and frame more succinctly what can be done to change a situation even when, by understanding context, there is a level of complexity and interdependence of factors.

My specific interest therefore was in whether realist methodologies (either evaluation or synthesis) do provide some rigour to an investigation through the formulation, testing and revision of CMO constructs.

I have found on the positive side that using a realist lens has real congruence with human ecology and if nothing else the process of conducting this research has reinvigorated my interest in my chosen discipline forty years from when I first began its study!

However, in the same way that for many years it was so difficult to explain the notions of human ecology to people as the concepts were so different to the norm, so I have found the language of realist research to be also difficult for people who are not themselves researchers to engage with.

Circular discussions of context and mechanism are in danger of being seen by both practice and commissioners of projects as being little more than academic self-congratulatory musings however, the one phase of the methodology that helped to manage that tension was the teach back sessions with both Community Health Development Project participants and then the JIF. The process of dialogue, explaining my understanding of the programme theories and CMOs and having them refined and fed back to me validated or amended was a vital process of both testing the constructs and in developing a real understanding of them.

Whilst I had anticipated some comfortable familiarity between a human ecology perspective and the use of realist lenses, I had not foreseen a similar synergy between the ideology that emerged of ‘Cynefin’ as a very ecological sensibility working as a force in community building; how easily it fits alongside realist ideas; and its obvious connections to the human ecology obsession of understanding the dynamic inter relationships between people and the world around them.

Less obvious was whether using realist lenses within this research might help to bridge the gap between community health development practice and its apparent preference for participatory research versus funders, commissioners, and policy makers more positivist preferences around evaluation of programme.

This dynamic played out in the constant battleground of outcomes and, as covered earlier, this issue emerged in all four case studies with self-determinism and respect for it becoming a major catalyst for resolving such tension, particularly during the pandemic.

This observation has prompted me to reflect whether this study goes some way towards offering community health development a new starting point when new programmes are being envisaged or designed. Does it offer to the field anything new with regard to the choice between following cases from potentially very different contexts, following sets of values and principles

versus, or by trying to interrogate the lessons from evidence-based practice and assessing their fit with a specific set of local conditions and resources.

The difficulties faced in these are that with respect to designing community health development programmes:

- evidence based practice doesn't go deep enough to find what exactly worked in context and be able to describe it so it could be developed in another context.
- there is plenty of evidence-based practice to draw from but so much of it is contextually specific to that programme and the relationship between contexts and mechanism in producing outcomes is opaque.
- values and principle, whilst important, remain too bland and unspecific for specific assurance of what will work circumstances, certainly with a level of assurance that may assure potential funders.
- therefore, whilst CMOs are difficult to construct they are a helping hand forward for the community health development field.

The primary goal of reflexivity Is not to merely check the positionality of the researcher and how this may have changed during the study, it is to reduce the likelihood of researcher bias.

This is important as in turn this will reflect upon the study's credibility. More positively, reflexivity can show researchers how their own values positively impacted the study (Delve, 2022).

The process involves more than reflecting upon the data and assumptions made, as above, as that reflection is required to be more rigorous than this and question the researcher's role almost as much as the subjects of the investigation and be prepared to accept that as a dynamic part of the whole process the researcher inevitably influences the research findings.

I came to this research study as a late career researcher after a lengthy public health career specialising in health promotion and community development, already equipped with a socio -ecological ideology driving and

framing my understanding of the nature of communities and society and the impacts of both on health and wellbeing.

Having also lectured in these subjects at postgraduate level, I was very familiar with much of the literature and certainly on where to find the most recognised theory and practice examples domestically and globally.

Throughout the research process I have been aware of these potential biases and frequently paused to take stock of how they may be influencing choices of approach and assumptions being made, and at each point discussing with the supervision team the potential mitigators for this.

One such example was in relation to the main literature search and selection of search terms. Being aware that my existing knowledge of the field may produce a ‘loaded’ set of search questions, the choice was made to replicate the Jane South search with an updated time frame, not just because they had already proven to produce a well-recognised set of results, it was also clear that a robust process had been used in their development and free from the potential bias that I might have inadvertently brought (South, Bagnall et al., 2019).

The second main bias, that of connecting ideas that reflect the ecological ideas of humans interacting in dynamic relationships with their environments, has already been alluded to. It is obvious that because of my degree specialism and career history I would be attuned to ideas such as Cynefin, but that awareness meant that I spent perhaps even more time and attention on checking this element out with stakeholders, testing and re-testing the idea to gather more insight and evidence of its existence from stakeholders.

This leads on to the third main bias, my experience as an educator in formal and informal settings. Even as a postgraduate lecturer, I have a broader experience than many, having taught both online and in face to face and blended learning scenarios for 26 years. This is combined with a longer history in running workshops and training programmes with informal groups such as members of the public and with multi professional and multi-agency teams.

Hence, I have specific competences in explaining and communicating often complex ideas about health and wellbeing. Paired with the bias around an ecological lens it required me to take extra care when feeding back concepts to stakeholders that I was following closely the methodologies of teach back and that these processes were not about educating stakeholders, but a process of the researcher learning from them about how candidate concepts gained their recognition or approval.

This was a constant reminder throughout that the purpose was testing and refining from feedback the programme theories, not a process of 'selling' the ideas or disseminating learning.

The combination of these three potential biases was an enduring feeling that at every stage I was 'over thinking' things and as a result being too hesitant to move the research forward at a brisker pace. Constantly fighting positionality and standing back to let the theories emerge, whilst essential, also had the impact that it created hesitancy and a self-doubt about the emerging findings.

It is also important to reflect upon how the very process of maintaining momentum in the research during this unprecedented period was challenging. Like many people, I struggled at times with the enormity of the pandemic, particularly during the early weeks and months when its transmission was rapid, and no viable prevention and treatment models were in sight.

Being a late career researcher brought alongside it a certain positionality in my own family. Being right at the centre of the sandwich generation I felt the full responsibility of managing the wellbeing of my elderly relatives (both parents in law dying early in the pandemic and my own mother's slow development of dementia) whilst at the same time 5 adult children were suffering with the impact of furlough and not knowing if their blossoming careers might ever restart. Maintaining enthusiasm and drive in that situation was difficult as completing a PhD could not compete with supporting my family's needs during that time.

In summary this research has not only been an exercise in academic rigour to tame the wider excesses of my own favoured holistic viewpoint, it was also somewhat cathartic as it has enabled me to look back along a lengthy career history utilising a human ecology frame within public health and it leaves me reflecting further on an important question - **'*would explicitly employing a realist set of lenses earlier in my career have made me more effective as a health promoter?*'**

Constantly revisiting my positionality within the research proved to be valuable. The Community Health Development Project stakeholders also highlighted it as an essential perspective of positioning alongside and in communities seemed to be one of the most powerful elements crossing through contexts and mechanisms.

> "*If you are going to work in communities you need to recognise that there is a very small window through which you will be judged. You need to really understand that you need to get close and work from where communities start from not from your external view…. assumptions if they are exposed can really break your credibility!*"

This comment was in relation to interventions in communities but was later repeated in the JIF to comment upon the nature of the research itself.

(Seiriol Worker)

One of Pawson's many musings on the role of theory is pertinent to consider at the end of this discussion section:

> "*… theories basically carry the two roles of insight and affirmation. Theories begin as common-sense hunches about the attributes that might contribute to an outcome and then, hopefully, become more sophisticated afterthoughts able to account for the complex interplay of attributes. Theory assembles the candidate conditions. Method sorts out which combinations are important. Theory makes sense of the resulting configuration*".
>
> (Pawson, 2018, p. 12)

There are many theories lurking within these eventual CMO configurations that were in plain sight at the start of the research, more than common sense hunches, they often were listed as fundamental values and principles for community health development, the use of programme theory here has brought them into powerful configurations which demonstrate the how, why and under which circumstances they work.

Pawson goes on to suggest why using generative reasoning and presenting the final results of this research, as they are presented here, provides useful learning for others and enables the final programme theories to have utility.

He suggests it centres upon the capacity for mechanism centred explanations to be recycled. Typical community health development values and principles and examples of good ways of working may appear portable but when lessons derived from one area or Community Health Development Project are applied in another place or case all the important conditions, coefficients, and configurations change and obscure the lessons.

This is not the case using the generative explanation of a realist programme theory as the central plank is the explanatory ingredients that describe relational elements that are generic. This means that regularities in one area or case may be offered for testing and refining in other areas and cases.

CHAPTER SEVEN: CONCLUSIONS AND PRESENTATION OF FINAL PROGRAMME THEORY

At the very beginning of this research journey an analogy of realist research as a black box flight recorder was used by one of the supervisors to explain the realist value, it is an analogy that appears regularly in realist writing (Salter, 2014) yet it could not have been imagined in the Autumn of 2018 how prescient an analogy that would turn out to be.

The following conclusions must be set in the context that the research was conducted within, as it was such an extraordinary period of time.

The events that emerged in early 2020 with the pandemic were a plane crash on a global scale with far reaching consequences for all communities, across all countries.

Whilst the cause of the crash that restricted communities from meeting and working together are well documented, many of the impacts of Covid and the lessons on how greatly it impacted upon wellbeing and attitudes and behaviours towards health and wellbeing are only just being realised. It may be some time until the impact becomes fully clear, particularly as intense economic challenges are now being faced alongside global political unrest centring on Russia's claims on Ukraine, plus the impact of climate change being increasingly felt (PHW, 2022).

Part of the response to these international challenges and other national drivers (such as the perfect storm of an ageing population getting sicker younger) is that there is a reawakening of a societal push to encourage communities once more to take on responsibility for their own resilience and wellbeing building, rather than that responsibility being retained at a societal level (UK Health Security Agency, 2022).

For example, the World Bank recognised that,

> "*In a crisis, locally organized communities and grassroot organizations are front-line responders who can potentially bridge last-mile delivery gaps, but we need to strengthen their capacity*".
>
> *(*Sachdeva and Patel, 2022)

They suggested that the immediate post pandemic period provides a window of opportunity to recognise communities as prime agents of change, and their pivotal roles in ensuring local contextually relevant solutions for the wellbeing of people and environments needs to be harnessed in 'co-producing community-driven, bottom–up plans for change' with governmental organisations.

Hence, communities themselves are positioned at the core of investigating the context and mechanism configurations that lead to wellbeing outcomes.

Stretching the black box analogy, a little further, in this research the black box has seemed at times more like a monochrome 'Rubrics Cube' (see figure 7.1). Core elements of context, mechanisms, and outcomes having become very evident from the early research stages, but through various processes of realist synthesis and evaluation they were twisted this way and that to test if they made sense in different configurations.

Unlike actual rubrics cube however, where there is clear distinction between coloured faces and how they interact in different patterns when moved through spatial planes, the configurations between context and mechanisms were not so crystal clear.

The illustration here is a sketch the researcher turned to regularly in this research as a conceptual device to demonstrate those C, M and O's that were being considered in early phases of investigation in this research, rather than the set which were finally selected after testing and refining.

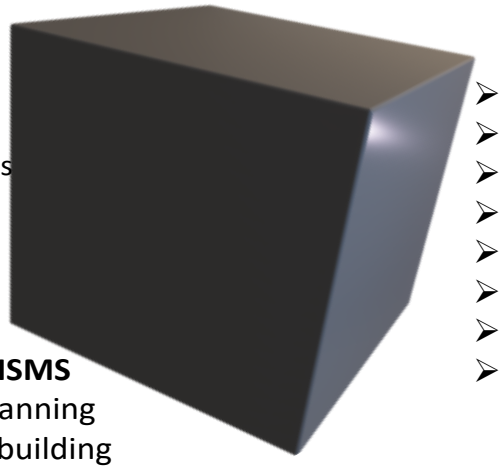
Whilst these terms and concepts regularly appear in literature, were described in the research case studies, and were quoted by stakeholders

and experts in interviews, their fluidity as terms meant that they were often very difficult to pin down specifically as context mechanism or outcome.

Sketching them out in this way enabled loose connections to be imagined, and any potential fluidity in those connections, without tying them down too soon into causal chains.

CONTEXT

- Relaxed demands on projects to produce
- A community anchor presence
- Community connector with face validity
- True partnership are operating between services
- Self determinism is expected and respected
- Inclusiveness
- Home making
- Social capital
- Digital capital



MECHANISMS

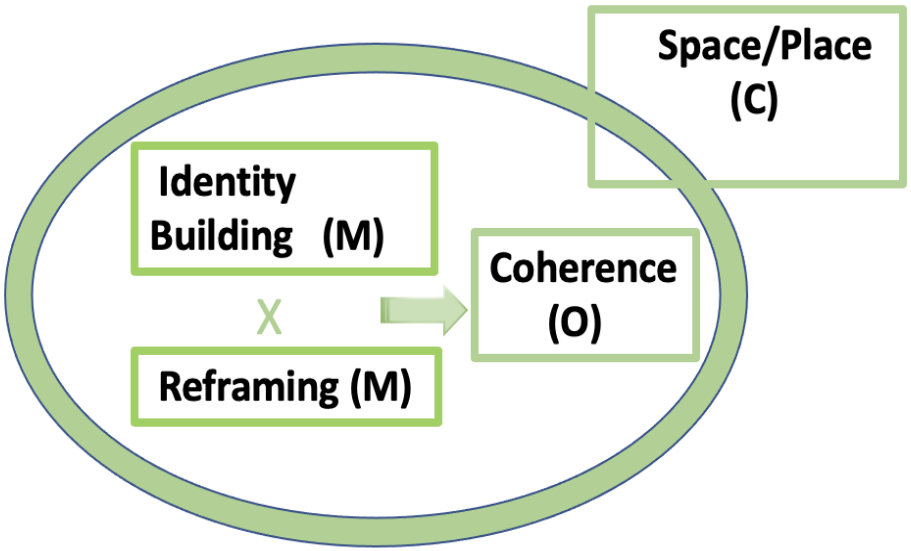
- Boundary spanning
- Relationship building
- Confidence building
- Trust forming
- Bridging
- Action planning
- Change facilitation
- Appreciative exploration

OUTCOMES

- Empowerment
- Ownership and control
- Resilience
- Coherence
- Confidence
- Bonds and relationships
- 5WW
- WFG Goals

Figure 7.1: The Black Box of Community Health Development

Developing CMO configurations that could be in some way ‘fixed’ did not prove initially to be easy in a field so complex and conceptually contested. However, following a determined process of working through the phases of a realist cycle, supported by much deliberation with stakeholders, the final Programme Theory on What Works in Community (Health) Development, how, for Whom, and in Which Circumstances developed throughout the previous chapters is now presented once more here (figure 7.2) as it does offer some elements of new learning for public health and community wellbeing policy and practice.



"When a community health development programme creates a space in which members of the community can feel safe to be, and feel able to 'be themselves' (C) identity building (M)and reframing (M) processes can be ignited resulting in individual and community wide experience of balanced wellbeing and a state of coherence (O)"

Figure 7.2: Visual Representation of the concluding Meta Programme Theory

In particular, it has provided causal explanations on aspects of community health development that are required to be supported, sustained, or even strengthened in times of real and unprecedented challenges such as a global pandemic.

Each of the four programme theories which make up this Meta Programme Theory have been described fully and supported with a suite of CMO configurations.

Figure 7.3 now presents the final versions reached following iteration with stakeholders and the Joint Interpretive Forum, which are now in a form amenable for wider debate with the fields of public and community health and wellbeing:

A realist evaluation of geographically distinct community (health) development projects: what works in Wales, for whom, how, why, and in what circumstances?
MPT*: When a community health development programme creates a space in which members of the community can be and feel able to 'be themselves' (C) identity building (M)and reframing (M) processes can be ignited resulting in individual and community wide experience of balanced wellbeing and a state of coherence (O)
FPT1** Space: A Place to be and to be me! Good community health development happens when there is a space for people to easily access that is welcoming (C) and where they feel actively welcomed and accepted (M), supported to explore their health determinants(O)
○ When a community space feels like a home, (C) members of that community lower their barriers (M) and open up to support (M) leading to feelings of belonging and acceptance (O) ○ When a place contains non-threatening focal points ('muses' or conversation pieces) around which to bond (C) community members are enabled (M) to discuss and test each other's views and express

	themselves in a safe way (M) resulting in strengthened connections between each other (O) and the development of trust (O) ○ A community space with a revolving door enabling people to enter and leave as they wish (C) empowers them to have control over their own boundaries (M) and feel safe (M) which helps them to connect (O), and to work collaboratively with others (O) ○ If community members can access a 'third space' – a place unlike the place they live in or the civic space they work or study in (C) – they can be supported to explore and express their own identity (M) and be themselves (M) facilitating a sense of acceptance, connection and belonging (O) ○ If diversity of culture and identity is reflected throughout a space (C) participants feel more comfortable, validated, recognised and valued (M) resulting in feelings of acceptance, affirmation and empowerment (O)
FPT2 **	Identity: A journey from 'me' to 'us' to 'ours' Good community health development happens when skilled facilitators support personal reflections (C) to builds bridges between and forms bonds (C) with other people around common issues(O)
	○ When community workers share similar socio-cultural attributes and characteristics of that community (C) the recognition enables bonds and relationships to form (M) resulting in the growth of trust, kinship and cooperation (O) ○ When a common cause or issue can be identified which has resonance across all community members (C) a sense of joint purpose may be nurtured (M) enabling the community to join together in a shared and cooperative action (O) ○ When there is a culture of validation and acceptance of all in the community (C) people are enabled to open up to recognising themselves and others around them (M) and form a spirit of appreciation, togetherness and trust (O)

	○ When a culture of confidentiality, non –recrimination and respect is established (C) people are enabled to tell their stories and be heard by others (M) resulting in growth of trust and feelings of acceptance and validation. ○ When the community identity is congruent with personal values and goals (C) relationship can be formed to echo a family or kinship (M) and a sense of togetherness and inclusion can be built (O)
FPT3 **	Reframing: From what's wrong to what's strong. Good community health development happens when individuals and communities are encouraged and supported to focus on their strengths and assets (C), and they can adopt a more positive perspective (M) taking control of their wellbeing challenges(O).
	○ When communities are enabled and supported to appreciate their strengths and assets (C) a more positive and optimistic perspective and attitude can be developed towards wellbeing (M), and they are empowered to explore the foundations and small steps for change they can make (O) ○ When there is acknowledgement across stakeholder services and partnership that existing silo interventions are ineffective in supporting communities (C) it enables the testing of holistic wrap around service provision (M) ensuring comprehensive attention to complex challenges (O) ○ When community facing workers, roles are focussed more upon supporting people to express what matters to them rather than delivering a service goal (C) engagement and coproduction of a wellbeing solution are strengthened (M) and faith, commitment and trust in positive actions and results are increased. ○ When community engagement begins with appreciative enquiry/ a 'what matters' conversation or focuses upon what is strong (C) the community is able to define its own starting point and small steps to take for action (M) with a sense of optimism and ownership for the intended change (O) ○ When communities remain fatalistic about their wellbeing (C) the lack of confidence and diminished faith in possibilities for change (M) provide obstacles to connecting with support and a lack of engagement (O)

FPT4 ** Coherence: Building a personal understanding of challenges, the value and meaning of change, and a consequent belief in an outcome

Good community health development happens when people are facilitated to untangle the challenges in their life (C), understanding the meaning in those challenges for themselves, (M) and, encouraged to make proportionate and achievable action plans for change (O)

- When a community project is rooted in a salutogenic approach (C) it is enabled to explore and compare personal understanding of challenges to wellbeing, the value and meaning of change, and the faith and beliefs in any outcomes (M) which provides a sense of balance and opens up options for action (O)
- When workers and community members work together in coproduction (C) more accurate and attuned theories of change may be defined (M) leading to proposed solutions with wider support and commitment to be tested (O)
- If a culture of achievable goal setting, positive change, reflection and small successes is built in a community (C) community confidence and a sense of progress (M) enables more positive risks and opportunities to be taken and further ambitious goals to be developed (O)
- If early intervention is valued and supported by stakeholders (C) communities are able to be engaged in an initiative before the drivers become too complex enabling a clearer understanding of the changes required (M) and the testing and refinement of learning strategies (O)
- When the organisational and cross partnership narrative changes from the importance of meeting silo based KPIs to prioritising a more holistic sense of success, then workers are able to focus on client needs and aspirations (M) supporting self-determined change and success criteria valued by the community itself (O)
    - When self-determinism is respected and valued by stakeholders (C) communities are able to be supported to make their own choices and decisions (M) increasing commitment to change and a strengthened partnership approach (O)

A series of initially unrecognised or un- triggered CMO configurations also became important when the pandemic meant a huge change in societal conditions, the most obvious of which was the restriction upon social contact outside of household arrangements for long periods of times
○ If a project is embedded in a wider area that has latent social capital (C) when usual ways of working are obstructed, community resourcefulness and neighbourliness (M) can be harnessed to provide support and guidance to sustain activities (O) ○ If community members and workers can draw upon digital capital (C) new ways of delivering programme activities can be designed evolving delivery from human centred platforms onto virtual and digital media (M) sustaining engagement and programme delivery (O)

*MPT = Meta Programme Theory **FPT = Final Programme Theory

Figure 7.3: Full Table of Programme Theories Supported by CMOCs

Reflecting upon the very early phase of the research encompassing concept mapping and concept testing and the confusion exhibited in the field on the exact meaning and application of well recognised concepts, the question to return to in concluding this research is whether using a realist lens has really helped with this confusion?

The research output and final Meta Programme Theory suggest that it has, but only in the sense that those very portable elements such as empowerment, social capital, and self-determinism can be described more definitively in realist terms and whilst each (when they are studied independently) can all emerge as either ‘context’ ‘mechanism’ or ‘outcomes’, they achieve a much greater sense and power of their application in a broader programme theory and, even as they are amenable to change as that programme matures, they retain a certain power.

Hence the findings here in the form of programme theories, themselves part of a meta programme theory, are offered to the field not as definitive lessons for adoption but as opportunities for their further refinement.

7.1 How Does the Final Programme Theory Answer The Research Question?

7.1.1. What Works

What works in community health development in North Wales is enabling people to connect with others and be empowered to take control of their own wellbeing.

What works is a combination of creating the right space for that community to be nurtured, personal and group identity to thrive, and, through using reframing techniques, support personal journeys towards a sense of balance with their own health and wellbeing goals.

Several existing well recognised substantive theories underpin this process, but it is how these are drawn upon and brought together within a programme

theory of community health development that appears to be crucial for success.

7.1.2. How?

There are a range of complementary mechanisms that are central to four programme theories of space, identity, reframing, and coherence.

Recognition, connection, and acceptance of others and self are key, and they all help to establish the trust and bonding between individuals to connect the community and empower the change.

They also enable people to feel safe enough to examine their health perspectives and be open to feedback and options for change.

7.1.3. For Whom?

It is remarkable that despite such seemingly different types of community across the case studies (from disaffected and excluded young people; homeless people using illegal substances; families living in an area of multiple deprivation; to, communities of isolated older people) and with equally varying wellbeing challenge and goals, that a strong set of common programme theories could be identified.

In addition, it was just as remarkable that these programme theories remain equally as relevant and consistent across them all when considering the varied local conditions that they operate in with quite different commissioners and degrees of funding and commissioning methods.

In summary, it can be confidently asserted that the programme theories will stand up for most types of communities, certainly across age ranges and also varied wellbeing challenges to those communities.

7.1.4. In Which Circumstances?

There clearly needs to be an element of capital available as the most basic circumstance to enable programmes to be developed. Programmes that need to create a space for people to be and be themselves need resourcing and programmes cannot run on the goodwill of volunteers alone.

This however does not only relate to financial capital to run programmes but to the human capital, the qualities of the workers and volunteers in programmes able to undertake the essential place making, identity building, connecting and reframing process so central to the programme theories.

Had the pandemic not impacted upon the projects during the research, the research may have missed the crucial importance of programmes being surrounded by almost **latent social capital**. Once this became evident, as it was recognised social capital had enabled the continuance of two out of the projects, it was possible to look back with greater insight into all four project histories and recognise latent social capital around all the projects had been an essential condition supporting their development.

Considering the pandemic period itself, a further condition became almost crucial in determining whether programmes could sustain themselves. **Digital capital** alone was essential for maintaining programme continuity when no-one could physically meet, but its combination with social capital was a game changer for community health development programmes.

This finding is in itself important for community health development programmes in the future as there remains an uncertainty about returning to pre pandemic ways of working across all types of health and social care, and the digital social capital possibilities that became evident have now established a new playbook for future programmes to learn from.

The final condition that became realised due to the pandemic, but as with social capital had not been well acknowledge previously, was a full appreciation by programme commissioners of the right to **self-determinism**. The contention of this research is that this condition is central to the struggle that most community health development programmes must deal with when chasing for secure funding for programmes and is what lies beneath most of the tensions between commissioners and programme deliverers when considering expected programme outcomes.

7.1.5. With What Outcomes?

South's Family of Approaches (South, 2015), cited throughout this thesis illustrates the potential range of wellbeing outcomes expected from a community health development programme. This research echoes them (figure 7.4).

Individual	Community level	Community process	Organisational
Health literacy – increased knowledge, awareness, skills, capabilities Behaviour change – healthy lifestyles, reduction of risky behaviours Self-efficacy, self-esteem, confidence Self-management Social relationships – social support, reduction of social isolation Wellbeing – quality of life, subjective and objective wellbeing Health status physical and mental Personal development – life skills, employment, education	Social capital – social networks, community cohesion, sense of belonging, trust Community resilience Changes in physical, social and economic environment Increased community resources – including funding	Community leadership – collaborative working, community mobilisation/coalitions Representation and advocacy Civic engagement – volunteering, voting, civic associations, participation of groups at risk of exclusion	Public health intelligence Changes in policy Re-designed services Service use – reach, uptake of screening and preventive services Improved access to health and care services, appropriate use of services, culturally relevant services

Figure 7.4: Community Health Development Potential Outcomes

All, or a mix of these outcomes, may be the reason that a programme has been commissioned but as has been substantially covered in this thesis the question is not whether programmes achieve these outcomes for

commissioners but whether there is congruence between wellbeing outcomes that the programme participants, workers, stakeholders, and commissioners all aim to achieve. The crucial factor for community health development questions whether there is flexibility for programmes to set their own outcomes in coproduction with participants themselves, and that itself depends upon if all parties buy into the concept and guiding principle of self-determinism.

At least in Wales there is now a more defined set of wellbeing outcomes to explore, and which are starting to shape commissioning of programmes in the forms of the Wellbeing of Future Generations' seven goals and five ways of working.

These were evident across all four projects and, whilst the Act was not yet explicit locally as the framework for commissioning and evaluating progress, it was clear through the soft systems workshops that the goals and ways of working were the implicit frame being used by commissioners.

It remains to be seen whether this does in time mature into explicit outcomes frameworks but the dissemination of commissioning tools by the Wellbeing of Future Generations Commissioner suggests that this will happen. Because the tools are explicit about the five ways of working, as well as the wellbeing goals, it means that at the heart of commissioning programmes there will be the demands to *integrate* partners goals for a programme, *collaborate* between all programme partners, and *involve* all parties with an interest of achieving the health and wellbeing outcomes in their design. Specific questions for commissioning programmes include:

Is there a framework and proportionate process in place for collective performance assessment, including from a citizen's perspective, and do you have accountability arrangements to support this?

- Do you understand what matters to service users, their strengths, and the strengths of wider communities in which they live? How is this used to inform the need for the service and how it is delivered?

- Is the service seeking to harness and build on a service user's strengths?
- Are service users involved in reaching decisions that affect them?
- Has the service been designed from the perspective of the service user, through involving them and reflecting the diversity of the potential users of the service? Ensuring people can access the service they need when they need it, and only for as long as they need it?

(Future Generations Commissioner, 2019)

7.1.6. Does North Wales Offer Special Circumstances?

The observation in this research that there is a strong culture of Cynefin in North Wales and that community health development programmes may be facilitated by this is an important finding deserving of further research into how this happens. Could this be encouraged and enhanced as a context for programmes?

Alternatively, could it be that it works more as a mechanism and programmes can work to establish the elements that will make it fire so that participants feel at home and are comfortable with the place and their identity reflected through their heritage being recognised?

If these questions were to be further explored the research may be more profitable by taking this scope a little wider to ask the question of how Welsh heritage and culture may be understood as a vital heuristic in community health development programmes.

It is possible that 'Hiraeth' may be at least as important as 'Cynefin' in such a study as that longing for a Wales that once was includes a yearning for communities and what they represent to people within that, and it is no coincidence that some of the most popular used words found on items in Welsh arts and crafts shops are Cartref, Cynefin, and Hiraeth, signifying that yearning for the comfort of a home, place and identity where people can

thrive. If this is felt at a wider societal level in this way, it is no wonder that community programmes build this in as their foundational element.

It is a complex question as it would need to also reflect upon how these very traditional ideas are sustained in contemporary North Wales social structures given the changing dynamics politically regarding independence within the UK (YES Cymru Ref), Brexit, and general mistrust for any political structures to the South (whether that be in Cardiff or London (Machura et al., 2020).

The conditions at a macro level for health and wellbeing are already so much more challenging than they were at the beginning of this research with even more weight of evidence on climate change, with economic recession looming and food and fuel poverty already experience in many Welsh communities, an uneasy uncertainty about further pandemics and the threat of a nuclear escalation of the war raging across the Ukraine/Russia border.

An examination of Cartref, Cynefin, and Hiraeth could not ignore these potential wider threats to wellbeing at community level and a rich but challenging multi-method research task is anticipated, although one which could also be valuable to other partners beyond the Health Board and its community and voluntary sector allies.

If community is just thought of as solidarity based upon shared interests or circumstances, it doesn't necessarily need a place. Place is incidental, not central to its understanding and practical expression.

However, when combined with a sense of place it can be entirely transformed as a force for change.

Bhattacharyya (2009) discussed community development and its rise in a modernist framework. With industrialisation, he postulated, peoples' sense of place weakens. Where previously communities would live play and work around the land in defined shared places, modernity diluted those ties and people related more to unknown people in a wide range of spaces and became engaged in very different norms and organisational structures than were they lived and played.

This step change is well documented but in the current era we are witnessing is arguably a substantially greater step change as these workplaces together with other ‘social’ environments like leisure, retail, and education are rapidly transforming to operate ‘without walls’, facilitated by the digital changes enabling them to operate virtually without the close proximity of people.

- Has this brought a nostalgia and even longing for people to want to relate to each other in a shared sense of place that virtual places simply do not satisfy?
- Will the concepts of Cynefin and Hiraeth now become even greater driving forces in the renewed attention to community and its development?
- Is community health development and its recent resurrection a very postmodern response to the erosion of solidarity and agency?
- Is community health development a way of buying into what has been largely eroded in our modern world?

7.1.7. Where Next for Community Health Development Through a Realist Lens?

This final section of the thesis returns to the deliberations about meanings and definition initiated at the start, with reflection on an often-expressed sentiment about two things which, like the idea of community, are universally regarded as a good thing but are themselves equally complex, frequently misinterpreted and hard to pin down exactly their true nature as they as all in the eye of the beholder.

Art, like love, is not a static thing it is dynamic and needs an exchange to make it work.

“Community” fits well alongside this analysis of art and love as it too is often regarded as a static element and its separate pieces and dimensions observed, but to make it work, live, become real, and meaningful it needs engagement.

Community is not universally regarded as one and the same thing - It is the meaning and purpose of community that people ascribe to it that is important.

Without actions such as the exchange of gifts by the people within it, it remains merely a place or a group of people with some similar characteristic, it is the interaction between them and the place of those interactions that is central to our deeper understanding of community and its role in today's world.

Community health development must be grounded in exploration and clarity about these basic ideas as building from merely accepting community as a group of people in a common place, or with a common interest or identifying characteristic, gives little clues about where to begin the process of growing more wellbeing. It is the interactions of people in a place and how they use the resources they can find that leads towards any form of wellbeing outcomes.

This is important as the notion of community is so romanticised that merely talking up the notion of community may satisfy some people, and there are vast examples of initiatives that have been simply branded as a community project with no further consideration of the things that are needed to activate the community building elements.

Considering this through the benefit of a realist lens reveals that approaches are blinkered if they pay only limited attention to context without then exploring how context fires the mechanisms that will make the programme work.

This research has found consistently across four projects in North Wales that there are four connected programme theories that explain the relationship between context, mechanisms, and outcomes and how they work in community development. Whilst they may be familiar as programme theories within community development theory and practice, this research has gone further to elucidate the way that they interact and strengthen each other if they are combined into a single purposeful process not one that merely

replicates something done elsewhere, but one rooted in exploring what will work in specific and local contexts and what mechanisms need to be fired to bring about wellbeing outcomes important to programmes and their participants.

In offering the programme theories and meta programme theory to the field as opportunities for further refinement, it is hoped that the unanticipated finding of the ripple effect across and within programme theories (figure 7.5) is further investigated as, in this respect, the research has raised more questions than answers.

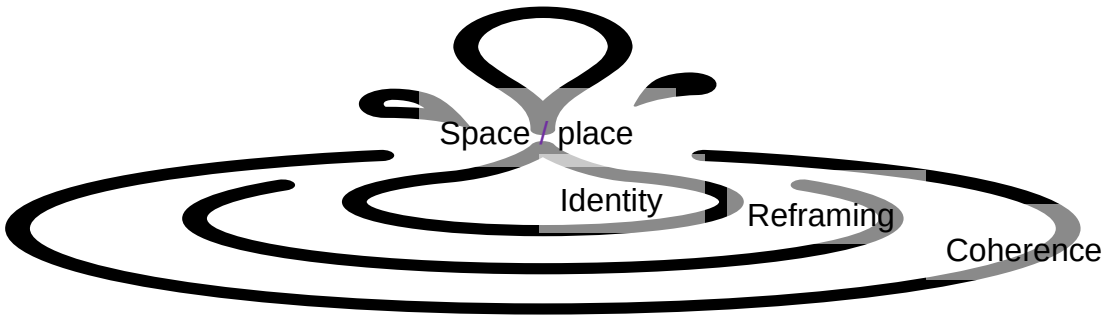


Figure 7.5: Meta Programme Theory Illustrated as a Ripple Effect

The most obvious research question inspired by this illustration of the programme theory is whether the programme theory would 'ripple' the same in another 'pool'. Taking inspiration from Pawson (2018) this research finally suggests that the regularities from programme theories may be further refined by testing them in other pools and testing variance in the ripple effects, such as

- Height of ripples, do the programme theories have a greater or lesser effect under different conditions?

- Distance between ripples, what is the period required from outcomes of on programme theory to enable context of the next or mechanisms to fire?
- Following JIF observations that the programme theory is not linear, but cyclical, is it always space /place that creates the initial ripple?
- Similarly, is the illustration too focussed and does the lens need to pull back to capture ripples to check if the programme theory does repeat or if something else then happens?
- Given that within communities most in need of health development there are multiple programmes in operation, what is the interplay and combined effects between similar programmes and programme theories in the 'pool', for example, do multiple initiatives committed to identity building cancel each other out or do they increase the size of ripples when they collide and combine?

These are all worthy questions for a field that does need to be actively engaged in further researching them.

The recommendations following this lengthy piece of research in a specific North Wales culture through an unprecedented time of pandemic and societal restrictions are that there are a set of strong programme theories suggesting what works in community health development, for whom and in which circumstances. These strong theories however now need to be further tested:

- Further research should explore further the ripple effects of the programme theories in community health development.
- Similarly, the complex interaction of social and digital capitals deserves to be researched further given the differential impact of the pandemic on sustaining programmes in communities.
- Existing community health development programmes are recommended to test the programme theories against their existing delivery to fine tune and improve their effectiveness.

- Within education a plethora of lessons are available for both research methods (primarily flexing methods when circumstances restrict planned approaches), and health promotion and public health in the design of community health projects.

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APPENDICES

Appendix 1: Ethics Submission

Study Title: A realist evaluation of geographically distinct community (health) development projects: what works in Wales, for whom, how, why, and in what circumstances?
Principal investigator: Paul Brocklehurst
Chief investigator: Andrew Rogers
Project team: (in alphabetical order)

Surname	First Name	Affiliation
Charles	Jo	Supervisor
Findlay	Gail	Supervisor (External)
Roberts	Glynne	Supervisor (Practice Based)
Williams	Lynne	Supervisor

Study start date: 16 October 2017 Study end date: 15 October 2020
Lead organisation and sponsor: Bangor University
Host organisation: Betsi Cadwaladr University Health Board

BACKGROUND

Throughout Wales, in line with a global trend, public policy continues to refocus attention upon the idea of community as a solution to most of the pressing challenges facing people and the planet (Adams & Hess, 2001;Gilchrist, 2005).Whether for health, environmental or other reasons, community projects are increasingly looked towards to provide the answers to the most challenging societal problems. In Wales, the Well-Being of Future Generations (Wales) Act (2015) provides further impetus to this through requiring all public bodies to not only work better together to make an impact upon sustainable development but also by driving them, through collaboration and joint action, to build wellbeing within communities (Welsh Government, 2015).

Such rhetoric is not new or unique to Wales and is also not without significant contradictions. The whole area of community engagement and development is a contested concept (Crow & Mah, 2012). Its roots in a United Kingdom context are in the 19th century, pre-the welfare state, when community efforts around wellbeing were independent of state mechanisms. Voluntary support for each other, collective efforts through unionisation and resource distribution through charities provided the glue to bind communities together.

In the twentieth century, alongside building the welfare state, government became more directly concerned with community development utilising it as an instrument of many aspects of government and service delivery at the very local level. Over time, the extent of this has waxed, waned (and waxed again) in health, education, social care, crime prevention, economic regeneration and more recently even the prevention of terrorism sectors. (Shaw, Armstrong, & Craig, 2016). However, despite its constant presence in policy at some level of attention, the relationship

between state and community development has never been entirely comfortable nor consistent.

Practically every sector now appears to buy into community approaches, and this brings with it expectations of a very wide range of outcomes, and also, some attendant technical and conceptual conflicts when trying to rationalise those outcomes across partnerships.
Within this research project the question moves beyond whether community approaches work in improving health outcomes to identifying what works, in what circumstances and for whom within a distinct North Wales context. This will be the first study of its kind, focused on providing an explanatory account of what works and what are the underlying generative mechanisms that explain 'how' outcomes are caused and also will seek to account for the influence of context within such projects.

RESEARCH QUESTION

In this study, the aim is to study two Health Board supported **community development programmes** in North Wales to provide an explanatory account of what works, for whom, how, why and in what circumstances.

AIMS AND OBJECTIVES

AIMS

To identify the conditions (context) and underlying generative mechanisms that explain what works, how and why in relation to community health projects.

To generate evidence and theory to guide NHS and community programme leaders to effectively implement future successful community health development projects which promote sustainable development and build wellbeing within communities.

OBJECTIVES

1.Generate an explanatory programme theory about community health development projects that explains what works, how and under which contexts.

2. Explore, through stakeholder engagement, decision-making processes associated with local community health projects.

3. Produce recommendations about ways in which different approaches and/or strategies can help NHS managers and community programme leaders plan and prioritise projects in a systematic and efficient approach.

METHODOLOGY

Realist methodology is a theory driven approach to programme evaluation and is suited to this study as it helps to penetrate the complexities of community (health) development programme evaluation through providing important evidence about what works regarding the process of engagement, the conditions which are conducive (or not) to the success of the programme, and the factors that lead to programme outcomes (Pawson & Tilley, 1997).
An initial programme theory will be developed, which will map conjectured CMO theoretical strands. C-M-O configurations are named context, mechanism and outcomes in realist methodology that reveal what works, for whom, how, and in

what circumstances across the projects (Pawson et al, 2005; Pawson 2006; Rycroft-Malone, McCormack, Hutchinson et al, 2012;Rycroft-Malone,et al, 2014).

Realist methods allow the researcher to deal with these multiple layers and explore how complex interventions might work better for some people than for others. The approach is cyclical, and it starts and ends with theory. The purpose is not just to work out if a programme works in a specific setting, it is more important in this methodology to formulate, test and refine a programme theory.

The initial programme theory sets out the hypotheses to explain how and why a programme is expected to lead to its effects and in which conditions it should do so. Central to this is the collective or individual reasoning and reactions of the actors involved, who are making choices to act or not (mechanisms) depending on the resources available which may hinder or facilitate change (within given contexts).

Mapped as conjectured CMO configurations, an initial programme theory proposes what mechanisms will generate the outcomes together with which features of the context will affect whether or not those mechanisms 'fire'.

Each of these CMO elements are made explicit at the beginning of the research process to enable data collection processes to be designed which will be able to test all the different elements of the programme theory.

This cyclical process will be conducted across four phases which will include generation of the initial programme theory, testing and refining that theory over several rounds of data collection using a range of methods, and a final phase which will test the wider validity, understanding and application of the revised programme theory through sharing the findings with a wider field and engaging in a knowledge – transfer activity (Rycroft–Malone et al 2011).

PHASE ONE: DEVELOPMENT OF THE INITIAL PROGRAMME THEORY (DECEMBER 17 – JULY 2018)

Phase One work will focus on developing the theoretical platform, designing an initial programme theory, and in developing relationships and the ways of working across a range of stakeholders.

Concept mapping

Concept mapping will capture theory and practice history and will identify any gaps and areas of contention within and between them. The purpose of this is to develop understanding of the complete range of drivers which may be important to different stakeholders and to establish any key themes for analysis.

Specific publicly available evaluation and policy documents will also be collected which may influence the selection of case studies, such as evidence-based recommendations and strategies from NICE, Cochrane Library, Public Health Wales, Health Boards and the Welsh Government; along with relevant legal frameworks for Wales (Taking Wales Forward, 2016; the Well-being of Future Generations Act, 2015; the Social Services and Well-being (Wales) Act, 2016). These documents may offer initial frameworks for outcomes, and essential elements of the wider conditions in which case studies operate. They may reveal some

underlying theories, but a more systematic scoping review will also be undertaken to supplement the high-level mapping.

Scope of relevant literature

We will use a systematic approach to search for, select and synthesise, existing published knowledge across the breadth of the field in order to map the concepts, understand the evidence base and the different forms of evidence and find any gaps in the evidence base relevant to the research. (Colquhoun, 2014).

Relevant existing scoping/systematic/meta-analysis/rapid reviews will be analysed to identify key theories.

Following the results of the scoping review a more extensive literature searching will be undertaken. Initial search terms are likely to include:

Why	Stakeholders	Community Development	Produces	Health outcomes	People
How	Politicians	Community Resilience	Creates	Economic outcomes	Children
Which	Decision makers	Community Engagement	Enhances	Socially cohesive	Older people
Do	Communities	Community Participation	Facilitates	Crime reduction	Families
In which circumstances	Academics	ABCD	Achieves	Environmentally sustainable	BAME
	Professionals	Community Empowerment	Increases	Equitable communities	Most deprived
	Public Health	Community Centred		Employability	People with LTCs
	Opinion Formers	Community control		Supportive/ Altruistic	People with disabilities
		Partnership Theory		Sense of Coherence	
				Cultural Change	
				Trust	
				Power sharing	
				Coherence	
				Social Value	

The search will also include a specific element to investigate whether there is a particularly Welsh cultural aspect to community projects and the outcomes expected from them.

The search results will be screened for relevance and rigour and a quality appraisal tool such as the CASP Critical Appraisal Skills Programme tool (CASP, 2018) or the MMAT Multi Methods Appraisal Tool (Pluye et al., 2011) will also be used.

To provide a focus for testing the initial programme theories, from the concept mapping and scoping review we will determine what topics would be appropriate to become tracer issues i.e. those issues that have the potential to have greatest impact (e.g. social network structure and the "ripple effect" (Jagosh, Bush, Salsberg et al, 2015).

Stakeholder workshops

As stakeholder engagement is integral to the realist approach and the development of initial programme theories, we will undertake a stakeholder analysis to determine which stakeholders are 'essential,' 'important,' and/or 'necessary' to involve during the course of the study. We will then undertake three stakeholder workshops with a range of programme stakeholders (e.g., Consultants in Public Health, Community Support Workers, Council workers, Housing Associations, Health Board and Primary Care staff, researchers, and representatives from the relevant communities).

The stakeholder workshops will contribute to the initial programme theory development through exploring with participants what's working well/how, where and under which circumstances in community projects in the Community Health Development Project areas.

Methodology

Participants will be identified across all parts of local community projects including any active participants, targeted resident populations, local service workers, project managers, voluntary, private and public-sector stakeholders and representatives.

Stakeholders invited to the workshop through existing networks will provide initial guidance on the relevant and essential invitees to invite for participation, and active snowballing techniques will be then used, to ensure all relevant stakeholders across the communities have the opportunity to be engaged.

Participants will be invited to attend through a letter of invitation supported by a consent form for their agreement by signature (Appendix A) and a Participant Information Sheet (Appendix B) which outlines the research, its purpose and their anticipated involvement within it.

At the start of the workshop, informed written consent will be sought from each participant. Two copies of the signed consent form will be required (one for retention by each participant, one to be securely stored as an electronic copy in the Bangor University study 'U' drive). Refreshments will be provided and travel expenses for attending the focus groups will be offered to all taking part.

Three workshops will be held at different times and days across a week, plus in different locations across North Wales, to maximise the opportunities for stakeholder attendance and to be accessible. Each workshop will last 3-4 hours.

The workshop discussions will be facilitated by the Chief Investigator together with other members of the Project Team experienced and competent in undertaking realist methods of working with focus groups.

Experiential learning activities based upon Soft System Methodology (SSM) (Checkland, 1999) (Wilson, 2001) (Burge 2015) will be used to draw out contrasts and comparisons of the different participant's expectations and understanding of the operation, methods, and likelihood of achieving outcomes through community projects.

SSM is a seven-stage process and a set of rich picture development and modelling tools, which enables stakeholders varying perspectives and mental models to be brought into rational and defensible 'conceptual models' (or, representations of what 'good' might look like which can be then compared with reality).

Data management

Data collection from the workshops will be via field notes taken by the research team. The outcomes of the SSM processes as rich pictures, models and comparison charts will be digitally photographed and the pictures embedded and stored within summary (Microsoft Word format) documents with the field notes (original drawings will be destroyed, and the photographs deleted). Notes will only be made and held on a laptop that is encrypted.
Digital audio recording (MP3 and MP4 or similar formats) of the modelling activities in the workshop will be collected where participants permit, for viewing and review by the research team only and in order to shape the initial programme theory.

The data from this will not be transcribed but downloaded and stored in entirety as per Bangor University Policies (Bangor University's Research Data Management Policy 2015) and Bangor University Information Security Policy 2015) to the 'U' Drive. The original recording will then be immediately erased from the recording device.

Should any personal information be inadvertently shared recorded information will be anonymised to ensure that there is no traceability.

Outputs from Phase One:
A theoretical platform on which to build the research approach.
An identified set of tracer issues
A scope of the literature
A set of 'rich pictures', models, field notes and comparison charts
An initial realist programme theory of geographically distinct community (health) development projects

Phase Two: Realist Review of Evidence (July 2018 to January 2019)

In Phase Two a realist review of evidence in the literature will be undertaken, to test the initial programme theory (theories) identified in Phase One.

Methodology

An in-depth scrutiny of the literature will be taken to find evidence related to these programme theories. For each theory area, a list of relevant and related search terms will be generated to guide literature searches.

This process is ‘purposive’ (Pawson et al, 2004) in that the results shape the progress of the search, and it is ended when significant findings ’dry-up’ and saturation point is reached where no new evidence or theories emerge.

This process is iterative in that new evidence may be followed and lead to new directions and focus for investigation. As such it is unpredictable however key steps will be undertaken to ensure results:

Decide and define a purposive sampling strategy.
Define search sources, terms and methods to be used.
Set thresholds for halting searching at saturation point.
Analysis of the quality of the evidence is then undertaken to test for rigour and relevance using two basic questions.
does the research address the theory under test (relevance)?
does the research support the conclusions drawn from it by the researchers or the reviewers (rigour)?

These questions will be explored by the whole research team with the aim of deciding which evidence is excluded or included (with a bias in approach towards inclusion as ‘good and relevant enough’ evidence is included if they relate to any of the initial theories). (Rycroft-Malone et al., 2012).

Data management

Evidence synthesis:

Data will then be extracted using a bespoke form developed for the study, drawn from the initial programme theory work, and then 10 to 20% of them checked by a second member of the team to assist with internal consistency (the extent to which all of the items of a test measure the same latent variable).

Analysis

The extracted information will be organised into evidence tables representing the different bodies of literature and undertake abduction and retroduction across the evidence tables to establish plausible CMO configurations (Meyer & Lunnay, 2012). Abduction (considering an observation and then looking to find the simplest and most likely explanation of it) and retroduction (the idea of going back from below or behind observed patterns to see what produces them) are important processes in realist research.

The refined programme theory to test in Phase Three will describe how interventions lead to outcomes and in which conditions, which mechanisms will generate the outcomes, and what features of the context will affect whether or not those mechanisms fire. It will be based on the concept mapping, scoping review and stakeholder engagement from Phase One and the systematic search for evidence from Phase Two.

The mid-range theory and C-M-O propositions are therefore made explicit at this stage in order to frame the data collection and testing in Phase Three (the exact types of data collected required will follow on from the specific hypothesis constructed).

Outputs from Phase Two:
Evidence synthesis - a refined programme theory for testing within case studies

Phase Three: Case Studies to Test the Programme Theory (January 2019 to December 2019)
The case studies will be selected from geographically distinct community projects across North Wales that Betsi Cadwaladr University Health Board has a stakeholder interest or some involvement in the delivery.

Methodology

The Community Health Development Project approach described by Yin (1981, 1984, p. 23) as a "research strategy in which a typology of Community Health Development Project designs is developed" will be used to guide the selection of case studies.

It is important to choose appropriate cases in order to be able to predict comparative or contrasting results across them (Yin, 2009). Within the conduct of this Community Health Development Project process, we will pay particular attention to validity and reliability but the most important focus will be on understanding what works in each unique Community Health Development Project.

The case studies will involve a range of processes including stakeholder interviews, non-participation observation, and documentation review. Through observations the comparison charts from Phase One representing what 'good' might look like compared with reality may be verified, and observations may provide rich data for a deeper understanding of local context and milieu (Mulhall, 2003).

Documentation review provides a mean to triangulate and verify the data from stakeholders and through observations and provide further breadth and texture to the background of each Community Health Development Project.

Data management

Stakeholder interviews:

Individual face to face interviews using a semi-structured interview guide will be conducted with (maximum 15) participants in both cases.
A sampling framework to consider who is essential/important/priority to include in the interviews will be constructed based upon findings from the initial stakeholder consultation and literature review identification of key stakeholders in community projects. Local collaborators in the project will be consulted in producing the sampling framework and asked to identify organisations and individuals in and around the Community Health Development Project that should be invited to take part.

The number to be interviewed will be dependent on the size and complexity of each of the cases but is likely to be approximately 15 in each case.

The interviews will be conducted in each Community Health Development Project locality in an independent and neutral venue (to emphasise the independent nature of the research from any particular stakeholder organisation) and will take no longer than 1 hour. As with stakeholder engagement in phase one, participants will be invited to attend through a letter of invitation supported by a consent form for their agreement by signature (Appendix A) and a Participant Information Sheet (Appendix B) which outlines the research, its purpose and their anticipated involvement within it.

Interviews will be digitally recorded and last up to one hour. The data from this will be transcribed verbatim and downloaded and stored in entirety as per Bangor University Policy to the 'U' Drive. The original recording will then be immediately erased from the recording device.

Interviews will focus on testing and refining the initial programme theories and will capture perceptions about what is influencing implementation efforts, both intended and unintended consequences. In the interviews, the realist principles approach will be used to maximise data capture to test and refine the programme theories as described in Manzano (2016) of a "theory driven" interview. A specimen Interview Spine is appended (Appendix B4).

In this reversal of interviewer/interviewee and teacher/learner roles the findings from the review will be explored with interviewees to seek to understand how they experience the programme and whether the proposed mid-range theory that we put to them fits with their experience and understanding of how the programme is working. The key to the approach is that the interviewee "learns" the programme theory being tested and then by return is able to teach the interviewer about the relevant components of the community project being studied.

Non-participant observations:

Non-participant observation will be used to capture real time data on how the community projects operate. Spradley's nine dimensions of observation (1980) will be used to form an observation guide (Appendix C) which will maintain a critical focus on the aims of what is to be observed, why it is observed, and also ensure that all relevant social dimensions are captured. These dimensions include space, actors, activities, objects, acts, events, time, goals, and feelings.

Observations will be undertaken in different places and across different activities depending upon the nature and stage of the community project in each Community Health Development Project, it is expected that 4 – 8 observations will be undertaken per Community Health Development Project, of approximately one hour each (these may include meetings, project presentations briefings or project led stakeholder engagement events).

Observations will be undertaken by the principal investigator and written up as field notes (which will be stored digitally on the U drive). All who are involved in the processes and events being observed will be informed of the observation through

Patient Information Sheets, consent forms) for individuals (Appendices A and B, and posters Appendix D) to inform the community and stakeholders that observation is being undertaken.

As it is recognised that individuals may perceive being observed in any manner as threatening and be concerned about confidentiality these resources are vital in providing reassurance in writing of anonymity and the steps taken to maintain confidentiality. This information will be repeated verbally at the point of each observation.

Documentation review:

Relevant documentation to provide a backdrop to each Community Health Development Project will be collected informed by the local collaborators. Likely documentation will include project proposals, needs and asset assessments, consultation findings, linked or associated project evaluations and reports, and related strategies.

Should any reports be shared, that may be deemed confidential, or not in the public domain, this will be checked out with the stakeholder concerned and permission sought to share with the rest of the research team. If this is not authorised the reports will be returned and not used within the research. The notes taken from analysing the data in these documents will be stored as per Bangor University Policies (Bangor University's Research Data Management Policy 2015) and Bangor University Information Security Policy 2015) to the 'U' Drive.

Data Analysis

The purpose of the Community Health Development Project data analysis is to develop and refine the links between mechanisms, context and outcomes to meet the study objectives. Comparisons across the two cases will determine how the same mechanisms play out in different contexts and produce different sets of outcomes, leading to a set of theoretically generalisable features.

Thematic analysis will be used to analyse within each case and then across cases. Thematic analysis is not specific theory dependent and is useful for developing a description of the richness and complexities of the data.

Thematic Analysis encompasses six clear steps to be followed to ensure transparency, clarity and rigour of the findings (Braun and Clarke, 2006):
Familiarisation with the data
Generating initial codes)
Searching for themes (connecting and ordering codes into potential themes and creating mind maps)

Reviewing themes to refine them and construct a thematic map.
Defining and naming themes in order to refine them and produce an overall narrative and final map in which each of them can be described in a couple of sentences
Producing a report bringing together all the themes analysed
ATLAS.ti will be used for data management to help to uncover and systematically analyse the complexities hidden in different types of data (text, images, audio, multi-media etc.) and to weigh and evaluate their significance and map the complex

relationships between them. It is capable of handling large volumes of different types of data and also offers a range of visualisation tools to assist in generating interpretations of the data collected.

Tabular displays and graphs to manage and present qualitative data, without destroying the meaning of the data through intensive coding, will also be incorporated (Andrews & Evans, 2008: Guba and Lincoln, 1989).

Outputs from Phase Three:
Findings from 2cases of two geographically distinct community projects/programmes
A tested and refined programme theory
Data on context, mechanisms and outcomes arising from Community Health Development Project methods.
Phase Four: Refine Programme Theory and Test Wider Application (January 2020 to September 2020)

To complete the realist evaluation cycle, we will further test and refine the programme theory or theories (validation), using a joint interpretative forum, which will be an opportunity for different communities to reflect on and interpret information from the emerging results of the study (Bartunek, Trullen, Bonet & Sauquet, 2003).

This is an essential step given the 'boundary spanning' nature of community projects and both professionals and practitioners will be included in considering the emerging findings (boundary spanning refers to the manner in which individuals in each organisation or sector provide linking and translational connections with those in other organisations and sectors trying to align or work towards common goals).

The wider reference of this group allows for a broad consideration of the data, different perspectives and ways of understanding the data, and application of existing knowledge paradigms.

With such a broad nature of perspectives and levels of experience and expertise in a forum of this kind strong group facilitation is required and will be conducted by members of the Project team with a high degree of experience and qualifications in group dynamics as well as realist methodologies.

Participants will be facilitated to challenge and interpret these propositions from their own perspectives and their deliberations and findings will be captured through the relevant multimedia (audio, images, and written documentation). This range of data will be synthesised and used to further refine the programme theory.
Given the nature of the projects being evaluated; community (health) development's re-emergence as a foremost driver in contemporary health policy in Wales; and the surge in popularity in theory and practice of asset-based approaches to wellbeing, we will follow the forum by also adding a wider knowledge mobilisation phase to ensure engagement with key communities and fully exploit the results of the study.

Data collection

No new data is collected therefore there are not additional ethical considerations to account for in the phase.

Outputs from Phase Four:
Theoretical generalisability of the findings will be mapped.
A wider field will be engaged in a knowledge – transfer activity
DRAFT publications and formats for open learning will be prepared.

SUMMARY OF DATA MANAGEMENT ACROSS THE FOUR PHASES
DATA PROTECTION

All data within this research project will be collected and stored according to the Bangor University's Research Data Management Policy (September 2015) and Bangor University Information Security Policy (2015). It will also be proactively managed through use of the Bangor University IT Checklist for Research Projects.

Documentary data, interview transcriptions, and all field-work diaries will be stored securely on the Bangor University study 'U' Drive. Information gathered in the field will be recorded onto an encrypted laptop and information transferred as soon as possible thereafter to the University U drive. Only the chief and principal investigators plus the academic supervisory team will have access to primary data.

Data will only be stored on the secure University drive and transfer of data will be by encrypted USB only. The length of data storage will also be governed by the Bangor University Research Data Management Policy (2015). The minimum retention period for research data and records is five (5) years after publication or public release of the work of the research, unless required by the funder to retain for longer.

ETHICAL ISSUES:
CONSENT

In line with good research practice the researcher will adhere to the highest principles in relation to consent, time and burden of participants. All engagement in the study will be voluntary, therefore they will all be provided with written information about the evaluation and details of the nature and purpose of the particular data-collection activities before being asked to provide written consent to participate.

We will maintain that all participants will have the right to withdraw consent at any point without providing any reason.

BURDEN AND TIME

The burden and time anticipated for the majority of stakeholders will be minimal, likely to be commensurate with their own professional or voluntary sector role, and in return for their involvement they should benefit from the results of the research through a greater understanding of their local community projects.
Expenses incurred in attending interviews and stakeholder workshops will be recompensed if the workshops are solely related to the research (i.e. not events observed within case studies led by other organisations), if they are not covered by an individual's own organisation, and any expenses will be governed by the relevant expenses policies of KESS 2 and Bangor University.

CONFIDENTIALITY AND ANONYMITY

A clear verbal and written explanation of the approach to confidentiality within this research will be provided to each interviewee and focus group participant. Commitments to ensure confidentiality will be maintained by ensuring any digital recordings are not shared beyond the research core team; that transcripts are anonymised and any details that may be used to identify participants will be removed from transcripts or concealed in write-ups.

Participants will be known to the researcher gathering primary data, but beyond this, they will be assigned codes and unique identifiers to ensure and maintain anonymity. Where individuals are recognisable due to information provided in, for example, audio-recorded interviews, at the point of transcription a process of anonymising will be used to ensure that they are not recognisable.

As it may be possible to identify staff who hold unique or unusual roles if their job title were used in the written reporting of data, alternative ways of recording these will be used, such a providing a general title to protect their anonymity.

DISCLOSURE

Whilst it is not anticipated that sensitive or personally challenging issues will be uncovered during data collection, all potential risk or harm to interviewees or others will be mitigated by robust precautions, and by following Bangor University and Betsi Cadwaladr University Health Board policies, signposting participants to resources, services or support around any issues that may arise in the course of the research process).

Along with informing interviewees and workshop participants of the confidentiality mechanisms of the research at the start of each process will be an explanation that if a safeguarding issue is raised, the researcher is required to use these escalating policies and discuss them in the first instance with the Principal Investigator.

RESEARCHER SAFETY

The research will be conducted in line with the guidelines set out by the Institution of Occupational Safety and Health (IOSH, 2012), which takes a health and safety risk management approach to ensuring that the researcher takes responsibility for their own health and safety and ensure that the research does not compromise the health and safety of others through the conduct of that research.

In particular the Principal Investigator will oversee and ensure that the research team and supervisors are competent in the research area and have been trained to undertake all the methods that are in the scope of the project and to undertake risk assessments.
All research tasks will be subject to an evaluation of the foreseeable health and safety risks before they are initiated. The resulting research risk assessment will be communicated to all the research team together with the proposed control measures for managing risk (for example ensuring that workshops are undertaken by at least two members of the research team not by a lone researcher).

WELSH MEDIUM PROVISION

All participant facing documents in this research project will be offered in Welsh as well as English.

PARTICIPANT CONCERNS

If any areas of concern are highlighted by the participants, they may contact the Principle Investigator who will discuss and review their concerns with them, and take appropriate actions, only with their expressed permission and ensuring their confidentiality and anonymity as above.

The gatekeeper for concerns will therefore be Paul Brocklehurst, Professor of Health Services Research and Director of NWORTH Clinical Trials Unit, Y Wern, Safle Normal/Normal Site, Bangor, Gwynedd, LL57 2PZ.

If a participant remains unhappy and wishes to complain formally, they may in addition contact Professor Chris Burton, Head of School of Healthcare Sciences, Bangor University, Fron Heulog, Bangor, Gwynedd, LL57 2EF.

TIMELINES

The phases of the study are set out along with the anticipated timelines within the appended Gantt Chart. (Appendix E).

Appendix 2: Consent Forms (Interviews, Stakeholder Workshops, Non – Participant Observation)

Appendix 2a: Interview Consent Form V3.0 (17/10/18)

Paul Brocklehurst
Professor of Health Services Research and Director of NWORTH Clinical Trials Unit
Y Wern
Safle Normal/Normal Site
Bangor, Gwynedd
LL57 2PZ

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT (INTERVIEWS)

Title of project	A realist evaluation of geographically distinct community (health) development projects: what works in Wales, for whom, how, why, and in what circumstances?	
Name and e-mail address(es) of all researcher(s)	Andrew Rogers Lynne Williams Paul Brocklehurst	hbpa5a@bangor.ac.uk lynne.williams@bangor.ac.uk p.brocklehurst@bangor.ac.uk

Please write your initials in the boxes to signal your agreement:

1 I confirm that I have read and understand the Information Sheet dated ……for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. ☐

3 I understand that relevant data collected during the study, may be looked at by individuals from Bangor University and appropriate regulatory authorities, where it is relevant to my taking part in this research. ☐

4 I understand that information collected in the course of the research through an interview may be shared anonymously with other researchers. ☐

5 I agree to take part in the above study. ☐

Name of Participant……..….

Signature …….…….….
Date ……..

Name of Person taking consent…….…….

Signature ……..…….
Date ……..

WHEN COMPLETED:

ONE COPY TO PARTICIPANT, ONE COPY TO RESEARCHER FILE

Appendix 2b: Stakeholder Workshop Consent Form V3.0 (17/10/18)

Paul Brocklehurst
Professor of Health Services Research and Director of NWORTH Clinical Trials Unit
Y Wern
Safle Normal/Normal Site
Bangor, Gwynedd
LL57 2PZ

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT (STAKEHOLDER WORKSHOP)

Title of project	A realist evaluation of geographically distinct community (health) development projects: what works in Wales, for whom, how, why, and in what circumstances?	
Name and e-mail address(es) of all researcher(s)	Andrew Rogers Lynne Williams Paul Brocklehurst	hbpa5a@bangor.ac.uk lynne.williams@bangor.ac.uk p.brocklehurst@bangor.ac.uk

Please write your initials in the boxes to signal your agreement:

1 I confirm that I have read and understand the Information Sheet dated ……for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. ☐

3 I understand that relevant data collected during the study, may be looked at by individuals from Bangor University and appropriate regulatory authorities, where it is relevant to my taking part in this research. ☐

4 I understand that information collected in the course of the research though stakeholder workshops may be shared anonymously with other researchers. ☐

5 I agree to take part in the above study. ☐

Name of Participant……..….

Signature ……..……..….
Date ……..

Name of Person taking consent…….……

Signature ……..…….
Date ……..

WHEN COMPLETED:

ONE COPY TO PARTICIPANT, ONE COPY TO RESEARCHER FILE

Appendix 2c: Non-Participant Observation Consent Form V3. (017/10/18)

Paul Brocklehurst
Professor of Health Services Research and Director of NWORTH Clinical Trials Unit
Y Wern
Safle Normal/Normal Site
Bangor, Gwynedd
LL57 2PZ

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT (NON – PARTICIPANT OBSERVATION)

Title of project	A realist evaluation of geographically distinct community (health) development projects: what works in Wales, for whom, how, why, and in what circumstances?	
Name and e-mail address(es) of all researcher(s)	Andrew Rogers Lynne Williams Paul Brocklehurst	hbpa5a@bangor.ac.uk lynne.williams@bangor.ac.uk p.brocklehurst@bangor.ac.uk

Please write your initials in the boxes to signal your agreement:

1 I confirm that I have read and understand the Information Sheet dated ……for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. ☐

3 I understand that relevant data collected during the study, may be looked at by individuals from Bangor University and appropriate regulatory authorities, where it is relevant to my taking part in this research. ☐

4 I understand that information collected in the course of the research through non – participant observation may be shared anonymously with other researchers. ☐

5 I agree to take part in the above study. ☐

Name of Participant……..….

Signature ……..…….….
Date ……..

Name of Person taking consent…….…….

Signature ……..…….
Date ……..

WHEN COMPLETED:

ONE COPY TO PARTICIPANT, ONE COPY TO RESEARCHER FILE

Appendix 3: Participant Information Sheets (Interviews, Stakeholder Workshops, Non – Participant Observation)

Appendix 3a: PIS Interviews V3.0 (17/10/18)

Y Wern
Safle Normal/Normal Site
Bangor, Gwynedd
LL57 2PZ

PARTICIPANT INFORMATION SHEET (INTERVIEWS)

You are invited to take part in this study which is evaluating two Health Board supported community (health) development programmes in North Wales to provide an explanatory account of "what works, for whom, how, why and in what circumstances". This is a collaborative project between BCUHB and Bangor University, and is funded by KESS 2 (the Knowledge Economy Skills Scholarships, which is a major pan-Wales operation supported by European Social Funds through the Welsh Government).

Two case studies will be explored, and stakeholders and participants of those projects may be invited to take part in interviews, stakeholder workshops or be part non-participant observation of the projects.

WHY HAVE I BEEN INVITED?

You have been invited to take part due to your involvement in or experience of community projects in your area. We are interested in the views of people involved

in any way with the project. We would like to understand, from your perspective, if, how and why the project is successful, and what factors help or hinder its success.

WHAT WOULD TAKING PART INVOLVE?

We would like to invite you to participate through a face to face interview, conducted at a date and time convenient for you in your local area. We will ask you to sign a consent form before the interview. The interview should take no more than approximately one hour. The interviews will be audio-taped and then transcribed.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

The findings from the interviews will be used to inform the study on whether community approaches work in improving health outcomes and identifying what works, in what circumstances and for whom within a distinct North Wales context There are many theories and an evidence base to draw from to indicate that community (health) development projects work in producing wellbeing, but little evidence exists on how they work. You may find it interesting to discuss your views on this and you will be helping to inform current and future research which has local, national and wider significance for health and community development.

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?

We cannot foresee any possible disadvantages or risks to you to taking part. However, we do appreciate the pressures on your time. We will ensure there is time at the end of the interview should you wish to further discuss/be provided with contact details for issues related to the study.

WHAT WILL HAPPEN IF I DON'T WANT TO CARRY ON WITH THE STUDY?

Taking part in the study is entirely voluntary. You can withdraw from the study at any point without giving a reason. If you wish to withdraw, any data that relates to you will be destroyed. If you wish to withdraw from the study, please contact Andrew Rogers via email hbpa5a@bangor.ac.uk

HOW WILL MY INFORMATION BE KEPT CONFIDENTIAL?

Your participation will remain confidential. Individual participants will be allocated codes and/or pseudonyms, so that no personal identifiable information is reported. Any reference to workplace, organisation, location, names of individuals will be removed from the interview transcripts. Any quotes used in study publications will not identify individuals or locations.

WHAT WILL HAPPEN TO THE RESULTS OF THIS STUDY?

It is anticipated that the results of the study will be shared widely. We will use our findings to formulate recommendations about community health development projects.

WHO IS ORGANISING AND FUNDING THIS STUDY?

This study is being organised by Bangor University and funded by the European Union backed Knowledge Economy Skills Scholarships (KESS 2) scheme, with the support of Betsi Cadwaladr University Health Board as a business partner.

WHAT DO I DO IF I HAVE ANY CONCERNS OR COMPLAINTS ABOUT THE STUDY?

If you have any concerns about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions by email at hbpa5a@Bangor.ac.uk . If you remain unhappy and wish to complain formally, you can do this by contacting Prof Chris Burton, Head of School of Healthcare Sciences, Bangor University, Fron Heulog, Bangor, Gwynedd, LL57 2EF.

WHO HAS REVIEWED THIS STUDY?

The study has been reviewed by the School of Healthcare Sciences Research Ethics Committee at Bangor University and NHS Research and Development.

SUMMARY STATEMENT ON GENERAL DATA PROTECTION REGULATION FOR HEALTH AND CARE RESEARCH

Bangor University is the sponsor for this study based in Wales. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Bangor University will keep identifiable information about you for 5 years after the study has finished/ until 2025.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at https://www.bangor.ac.uk/library/documents/RDM/BU%20RDM%20Policy_redraft_Feb18_Final.pdf and/or by contacting Andrew Rogers at hbpa5a@bangor.ac.uk.

FURTHER INFORMATION ABOUT THIS RESEARCH STUDY:

Paul Brocklehurst
Professor of Health Services Research and Director of NWORTH Clinical Trials Unit

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Appendix 3b: PIS Stakeholder Workshops V3.0 (17/10/18)

PRIFYSGOL
BANGOR
UNIVERSITY

Y Wern
Safle Normal/Normal Site
Bangor, Gwynedd
LL57 2PZ

PARTICIPANT INFORMATION SHEET (STAKEHOLDER WORKSHOPS)

You are invited to take part in this study which is evaluating two Health Board supported community (health) development programmes in North Wales to provide an explanatory account of "what works, for whom, how, why and in what circumstances". This is a collaborative project between BCUHB and Bangor University, and is funded by KESS 2 (the Knowledge Economy Skills Scholarships, which is a major pan-Wales operation supported by European Social Funds through the Welsh Government).

Two case studies will be explored, and stakeholders and participants of those projects may be invited to take part in interviews, stakeholder workshops or be part non-participant observation of the projects.

WHY HAVE I BEEN INVITED?

You have been invited to take part due to your involvement in or experience of community projects in your area. We are interested in the views of people involved in any way with the project. We would like to understand, from your perspective, if, how and why the project is successful, and what factors help or hinder its success.

WHAT WOULD TAKING PART INVOLVE?

We would like to invite you to participate with other stakeholders in a workshop on how community projects work. We will ask you to sign a consent form before the workshop. The workshop will take no more than five hours. The workshops will focus on jointly developing ideas that can be captured in drawings and diagrams. These will be drawing will be captured on digital photographs, the process of making them captured on video, and discussions of them audio-taped and then transcribed.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

The findings from the stakeholder workshops will be used to inform the study on whether community approaches work in improving health outcomes and identifying what works, in what circumstances and for whom within a distinct North Wales context.

There are many theories and an evidence base to draw from to indicate that community (health) development projects work in producing wellbeing, but little evidence exists on how they work. You may find it interesting to discuss your views on this and you will be helping to inform current and future research which has local, national and wider significance for health and community development.

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?

We cannot foresee any possible disadvantages or risks to you to taking part. However, we do appreciate the pressures on your time. We will ensure there is time at the end of the workshop should you wish to further discuss/be provided with contact details for issues related to the study.

WHAT WILL HAPPEN IF I DON'T WANT TO CARRY ON WITH THE STUDY?

Taking part in the study is entirely voluntary. You can withdraw from the study at any point without giving a reason. If you wish to withdraw, any data that relates to you will be destroyed. If you wish to withdraw from the study, please contact Andrew Rogers email hbpa5a@bangor.ac.uk

HOW WILL MY INFORMATION BE KEPT CONFIDENTIAL?

Your participation will remain confidential. Individual participants will be allocated codes and/or pseudonyms, so that no personal identifiable information is reported. Any reference to workplace, organisation, location, names of individuals will be removed from the workshop transcripts. Any quotes used in study publications will not identify individuals or locations.

WHAT WILL HAPPEN TO THE RESULTS OF THIS STUDY?

It is anticipated that the results of the study will be shared widely. We will use our findings to formulate recommendations about community health development projects.

WHO IS ORGANISING AND FUNDING THIS STUDY?

This study is being organised by Bangor University and funded by the European Union backed Knowledge Economy Skills Scholarships (KESS 2) scheme, with the support of Betsi Cadwaladr University Health Board as a business partner.

WHAT DO I DO IF I HAVE ANY CONCERNS OR COMPLAINTS ABOUT THE STUDY?

If you have any concerns about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions by email at hbpa5a@Bangor.ac.uk . If you remain unhappy and wish to complain formally, you can do this by contacting Prof Chris Burton, Head of School of Healthcare Sciences, Bangor University, Fron Heulog, Bangor, Gwynedd, LL57 2EF.

WHO HAS REVIEWED THIS STUDY?

The study has been reviewed by the School of Healthcare Sciences Research Ethics Committee at Bangor University and NHS Research and Development.

SUMMARY STATEMENT ON GENERAL DATA PROTECTION REGULATION FOR HEALTH AND CARE RESEARCH

Bangor University is the sponsor for this study based in Wales. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Bangor University will keep identifiable information about you for 5 years after the study has finished/ until 2025.
Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at https://www.bangor.ac.uk/library/documents/RDM/BU%20RDM%20Policy_redraft_Feb18_Final.pdf and/or by contacting Andrew Rogers at hbpa5a@bangor.ac.uk.

FURTHER INFORMATION ABOUT THIS RESEARCH STUDY:

Paul Brocklehurst
Professor of Health Services Research and Director of NWORTH Clinical Trials Unit
Y Wern

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Bangor, Gwynedd
LL57 2PZ

Appendix 3c: PIS Non-Participant Observation v3.0 (17/10//18)

Y Wern
Safle Normal/Normal Site
Bangor, Gwynedd
LL57 2PZ

PARTICIPANT INFORMATION SHEET (NON – PARTICIPANT OBSERVATION)

You are invited to take part in this study which is evaluating two Health Board supported community (health) development programmes in North Wales to provide an explanatory account of "what works, for whom, how, why and in what circumstances". This is a collaborative project between BCUHB and Bangor University, and is funded by KESS 2 (the Knowledge Economy Skills Scholarships, which is a major pan-Wales operation supported by European Social Funds through the Welsh Government).

Two case studies will be explored, and stakeholders and participants of those projects may be invited to take part in interviews, stakeholder workshops or be part non-participant observation of the projects.

WHY HAVE I BEEN INVITED?

You have been invited to take part due to your involvement in or experience of community projects in your area. We are interested in the views of people involved in any way with the project. We would like to understand, from your perspective, if, how and why the project is successful, and what factors help or hinder its success.

WHAT WOULD TAKING PART INVOLVE?

We would like to invite you to participate through your potential involvement in an event that we are observing as part of the research (for example in any meetings, project presentations briefings or project led stakeholder engagement events that you may be attending).

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

The findings from the observations will be used to inform the study on whether community approaches work in improving health outcomes to identifying what works, in what circumstances and for whom within a distinct North Wales context.

There are many theories and an evidence base to draw from to indicate that community (health) development projects work in producing wellbeing, but little evidence exists on how they work. You may find it interesting to contribute your experience to this and you will be helping to inform current and future research which has local, national and wider significance for health and community development.

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?

We cannot foresee any possible disadvantages or risks to you to taking part. However, we do appreciate the pressures on your time. We will ensure there is time at the end of the observation should you wish to further discuss/be provided with contact details for issues related to the study.

WHAT WILL HAPPEN IF I DON'T WANT TO CARRY ON WITH THE STUDY?

Taking part in the study is entirely voluntary. You can withdraw from the study at any point without giving a reason. If you wish to withdraw, any data that relates to you will be destroyed. If you wish to withdraw from the study, please contact Andrew Rogers email hbpa5a@bangor.ac.uk

HOW WILL MY INFORMATION BE KEPT CONFIDENTIAL?

Your participation will remain confidential. Individual participants will be allocated codes and/or pseudonyms, so that no personal identifiable information is reported. Any reference to workplace, organisation, location, names of individuals will be removed from the observation notes. Any quotes used in study publications will not identify individuals or locations.

WHAT WILL HAPPEN TO THE RESULTS OF THIS STUDY?

It is anticipated that the results of the study will be shared widely. We will use our findings to formulate recommendations about community health development projects.

WHO IS ORGANISING AND FUNDING THIS STUDY?

This study is being organised by Bangor University and funded by the European Union backed Knowledge Economy Skills Scholarships (KESS 2) scheme, with the support of Betsi Cadwaladr University Health Board as a business partner.

WHAT DO I DO IF I HAVE ANY CONCERNS OR COMPLAINTS ABOUT THE STUDY?

If you have any concerns about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions by email at hbpa5a@Bangor.ac.uk . If you remain unhappy and wish to complain formally, you can do this by contacting Prof Chris Burton, Head of School of Healthcare Sciences, Bangor University, Fron Heulog, Bangor, Gwynedd, LL57 2EF.

WHO HAS REVIEWED THIS STUDY?

The study has been reviewed by the School of Healthcare Sciences Research Ethics Committee at Bangor University and NHS Research and Development.

FURTHER INFORMATION ABOUT THIS RESEARCH STUDY:

Paul Brocklehurst, Professor of Health Services Research and Director of NWORTH Clinical Trials Unit, Y Wern , Safle Normal/Normal Site, Bangor, Gwynedd, LL57 2PZ.

APPENDIX B4 SPECIMEN INTERVIEW SPINE V3.0 17/10/18

Ysgoloriaethau Sgiliau Economi Gwybodaeth
Knowledge Economy Skills Scholarships

PRIFYSGOL
BANGOR
UNIVERSITY

Y Wern
Safle Normal/Normal Site
Bangor, Gwynedd
LL57 2PZ

INTERVIEW OUTLINE AND CHECKLIST

This interview will focus on testing and refining the initial programme theories and will capture perceptions about what is influencing implementation efforts, both intended and unintended consequences. In the "theory driven" interview the realist principles approach will be used to maximise data capture to test and refine the programme theories.

Check that the participant has received and is happy with the information provided in the letter of invitation, consent form and Patient Information Sheet, and a signature of consent/agreement to participate has been obtained.

The nature and style of the interview will be outlined (length of time, general type of questions to be covered, how recorded and stored) at the start of the interview and the issues of confidentiality already presented in written information will be repeated verbally.

Introductory sentence to be read at the start of each interview

> "You have been invited to take part in this study which is evaluating two Health Board supported community (health) development programmes in North Wales to provide an explanatory account of "what works, for whom, how, why and in what circumstances". This is a collaborative project between BCUHB and Bangor University, and is funded by KESS 2 (the Knowledge Economy Skills Scholarships, which is a major pan-Wales operation supported by European Social Funds through the Welsh Government). My name is Andrew Rogers and I am the Chief Investigator in this Research Project.
>
> You have been invited to take part due to your involvement in or experience of community projects in your area. We are interested in the views of people involved in any way with the project. We would like to understand, from your perspective, if, how and why the project is successful, and what factors help or hinder its success.
>
> Do you have any questions or things that you would wish me to clarify before we start the interview?"

Interview Outline

Your role/Involvement in this case (project, place or community of interest)

-
-

Community Needs

-
-

Community Assets

-
-

Thoughts on Challenges and Opportunities for community wellbeing

-
-

Perspectives on Community Interventions (general)

-
-

Perspectives on Community Interventions (locally and now)

-
-

Perspectives on effectiveness and efficacy (what works well)

-
-

What stops progress (barriers to change)

-
-

Throughout these general questions the discussion will be oriented toward outlining the initial programme theory and fining evidence to support or refute it.

> End by acknowledging the support of the interviewee, thanking them for their involvement and providing assurance on all issues of confidentiality and data storage.

.

APPENDIX 4: Direct Non- Participant Observation Schedule

Appendix 4a: Direct Non- Participant Observation Schedule (Spradley's Dimensions) (17/10/18)

What works in community (health) development projects in Wales: A Community Health Development Project

Code	Direct non- participant observation schedule
Date and Times	

Dimensions of Observation	Notes
Space	
Actors	
Activities	
Objects	
Acts	
Events	
Time	
Goals	
Feelings	

APPENDIX 5: Interview Invitation Letter and Information Sheet

Appendix 5a: Invitation Letter For Interview V3.0 (17/10/18)

WHAT WORKS IN COMMUNITY (HEALTH) DEVELOPMENT PROJECTS IN WALES: A COMMUNITY HEALTH DEVELOPMENT PROJECT

I am a researcher from Bangor University doing a study in this community. I am particularly interested in finding out more about how community projects in the community work in improving heath.

As part of the study I am carrying out some interviews with people who can provide their ideas and views on how community projects are run day to day, how they work, and if they achieve health outcomes.

As someone who is a key stakeholder in a community project; participates within one or more parts of the project; or is affected by it, I would like to interview you to gain your views.

The attached Patient Information Sheet (PIS interviews V1.0) explains the research project and how it will be conducted.

The interview will take no more than one hour. We don't anticipate that there are any risks associated with your participation, but you have the right to stop the interview or withdraw from the research at any time.

If you would like to know more about the study, please do not hesitate to contact me:

Andrew Rogers
c/o
NWORTH Clinical Trials Unit
Y Wern
Safle Normal/Normal Site
Bangor, Gwynedd
LL57 2PZ

Email: hbpa5a@Bangor.ac.uk

What if I have concerns about this research?

If you have any concerns about any aspect of this study, or if you are concerned about how it is being conducted, you should ask to speak to the researchers who will do their best to answer your questions by email at hbpa5a@Bangor.ac.uk .

If you remain unhappy and wish to complain formally, you can do this by contacting Prof Chris Burton, Head of School of Healthcare Sciences, Bangor University, Fron Heulog, Bangor, Gwynedd, LL57 2EF.

Appendix 5b: Study Information Sheet V3.0 (17/10/18)

WHAT WORKS IN COMMUNITY (HEALTH) DEVELOPMENT PROJECTS IN WALES: A COMMUNITY HEALTH DEVELOPMENT PROJECT

I am a researcher from Bangor University doing a study in this community. I am particularly interested in finding out more about how community projects in the community work in improving heath.

As part of the study I am carrying out some observations of how community projects are run day to day and will be observing a number of meetings, presentations and consultation events.

If this involves any observations of you in any interaction with the project, or the people involved in delivering it, I will firstly ask your permission. I will not be collecting any data about you.

If you decline to give your permission, I will not carry out the observation.

If you would like to know more about the study, please do not hesitate to contact me:

Andrew Rogers
c/o
NWORTH Clinical Trials Unit
Y Wern
Safle Normal/Normal Site
Bangor, Gwynedd
LL57 2PZ

Email: hbpa5a@Bangor.ac.uk

APPENDIX 6: Soft Systems and Rich Picture Community Health Development Project Workshops

SEIRIOL CATWOE AND RICH PICTURE

21 participants including one project beneficiary from the men in sheds project and various workers (current and retired) with a wide range of community development experience
Introduction to the workshop and its position in the research process was given by way of slide deck and questions were few but were fully responded to.

2) **Rich picture and feedback (audio recorded)**
"What would make a good/successful project?"
Group One

TAPE RECORDING
Pre-amble..
Community assets – key people are important – even in needy communities you need to work out what different people can bring – what they can do
To make any community project you have to have community members and you must have an understanding of what assets are there in a community – the key people – like you know the best people in your community, and what they are interested in.. you cant go in and ..say, lets do hang gliding if no one is interested in doing hang gliding
Feedback

"so the question is ..what makes a good community health development project"
Sometimes they just happen without anyone really thinking about it
Some of the elements you really cant pull apart because in isolation they wont really work

But where you should start is with a conversation about what really matters to people – because it then gives a grounding for everything else that then flows into it
And then you can look at what assets are there that can make that happen
There need to be a problem to solve or an asset to build on that it is recognised by the community.

Find what the community needs first – when we started Seiriol we didn't know what the need was so we had to go in looking for a community vision. Seiriol was about how we could make that area sustainable (not like usual where we react to a defined problem) and everything that has come out since is not what we expected.

Health – e.g. – we couldn't just go in and say weight is an interest – it has to be what they are interested in.

Sometimes we are driven by national needs and assets = we know that there are people going to the doctors that don't need to go to the doctors, we know that its mainly about loneliness, but we have identified that need they haven't identified that as a need

We then need to connect people with that and get them interested.

In a health project they are not – they haven't been involved in it from the beginning g – it's the engagement then that's important – the community to be involved in that early stage to get that bottom up approach (SIC – so not really bottom up as it was still externally defined but then persuade/motivate community understanding and buy in?)

Even if it's the third sector it can still be just top down, it's not necessarily the people coming together to say we've got a problem what's the solution and they go "oh" I've heard we can get funding from A B or C and we go as the CVC oh no – you don't need money you need to do this first, you need to engage, you need to talk to people about what they do need, what their ideas are because without their ideas you are not going to get very far. So it is about linking and us as the third sector influencing what government will fund.

What really matters? Is this about finding what issues are going to fly?

Yes its both really, our approach has always been what is it important to you in your communities so that we can then work on getting the evidence to support you, but it really does come down to engaging in what they are interested in

What main things are the focus of your approach?

- The people
- The what matters conversation
- Finding the assets
-

Are communities driving this themselves or is this coming from outside pressures? Austerity etc?

Its definitely changing and the impact of the Future Generations Act and health and social care Act are being felt. and austerity . it used to be that we couldn't get the [public sector to engage for love or money but now they are looking to the third sector to get involved for … to problem solve.. and now they see the huge benefit to heath and lifestyles etc of this work as it will reduce the impact upon services of ill health but there is an element to the work in Seriol ward that is about help coming in from outside into the ward with an assumption that if there is some major catastrophe or need the ward itself will rise up and do something

There is also something about us facilitating rather than driving, we did come in saying that there is no more money what can this community do for itself? but now 5 years down the line that alliance is the other way around where we invite services in when we need them rather than what's on their agenda

But that conversation started five years ago – and then the acts came in and have helped legitimise that approach – in certain communities – we are trying the approach in other areas now and they are totally different ball games (Amlwych and LLifon)

We have the engagements in Amlych but not LLifon. There is so much things going political on that its hard to bring the focus down to what is going on and matters for the community. One thing they want to pick.

The problem is now that things are so complex and there are **perfect storms** in a way – actually though in a good way if the public sector are now engaging with the third sector – we are now all trying to get our heads around being popular.

Communities first approach changed – ten years ago programme funding meant that you were trying to get public services to change their delivery based upon the evidence that you were getting from communities, and then, they changed the focus and new priorities were imposed .. and it just seems as though we are now going full circle back to those days again

Are you saying the partnerships that are formed are having to change again somehow?

Presumably its still the same people around the table are some engaging more now?

As a CVC we are gov.funded – communities first were too – we are still pushed by the government into doing what they think are the good ideas and the new act has helped do this e.g. village hall needing repairs used to take ages but now its happening quicker because of the act – not quick but quicker – people do seem more empowered to start things off because there is more support when they do … if they see something having success it does motivate others to have a go e.g. if in a deprived area two or three things come off when they are tried others see that there is a different environment for things to work in – it's a mixture of key people and an environment together – that will support them

Thinking about the formal v informal… the projects that start and evolve naturally are more likely to last longer although people who get involved might not even know they are in a project – its just something they get something out of being involved in – they do last longer than those which we put on a project format with objectives and outcomes and that

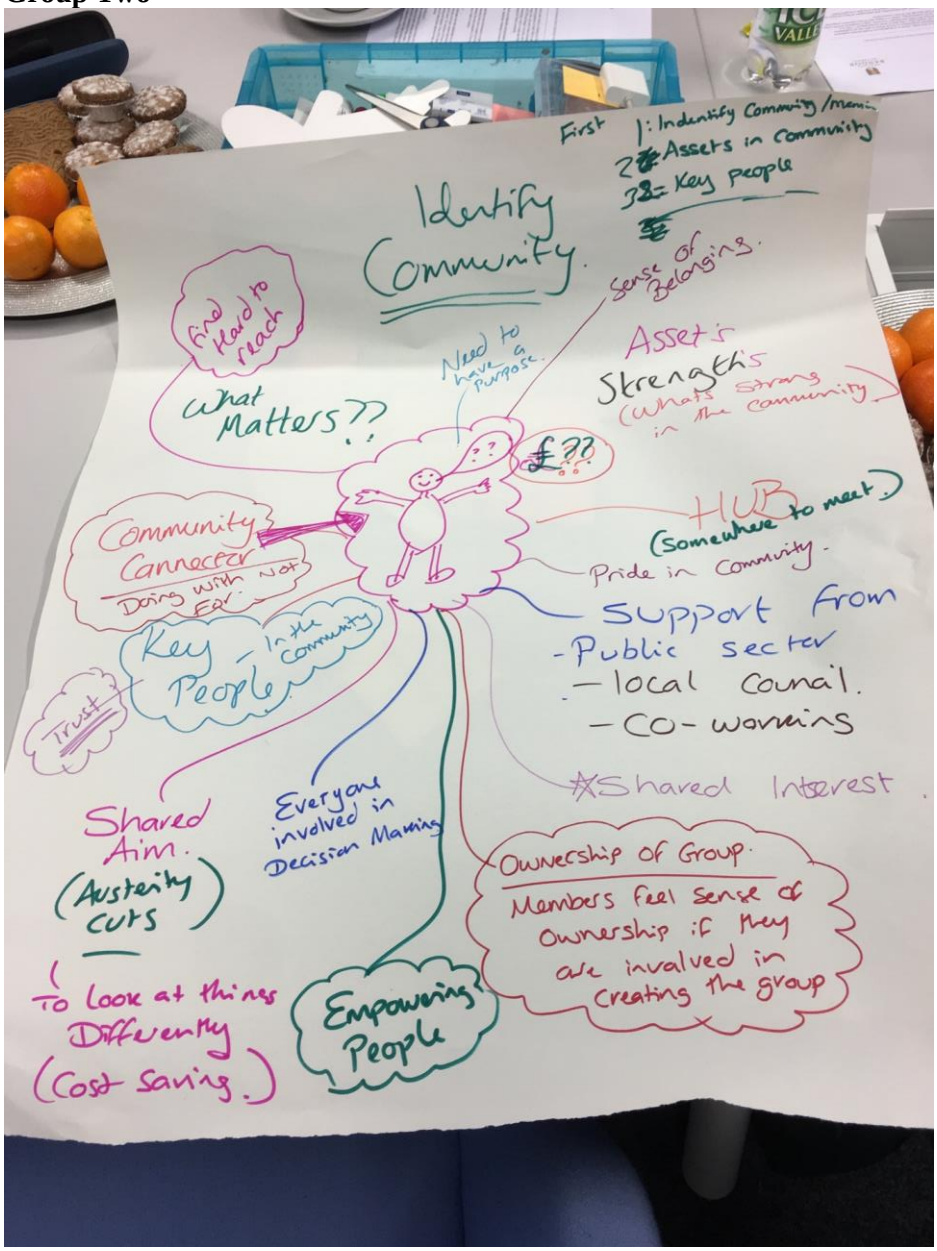
What really matters in measuring is the journey that people go on rather than measuring what they get out of it and can we count any quality as a result. The what matters conversation is central for keeping the project sustainable.eg men in sheds you can count the number of people turning up over a series of weeks and it might not look so good but just listen to the two or three stories and they journey that is reflected in those stories and its really powerful – much more than a stat that says ten men meet for two hours each Thursday!

Key ideas

- Conflict between truly bottom up and who defines the initial need or asset
- What matter conversation is a key process
- Changing dynamic between third and public sector
- New acts are having a distinct impact on changing that dynamic

- Informal processes more effective than formal project management tools and measurement – the power of a good story

Group Two



TAPE RECORDING
The facilitator is central – key characteristics are friendly and welcoming with open arms

Having such a person is key to begin with. When the other things are developed things that can also support – the key person can move back into a more supporting role – having that support is crucial – knowing where people can get support. At first people don't have the confidence to do it for themselves - balance giving them support but no point doing things for them because by having a go and doing it themselves they learn by experience and build up their knowledge of support available

It's about building their knowledge and skills and recognising what is already strong in the community - what they already have
They do need somewhere to meet – like a hub

And also some ideas of what is a community or communities – like you have a traditional community but you can also have a community of interests – shared interests that's a community as well – a shard idea if what is important – finding what matters I always the first step isn't it

Every community has key people, key members of the community that they know, you need to find out before starting any projects who these key people are and what they think matters in that community – speak to the community and find out what sort of community it really is

What Is the What Matters conversation? It's a health, or actually it's a WAG initiative, social services adopted it mostly and it has seven key questions – it has been picked up by the assets approach – finding out from people what really matters to people and helping them to work through finding solutions to them. As a CVC we are also adopting the approach to help people to have a wider conversation about what matters to them rather than making it highfalutin – bringing it back to basics

I keep seeing these posters saying what matters to you – and its not that – it's a shift from what the matter with you to what matters to you?

Eg B said what mattered to him in Mens Shedz was talking to family in New Zealand – this came out of a What Matters conversation and now following training B is a bit of a local expert on skype. What matters is a positive conversation about the things people, really think matters to them (like getting bread at a certain time each day). It's about bringing things back to basics.

It's a casual conversation approach that brings this out – being used more by health and social care workers now and is well received – it shies away from the formal and any recording is done outside of the casual conversation NO FORM FILLING

A sense of ownership of the group is important and being proud of their community Building a sense of belonging is important in the communities.

What role should the communities local councillors play? The elected members? Sometimes its disappointing about their commitment – because they should be in tune with these communities and what they are saying they need. Sometimes it does work – some individuals can do it – some can be that important person for the community and a councillor.

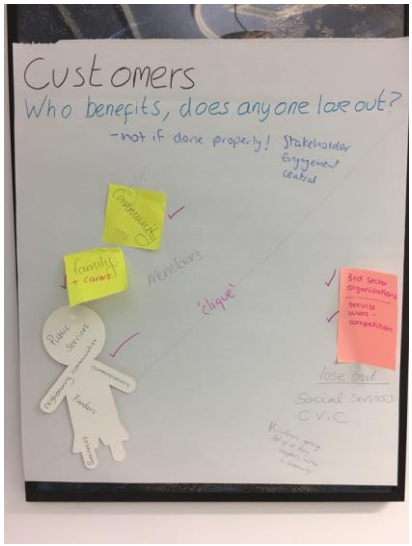
Our councillor for our area is also the older peoples champion and they can sometimes support with power and resources – sometimes money is important and they can harness it.

What is driving all this? why is this focus now changing – is it about assets approach or is it about national policies (FGA and Health and Social care Act)?
It's both!

Key ideas

- People skills are crucial in community connectors
- Now a new environment in which bottom up working has a chance of being supported
- What matters conversations a real facilitator
- Everyone involved in decisions ma king
- Community ownership
-

3) CATWOE

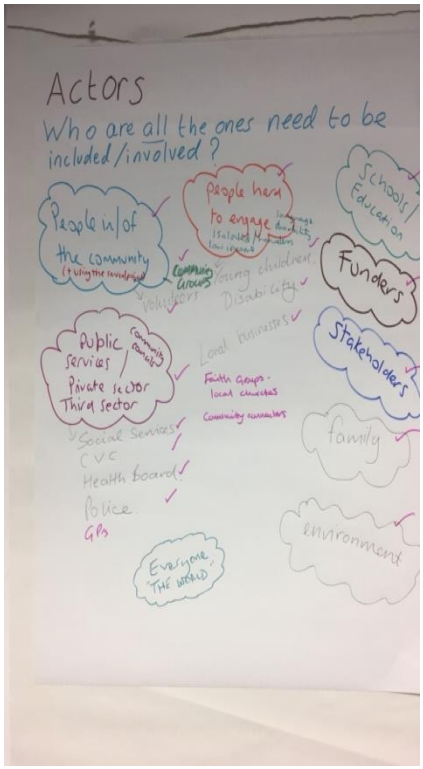


Customers

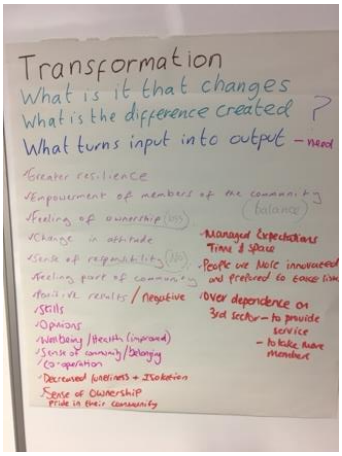
- no one should lose if it is done properly
- Stakeholder engagement is central to the approach working for everyone
- Key customers are the community itself/families/carers/service users/public services/neighbouring communities/funders/commissioners/business
- Third sector organisations
- It can though create competition between service users
- Potential losers are social services and CVC – and also volunteers themselves can get exhausted – fed up of doing everything in the community – this suggests there may be limits to sustainability of CHD and limits to resilience etc

Actors

- People in the community
- Community groups
- People accessing the new services provided/initiatives/interventions



- Hard to engage groups of people (due to language/disability/low income/isolation/homeless
- community councils/public services/third sector/private sector/local businesses/social services/health board/police/GPs
- Schools/education
- Funders
- Stakeholders
- Families
- Environment
- Everyone “the world”

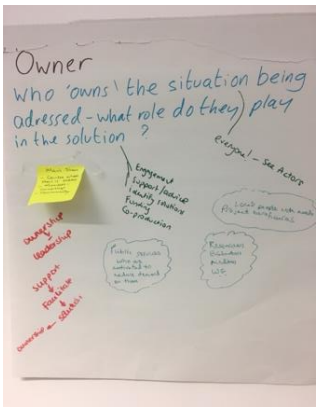


Transformation – what changes because of this project?

- **Need**
- **Greater resilience**
- **Empowerment of members of the community (*balance*)**
- **Feelings of ownership (*loss*)**
- **Change in attitude**
- **Sense of responsibility (*no*)**
- **Feeling part of the community**
- **Positive results/negative**
- **Skills**
- **Opinions**
- **Wellbeing and health improved**
- **Sense of community and belonging**
- **Co-operation**
- **Decreased loneliness and isolation**
- **Sense of ownership**
- **Pride in their community**
- **Managed expectations**
- **Time and space**
- **People are more involved and prepared to take risks**
- **Over dependence on 3rd sector to provide services and take in more members**

World View

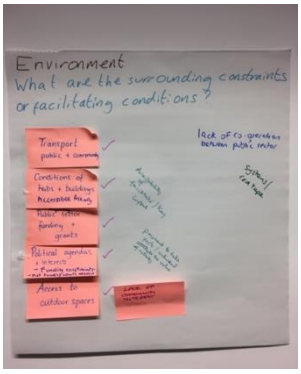
- Age – changing demographics – ageing population
- Austerity
- Population movement
- Loss of family support
- Global warming
- Competition for habit
- Brexit
- Increase in chronic conditions
- To redress lost resilience, lost knowledge, reliance on technology
- Data rich information poor
- Risk averse
- Public health
- Frustrated communities not being listened to
- Wylfa B
- Communities now aware of the BIGGER picture
- Reacting too slowly – reaction vs prevention
- No volunteers



Owner

- Everyone – see actors
- ownership – leadership
- Support – facilitation – solution – owner
- Local people with needs
- Project beneficiaries
- Researchers/evaluators/auditors/ WAG
- Public services who are motivated to reduce demand on them
- Mens Shedz – centre where shed is based/members ownership/community

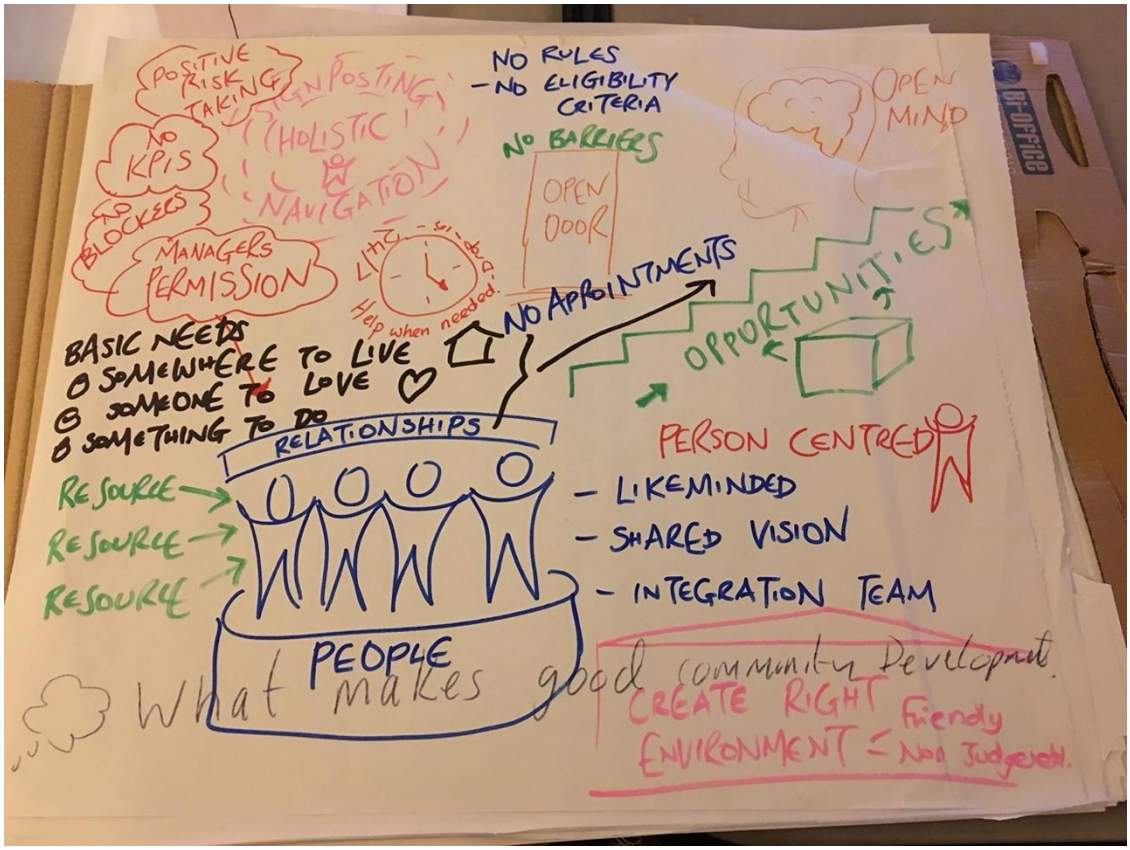
Environment



- lack of co-operation between public sector bodies
- Systems/red tape
- Transport public and community is weak
- Condition of hubs and buildings is poor
- Accessibility is poor
- Lack of availability of facilitators/key support
- Public sector funding and grants
- Political agendas and interests, funding constraints – not funding what is actually needed
- Access to outdoor spaces
- Lack of community interest

WREXHAM HOMELESSNESS CATWOE AND RICH PICTURE

Wrexham Homelessness Project 22 Feb 2019
3rd meeting of steering group
Present: GP, Police, Counsellor, Voluntary Council, Shelter, BCUHB Drugs Outreach, Interior Designer, participants
What Makes Good Community (Health) Development



- Its about the people who get involved
- Not about the range of skills, its mainly about their attitudes, and about their values and qualities as human beings
- Essentially they have to be person centred
- But they also have to be able to work in a wider team with a shared perspective
- A space is needed for people to be which has the right environment where people are able to be supported and it has to be non-judgemental
- Workers and organisations have to be open minded and not bound by corporate objectives
- Timing of interventions in crucial and giving people time
- Small steps are important – in the Maslow sense building when needs are met but also that tiny steps and giving people feedback about their progress is important
- A key issue was having an open-door policy and reducing organisational barriers
- Linked to this is the joint approach in removing or ignoring silo working and KPIs
- Bridging between the chaos around a person and the pathways into help – clarifying and empowering – belief from fatalism

Transcript of verbal feedback describing the pictorial representation of "good community (health) development

I think we all agreed that the key thing is about people and relationships … so I think its about the relationship between the people that turn up to try to deliver services

and the fact that the right people come along, they are obviously a self-selected group of people that want to be there and have fought with their management to take part in the project and then it is about relationships with the people who come to use services and the fact that we don't judge and it's a friendly environment (GP)

…The way we adapt also to the needs of each client because of their complex needs or adaptations (DW)

And we forgive, we don't stick goals on people and then if they fail we don't penalise them for it, we do let people dip in and out as it suits them – so its about building relationship and trust I think (GP)

Is there anything about the skills of those people or is it just attitude? (AR)

I think its attitude – 100% its about attitude, I could be a rubbish doctor but it's the fact that I am kind – its definitely about attitude, its all about people for me, massively its about people and relationships.

And it helps then that we have an open door, I guess when we first started the project we did it in a place where there were lots of rules and it was erm it was almost quite intimidating wasn't it in the early days? It was quite – there was a lot of heightened emotion and you know people kept kicking off and getting cross and there was a lot of people being banned and it felt a bit intimidating being there and then we went over to the salvation army and we said let's try it with no rules and so let's have an open door policy and anyone can come in that needs help and there is no eligibility criteria and we will support you in the best way that we can, and we wont judge and that's really .. that combination of people and the open door and no barriers – yes we get lost done on the same morning (GP)

But that's not only clients coming through that's also inter-agency, no-one is in competition, no-one is telling each other what they should or shouldn't be doing, they are learning from each other, giving them a better picture (C)

I think you are right its that breaking down barriers between – even within health – you have that "oh GPs are lazy" and " you know SMS don't this" but you know that's how it always has been and then actually because you then have a person that you know I know mental health nurses, and I know you guys really well and the SMS team and you build up that relationship where you start appreciating the nurses job and you learn from them and you upskill which I think is really helpful (GP)

Which is what I mean, the guys have got this relationship with each and every person from all the different services, and we all work together really well as a multi-disciplinary team so it works for **them** because **we** are all working together (DW)

I think its about that we are almost an integrated team rather than just created, we all talk to each other and learn from each other, and that team has evolved its almost like a family isn't it. It feels like we have created this community of **us** – the people that deliver the services and come for services (GP)

How hard was it for you to put the rules aside when you are in a rules based organisation? (AR)

For me it was easy, but that's just me isn't it? A couple of weeks ago we had, I walked around a corner and saw two cop cars outside and someone was getting searched and I was like "oh Jesus" you know? All the good work you do and when you can sit down and have a brew with someone can be undone very quickly cant it? But that's about individuals again – and some Bobbies will never have that, some Bobbies will never see what's happening there as a good thing, they will think its one thing or the other, so its just about having the right person. You could put someone else in there and I wouldn't be here would I in fairness? But there is numerous times when – especially at the time when Spice was at its worst – where I could easily have locked somebody up but I've marched them to Ty Groes or I've marched them to Salvation Army and can you get them a cup of tea and kinda we will try and deal with the other stuff afterwards. Its very easy but I've got a good boss behind me who gives me that free reign, if he goes that could change you know (PC)

Is that this here, "permission" (AR)

Yes its that permission from above and a lot of people have had to fight, and are still fighting, to be there and its really quite tragic when the projects so successful. (GP)
You have to keep all of that don't ya? You have to keep selling the story really (PC)

So the top corner there – the "open mindedness" seems to go right through this doesn't it, the open mindedness of the systems and the owners of these systems to give it chance (AR)

And the open mindedness of the people to each other … so some of the things we talked about earlier about that people aren't judged immediately and it's a non judgmental service and its not "oh its them again" and people can come back and come back and it might not always work because it might not serve need but it doesn't make any difference to the next time they come back as they still are going to get support (CVC)

And for all the services it's the same we all sing from the same hymn sheet we all want the same things (DW)

A lot of it you know, certainly for me, if I arrest somebody for a ten pound shoplift for a piece of cheese, that a waste of time for me, I am wasting my time coz nothing good is going to come of that for anybody – whereas if I can march them up to Karen or whoever and sort this out for them that's got a much better effect for everybody hasn't it? Stop the offending that's better for everyone isn't it (PC)

And what frustrates me is that there are different rules for different people in society so if these guys are ten minutes late for their appointments they cant be seen for three weeks with their script so they don't have their methadone and they go cold turkey they go out and shoplift to buy drugs and you just think what are we doing? I can be ten minutes late for my GP appointment and its highly likely that they will say "oh go on we will see you or we will speak to you tomorrow (GP)

But there is a real double standard there and I know why it is but if you go for a GP appointment you usually have to wait at least half an hour …but yes there are double standards between professional its not just GPs

But to be fair that due to what a person comes in with isn't it ?

To be fair its an archaic policy isn't it ? I know its still on our books but I want to change it to make it that we don't have an exclusion policy- that we have a supervision policy, if someone kicks off we will never take their service away its just that they cant come into the building unless their care navigator is on the site the whole time they are there (C)

And its inevitable that the people that we work with, the chaos that they, they do have everyday, they are going to kick off, they are going to clash with other people "you owe me money – you did this – etc" its going to happen, we just have to deal with it in the right way rather than "you've got a ban for two weeks you're having a ban" its just ridiculous – these are the barriers to a good service (DW)

So, we say you are ten minutes late you can't have what you've come for, they then get cross and then they are banned (GP)

So, can I take it from this that you are all trying to deliver one another's objectives? So you are not just a GP you have also got other people's objectives at the back of your mind as well and ultimately it making it better for that person and society, not just doing you health bit or your crime bit? (AR)

Yes its that person being at the centre of it (CVC)

Yes its that, its about the whole person, we are all trying to … I think it also when you see some of the successes - someone like "Sam" who as we were saying this morning, Sam was public enemy number one and he was a complete nightmare, only thirteen months ago on the streets in and out of prison, shoplifting galore, and he now volunteers and he is working for us and I think we all want everyone to have that opportunity and that goes back to that shared vision and we want to help all of those guys to sort their lives out (GP)

What I thinks is really nice as an outsider looking in on you is that there is a really nice shared story telling phase – you've said it a number of times that there are a number of people that have moved through and this is now what they are doing and I think that's a really nice part of the community isn't it that it has its own stories (ID)

Yes you need those success stories as well don't you? YES when you see someone doing so well it give us all hope absolutely (PC)

Patrick one of our new starters he has just started volunteering and there are others (GP)

Well we said to Sam right now – what were the successful points and its not from what we think – I went and asked Sam what was the point that … and he says proudly that its when this one (GP) said she cared about him (C)

And then when we keep giving that positive feedback, you know you are doing amazing, e are proud of you and then it just keeps reinforcing what they are doing (DW)

You find the "in point" everyone has an in point (C)

It that caring that's really important as well, it s community, we are like family, and we value ourselves (ID)

It has echoes of Youth Shedz in Denbigh when I asked what worked for you and they said someone gave us space, and pizza, and the pizza was a distraction to talk about … and then no-one talked down to us they talked to us about who we were, so we discussed at the end of that session this journey from finding a me to forming and us and the ours. But the most important point was that someone recognised them and they that they are alright actually and that others are in the same place as you, and then they moved on from there (AR)

We also had a lady who was found dead in the stairwell in a smelly old car park a few months ago and so that can also make people thinks we are not doing enough here because if that's still happening we are not there yet then are we (PC)

And I think its that move on isn't it? We can trace up, do the basic health provision, benefits, housing and actually I have just written that old Maslow stuff down its about giving someone somewhere to live , somewhere to love, new relationship, something to do, a new purpose, so actually that's where we are up to now – we have done the basic bits but its not enough – and that's what that rooms doing (*peer group support training in the next room*) saying how do we link in private landlords so we can get accommodation independently of the council? How do we build up social networks? Relationships?(GP)

So are these the steps here in the picture? The small steps going up? (AR)

Yes its what we are doing at the moment and then its moving on into something to do to have a purpose, so with the peer mentoring we have invited some of the chaps to come along and be part of it with us and we have chosen quite a mix of people who have stayed in hostels, we have Craig who is still out on the streets, and Craig said I cant believe that have you chosen me you know I am still using don't you and we said yeas its fine yes, and he was blown away, apart from today he said he couldn't come because he is exhausted as he had a bad night on the streets> every Friday he has arrived on time and he has really contributed and everything. For him that's just a little glimmer of they have belief in me and they think I can do this. Its just been enough to entice him in and yet traditionally he would be ignored on streets. On a project he would be deemed as too chaotic. He wouldn't be even considered for anything.

Yes he would have to be stable before service would do things…

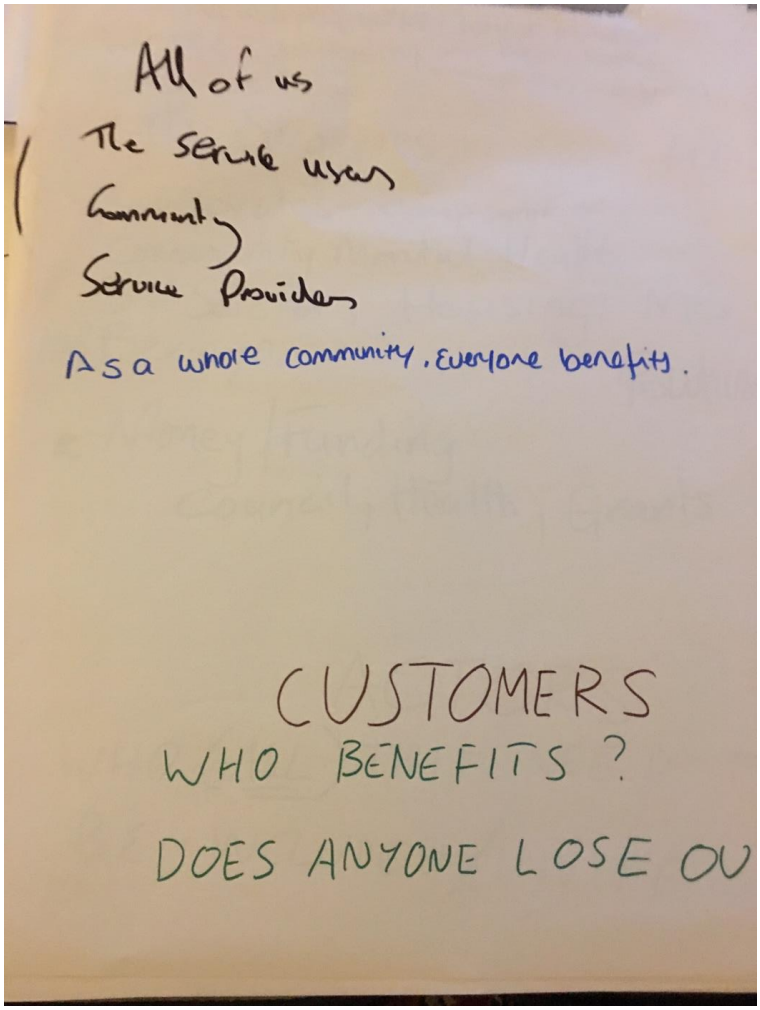
You haven't got really strict KPIs . you work with just the initial need – along the way you might then meet other needs but just start with that initial need for a bacon sandwich – and its met and the other need are gone and that is enough coz they are

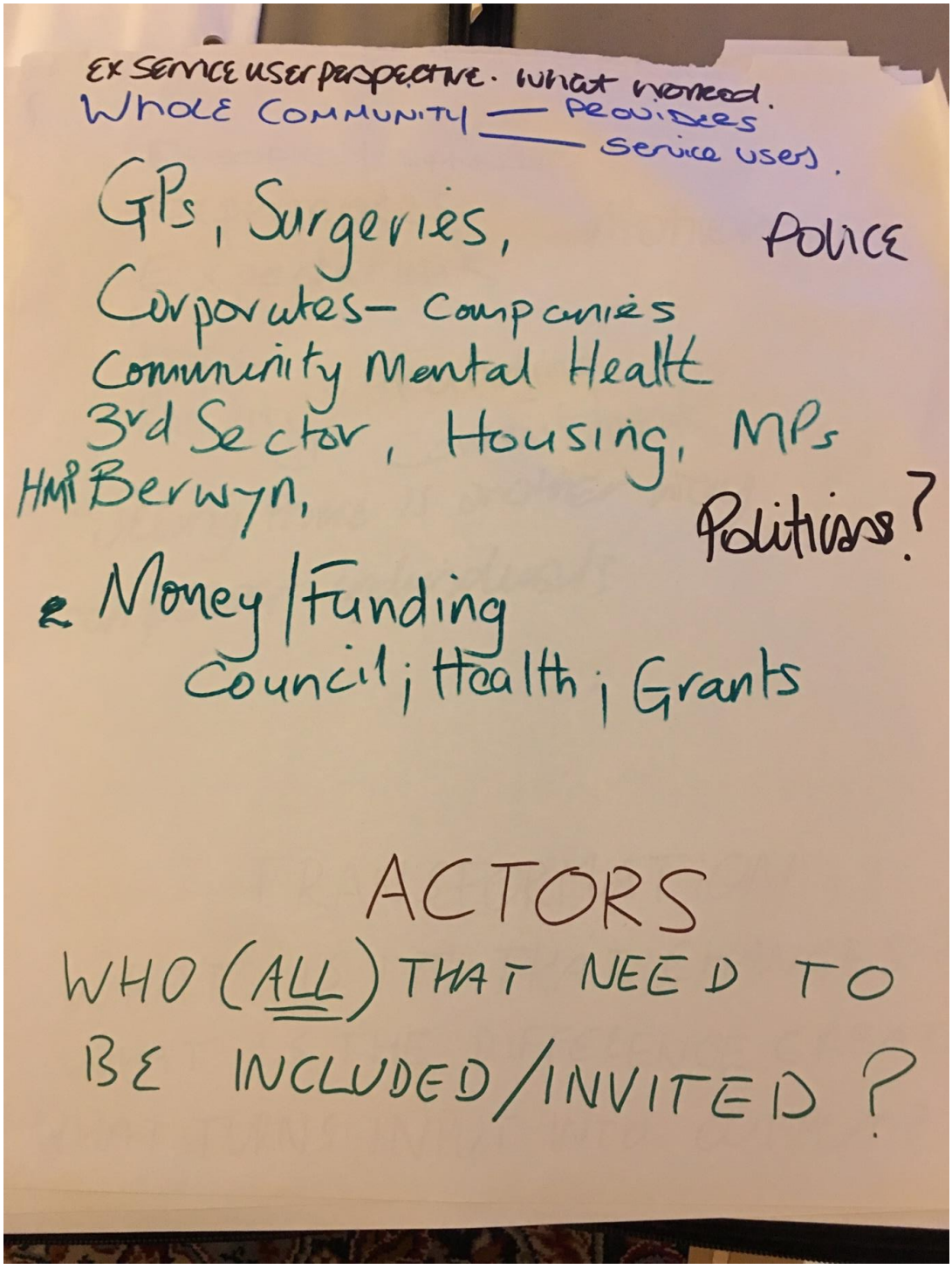
not inundated, they can just have the butty and go – because you know sometimes as services we are like but we've got this massive care plan and its intimidating – and they don't want to know – well yeah because you are bombarding them then and it scares them off (CVC)

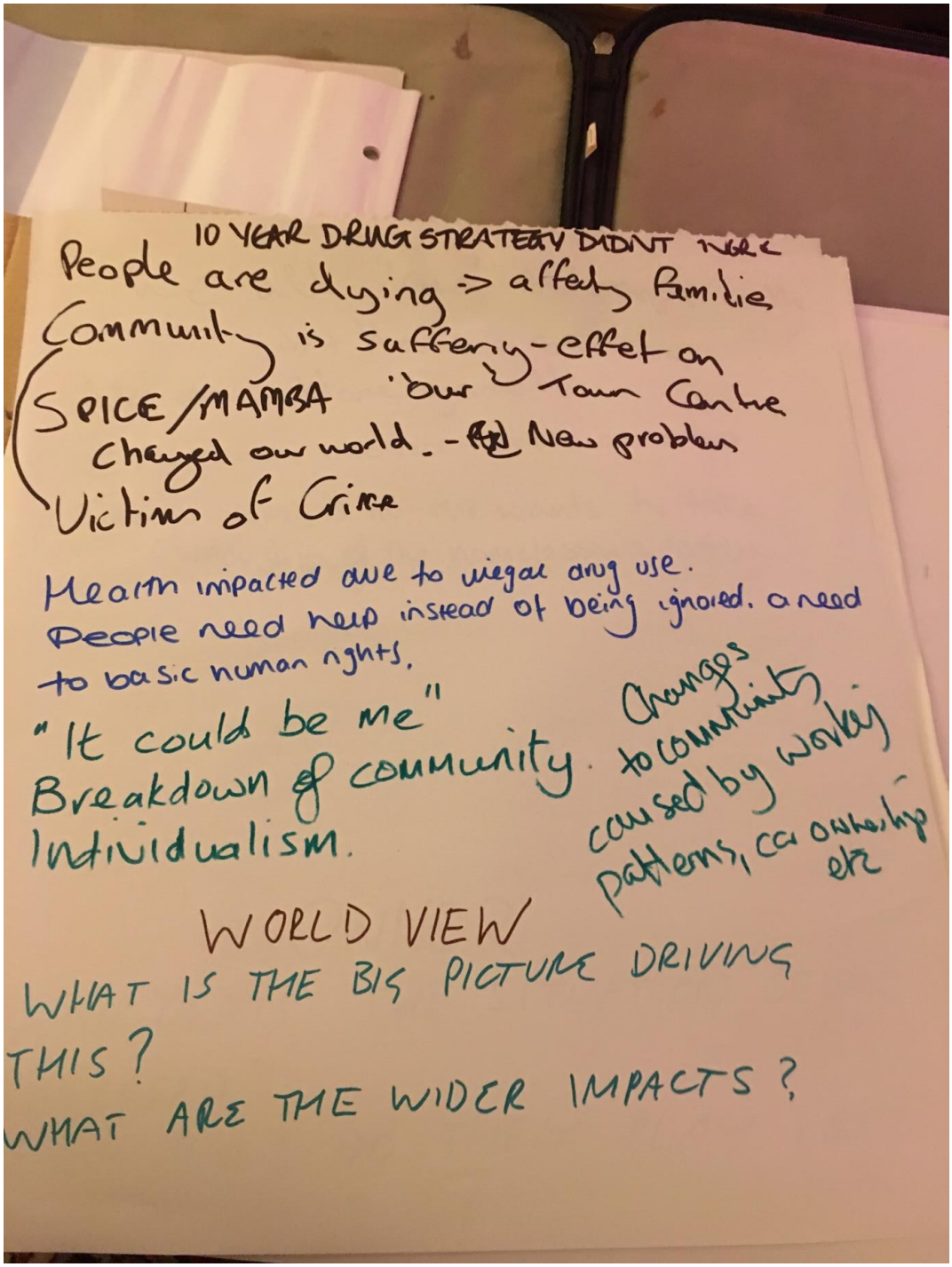
It's got to be at their pace hasn't it? And they say I don't what housing when I come out of prison this time, I'm not ready, what can you say to that, if they have capacity to make that judgement. And I think some of its about what you judge as success isn't it because I think often in projects they say you've got to be clean, you've got to be doing this or you've got to be doing the other but for me success is a client will come in and say I have bought any diazepam this week – that fantastic its a huge result for him whereas that would never be deemed a success in anybody's project would it?

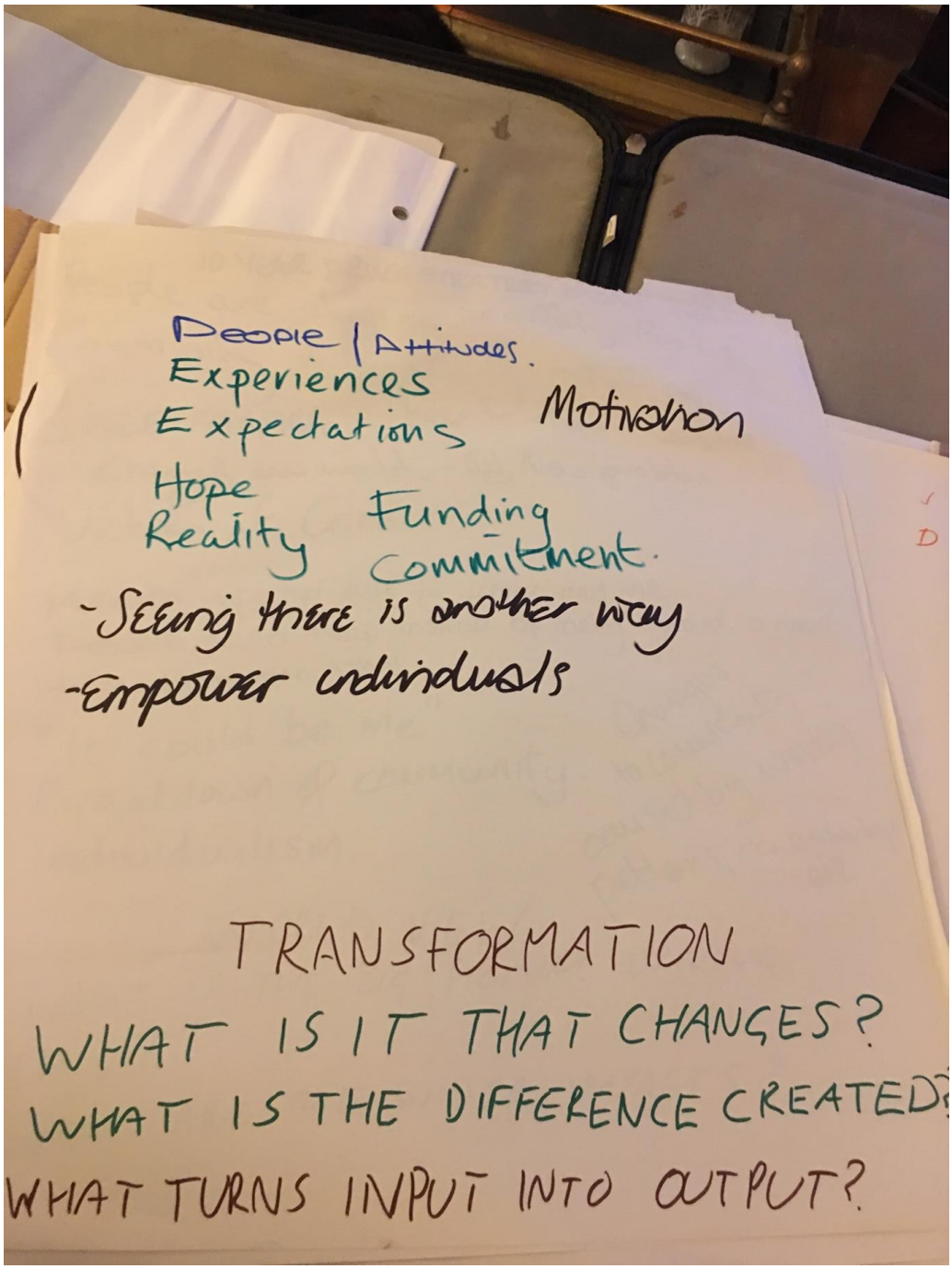
It like one client will now come and look at me in the eye now and smile – didn't even look at me for eight months – so it those sorts of smaller things that's actually a huge success but nobody captures those successes (GP)

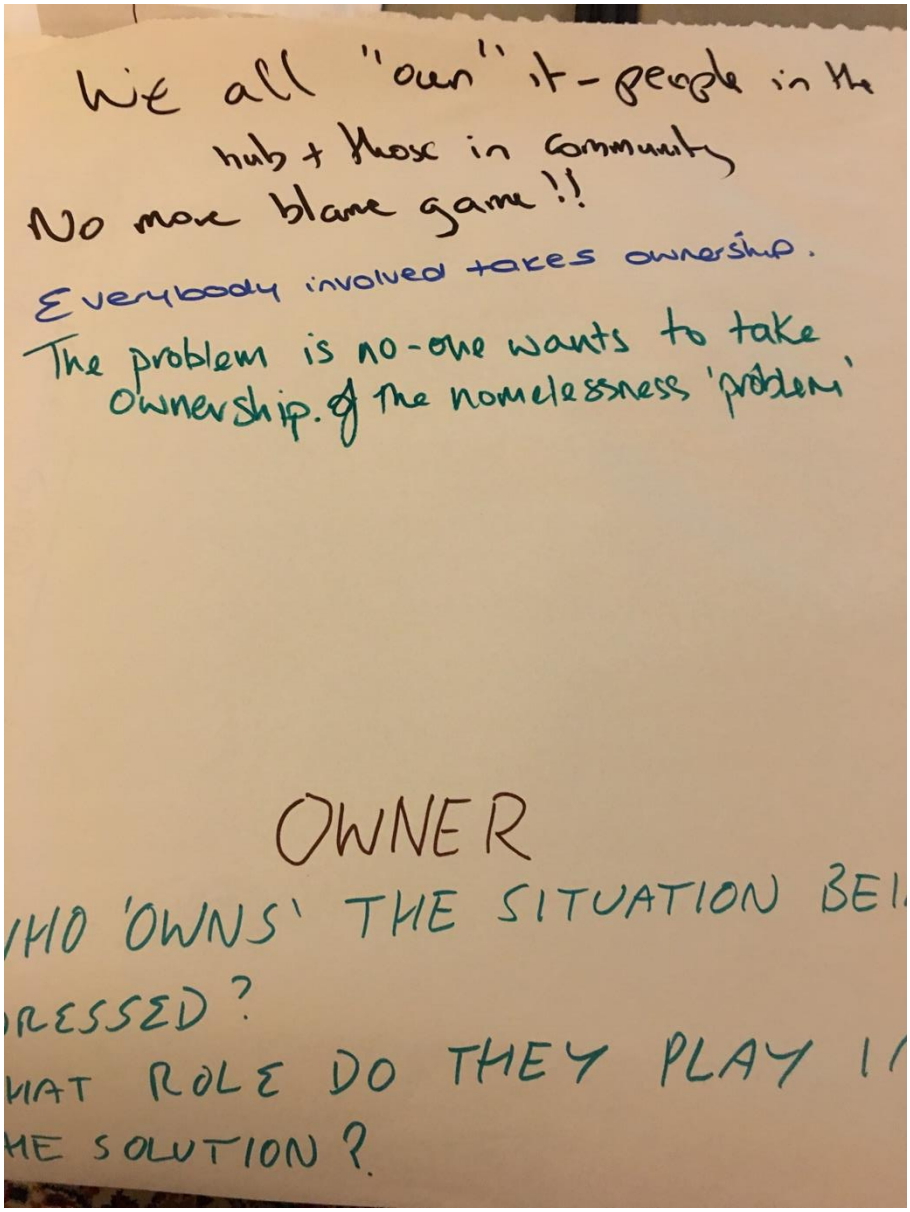
Key issues:
Personal attitudes
Permission from organisations to work more holistically
Deliver each other outcomes
Non judgemental approach to people on the streets
Acting beyond authority and certainly outside professional role
CATWOE


All of us
The service users
Community
Service Providers
As a whole community, everyone benefits.
CUSTOMERS
WHO BENEFITS ?
DOES ANYONE LOSE OU


EX SERVICE USER PERSPECTIVE · WHAT WORKED.
WHOLE COMMUNITY — PROVIDERS
SERVICE USERS.
GPs, Surgeries,
POLICE
Corporates- Companies
Community Mental Health
3rd Sector, Housing, MPs
HMP Berwyn,
Politicians?
Money/Funding
Council; Health; Grants
ACTORS
WHO (ALL) THAT NEED TO
BE INCLUDED/INVITED?


10 YEAR DRUG STRATEGY DIDN'T WORK
People are dying -> affects Families
Community is suffering - effect on
SPICE/MAMBA 'our' Town Centre
changed our world. - New problem
Victims of Crime
Health impacted due to illegal drug use.
People need help instead of being ignored. a need
to basic human rights.
"It could be me"
Breakdown of community. Changes
Individualism. to communities
caused by working
patterns, car ownership
etc
WORLD VIEW
WHAT IS THE BIG PICTURE DRIVING
THIS?
WHAT ARE THE WIDER IMPACTS?


People / Attitudes.
Experiences
Expectations
Motivation
Hope
Reality
Funding
Commitment.
-Seeing there is another way
-Empower individuals
TRANSFORMATION
WHAT IS IT THAT CHANGES?
WHAT IS THE DIFFERENCE CREATED?
WHAT TURNS INPUT INTO OUTPUT?



YOUTH SHEDZ DENBIGH CATWOE AND RICH PICTURE

Stakeholder Workshop One: Youth Shedz, Denbigh, 7 December 2018

Notes
9 participants including one Youth Co-ordinator/Educator and 5 young people over the age of 18

The project is for young people aged 14-24 and is gaining national recognition, plus stimulating other areas to develop their own models and forming a network of Youth Shedz projects

It has been running 22 months

The individual stories of the young people involved include a number who were subject to numerous ACES, including as a child buying heroin for a parent regularly

and being involved in multiple statutory services throughout childhood and adolescence, the same young person has now undertaken school visits doing education sessions for young people on drugs, has spoken of the community project in national conferences and is working towards University study for a degree

The Logo itself says a lot about the project as it was co designed between the young people and an artist and it embodies all the main values of the project

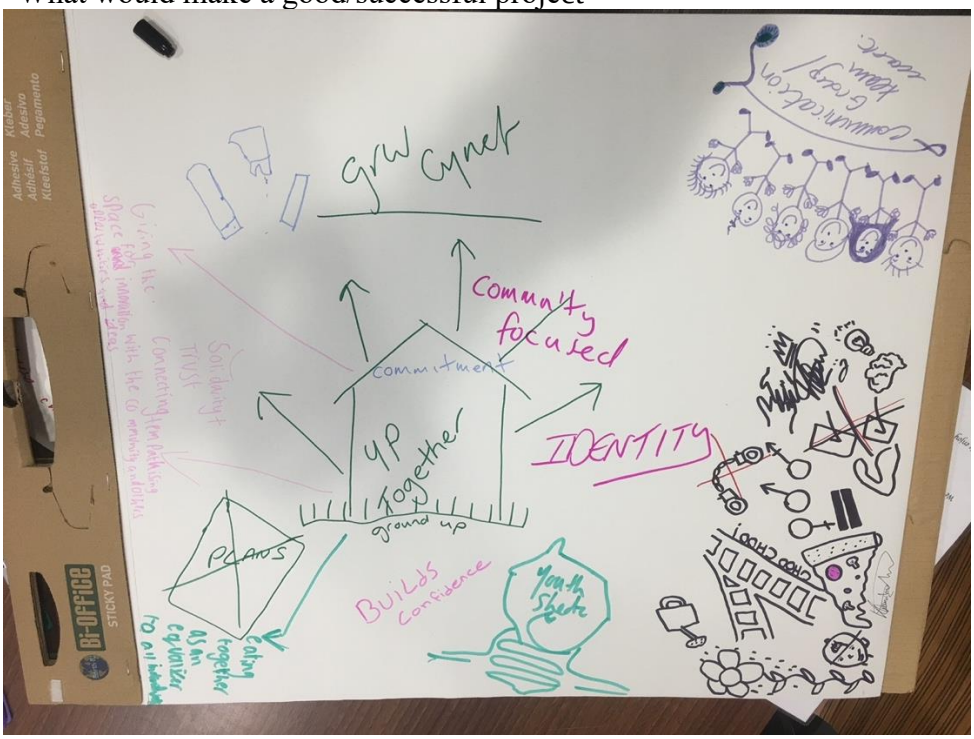
Workshop outline
Initial workshop set up verbally and a robust discussion of why it was necessary to have a PIS and consent form signed followed on from initial introduction and background.

This was a powerful way of gaining engagement and establishing a trust platform – the participants explored what recording were to be used for and how they might help the research.

Introduction given by way of slide deck and questions were few but were fully responded to.

4) **Rich picture and feedback (audio recorded)**

"What would make a good/successful project



Key ideas
Pizza

- Original idea came about by sitting together eating pizza
- Now we have pizza in every session and have that communication and speak to each other face to face
- Its our trademark

- Pizza has helped us to empathise (through listening) and its also been an equaliser – brings everyone onto a level with each other – also has enabled more honest conversations
-

Acting Together
House – Home
Space (to do things, safe space, space to develop – given by Grwp Cynefin not restricting it to plans and outcomes)

Inspiring innovation, ideas and opportunities

Communities within communities
Changing perceptions (e.g., Tagging) Building understanding of this community

Inspiring others and raising Aspirations

Building confidence – empowerment

Empathising within and with community outside

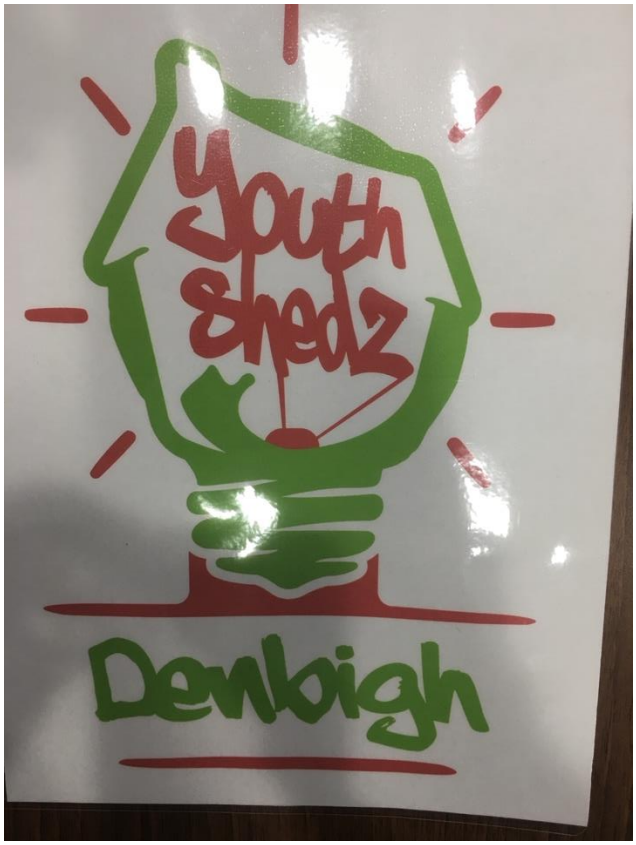
Commitment

Bottom (ground) up

Doing things differently – not about plans – doing thing differently

Developing trust and solidarity

The biggest discussion that came through this was the design of the Youth Shedz logo that had crystallised a lot of these themes in its design.



Grwp Cynefin brought in a graphic artist to work with the young people – asked each person one word that Youth Shedz meant to them – resulted in "community/identity/safety/home/family/inspiration/ideas/creativity/"

Each person then drew a picture of that word (like hand or home) that was then worked up into a draft logo

One of the members was into 'tagging' and she was asked to design the centre piece artwork)

Elements of the Logo that are important".

- Light Bulb for creativity, and, ideas
- House, Home, Safety, security
- The arm is about bringing people in, being a part of it, from the community – and doing stuff for the community and what not.
- Tree for foundations and growth – acting from the ground up and out.
- The lines out are both inspiration and also represent different Youth Shedz in other areas that are developing
-

The young people are happy that represents them

People do seem to understand and get it! and they are now going to get it out there more

The tag has become the centre point of the logo the importance is that tagging is seen as antisocial but this has turned it around "it's sort of the essence of it coz people

look at it as sort of an urban thing, look at it as sort of a bad thing, like a negative thing about young people and stuff but to be able to turn it around into a positive things is really good – like a positive contradiction"

It's like flipping it on its head and being innovative.

Another important element is that the house isn't hard like just a place – it's a home – and the project is like a family – the community project has created its own family.

It's also about us empathising and connecting with the community (HERE MEANT AS THE WIDER COMMUNITY) and that we are not always having a negative impact on the COMMUNITY, and we can put back positively

e.g. a disabled man needed a garden redesigned so he could carry on gardening and we made him raised beds

The logo production process has also enabled individuals to be seen within it – ME is in there (identity) everyone's input seen and valued.

Communication group – brings skill building in communication and teamwork.

Communication was emphasised as the key to success in the project – it's how we get the word out that we are trying to do something good.

Newer arrivals to the group are quickly inducted to the way of the project – communicating what it is about to new members.

Commitment is a key factor and dedication in keeping things going, we want to keep coming back – "even when I go I will want to keep coming back to support it, be a part of it

Its also about ownership and integrity – "It's us that have done this = an honesty – we have done this"

Plans – the challenge has been that as a teacher I am so used to go in with a plan and an agenda – I am in charge and telling everyone what to do – the challenge in this was not to do that – to come in and keep it safe but… and motivate and what not ..but not give ideas but listen to the ideas and help them , facilitate them, making it happen

It's a fine balance though because if we don't have any structure, we feel we need more to progress – so it was important at the beginning not to have a defined structure or plans to stifle but now we need some organisation, we started with no plans just used a problem solving exercise and then gave them space to do that – we needed to have a balance

An idea of the sorts of project being delivered came from "teacher" backing off and letting the odeas come from the community project – Scott left the group with 3 questions on a bit of paper around What would you like to see at YS over the next six months

The result was SHED FEST – is a new idea that is bringing them together as an activity – bringing together arts and music and crafts into a festival (in the summer) bringing communities together including connecting the other Shedz Projects

If Scott wasn't there would this work? We needed him to start off it – to facilitate it – without any structure it's a challenge.

Grwp Cynefin haven't swamped it with expected outcomes? It wouldn't have worked – none of this would it have happened – but Grwp Cynefin took a risk – gave us the space and trusted us to work something up without specific outcomes for the investment being set out.

But, yet, it has produced outcomes – including three other Shedz being set up – and it has now become a charity – this wouldn't have happened if it had been Plan led at the start.

Handcuffs – this project has helped me to stop offending – I now have something to do! I can help society not be a burden on society and my community.

Scott has been real role model teaching us how to take our negatives and turn them into positives – like our tagging.

Male female symbols – doesn't matter who we are – we are all accepted – inclusion and equality.

Tag – the script is designed from the "tag" designed by one of the young people, and is in itself iconic in that it Tags are regarded by wider communities as anti-social whilst they group regard the Tag as a way of expressing who they are (identity)

This has been discussed a lot by the group and how its use in this form – possibly more conventional – has helped get across more to wider communities that they are productive and not a threat – changing perceptions (ADR – is this something around learning how to change the system? And play the game?)

5) CATWOE

Customers

Who benefits – COMMUNITY, everyone!

Primarily the young people who get help, role models, guidance and inspiration and a future

Give them positive skills and something to aspire to

This group do understand what they have started – really happy that police in Kimmel Bay are asking them to go over and start having Pizza with a small group of young people there who are on the fringes of trouble and have potential, they are 13 years old and are thinking of developing their own Shedz

Already this new group of young people – inspired by youth Shedz have started their own peer education with other young people causing trouble around the library in Kimmel Bay

It is having wider implications for young people across North Wales – a network is developing.

- Young people – us
- Wider community
- Younger people – gives them aspiration.
-

Why the wider COMMUNITY – we can give back to them = giving our young energy in positive ways (our community gives to the wider community

The wider community now recognises us more = we can give them our energy and we can give back to them – using our energy in positive ways

It is now getting recognised – and now this project is the good news for Denbigh.

Does anyone lose out? no its all-good news!

Actors
The young people
The funders
Barnardo's
Steve Morgan foundation
Other Youth Shedz Projects – we want to bring lots more people into this
Our vision is a Youth Shedz in every town.
Each of them connected by exchanges and virtually.
How would you get these other things started? – the original shedders go out and help others set up.
But then need other supporters from the community to help support its development.
How do you do that? you have to approach as them as equals – offer pizza and a chat – start like that – instead of belittling them you just educate them – but don't be like teacher be approachable and off them something – some activity to get to involved in – so we are now looking at our social enterprise – every person on the group can benefit from
Now working in an induction pack to help welcome them into the group.

Transformation – what change because of this project?
The people – me as an example – my behaviour has changed from being anti-social to being proactive and my attitude to social and education and my future has changed to positivity
Instead of dwelling on my past I accepted it Shedz helped me work out who I am and accepts that my past shaped me but I can change
What brought this together was going on behalf of the project to speak to young people about drugs – presentation to 160 young people
It was so powerful – so basic yet so empowering and I think the education system needs to change to stop teaching from text books and start teaching from actual life stories

We ended with a rant about how the whole teaching system needs to change

World View
Why do you need this sort of project
We need something to do
We need space to find our identities – without this online we can get bullied, there are just so many factors that can affect members of society – mental health etc so its important that in projects like Youth Shedz young people can find a safe space and someone to talk to, to have support when they need it, about who they are and their mental health – its not just ticking boxes its about helping each other and finding out who you are
The education system doesn't do this – its awful – I have never needed algebra but I have needed to know how to deal with my mental health – instead of double maths there needs to be more about basic food and budgeting not fancy recipes and algebra .. rent not Pythagoras.
We could learn so much about real stuff people need to live in the future – you know – simple stuff – how to use your skill – putting a shelf up.
So, yes, they do teach about basic sex education, but they don't teach about things like consent, sexual orientation, sexual health, where to go to get contraception. The teachers need to be re-taught on how to do real world teaching - basic life skills and in a peer - peer way not teaching down to people
That how we do it here.
It "doing real life"
Who brings this real-life conversation in here? We all do eh religion, rain forest, sexuality.

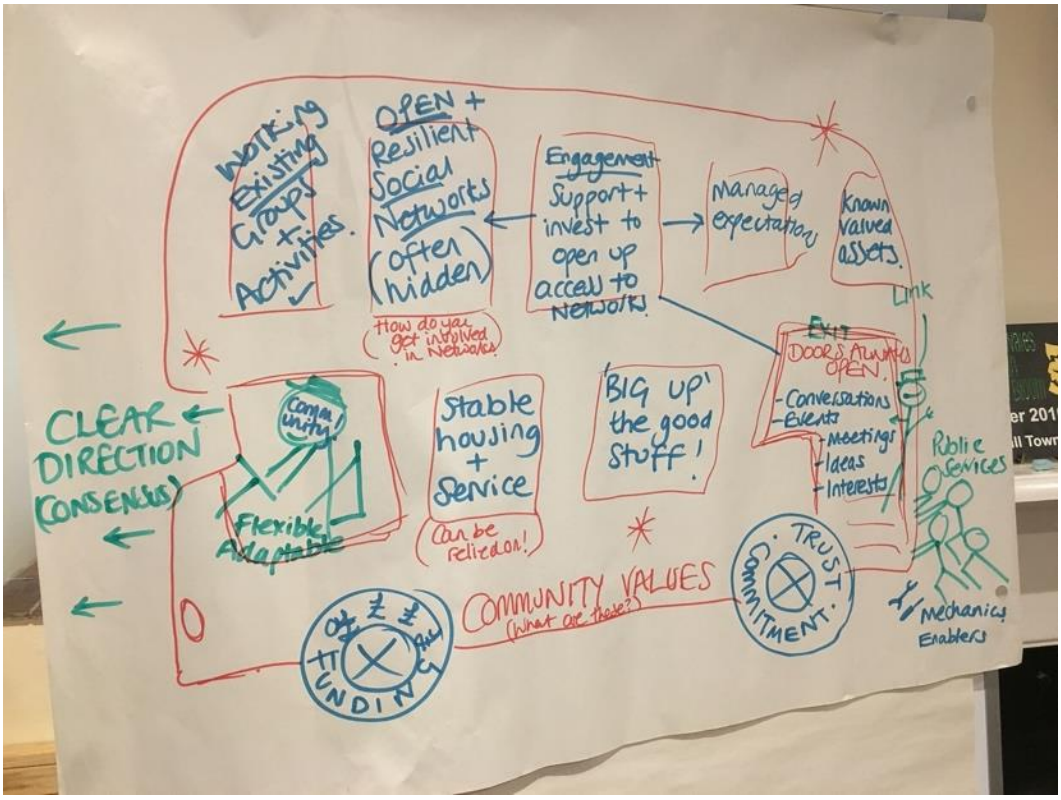
Owner
The government and councils aren't listening to young people, the system makes anti-social behaviour worse – they don't listen to us = they think we don't know what we want but given the space and support we do know what we want
Now we have MPs and AMs visiting – plus the High Sherriff (Queens Council)
So, we are now being noticed by WAG.
The impact is becoming huge.

Environment
Is it just funding needed?
We need space and communication mechanisms and pizza.
Even if we hadn't the funding, now we have done it, if we just have access to safe space and ability to bring in pizza we can have the communication
Once you have the base of it it's like a jigsaw puzzle you can put the rest together – if we can look to some awesome role models or awesome skills we can progress.
We started with pizza and an old shed … and we now are the bomb!
We don't really need permission ------
ADR fed back and checked out the key reflections.
Identity important in finding "me".
Supportive non-judgemental facilitation and support has been important but so has a role model who treats young people as equals – Youth Leader leading the way but not judging.
Pizza – something to all get around that was non-contentious and rewarding.
Space and place that could be owned.

First start with Pizza, treat people with honesty and integrity, find a safe place, facilitate communication, find the common issue/cause.
Don't strangle with plans and outcomes

THE HOLWAY CATWOE AND RICH PICTURE

The Holway Stakeholder Workshop: 18 January 2019
Notes
Holway is a recognised place-based community within Holywell, Flintshire. It consists of approximately 400 households.
It is a place of multiple challenges and high on the agenda of all public sector agencies plus has a range of third sector input across all age ranges and wellbeing issues.
Community development programmes have been run on the estate since the early 1980s.
Participants in the workshop represented local authority departments, health, police, third sector and independent consultants who are providing local input. One participant is also a resident of the estate although was attending because of her job role.
Particular features of the community that were deemed to be important right at the start of the workshop by a number of participants are that there are criminal elements at the heart who have a disproportionate impact on the rest of the community, and equally, some key families that have been in the community over numerous generations.
In addition to these specified communities there are also transient communities to consider.



1.1) Rich picture and feedback (audio recorded) Group One

Key Ideas

- Community driving change itself with public sector supporting/fixing/repairing to assist with the progress
- Wheels to ease the progress are finance and trust/commitment (in equal measure)
- Both of which can stop the journey if they get punctured
- Move towards assets approach and focus on what's strong not what's wrong
- Create opportunities and networks
- Key community empowerment is in creating flexible/adaptable skill set
- Need to establish what the communities own value system is
-

….We needed some idea to organise our thoughts about how to represent the community so this is it – it's a bus!
It came out of talking who might be driving a healthy community development project – the bus I suppose - really it should be the community
We were talking about how difficult it was for drivers from the community to emerge and perhaps the usual ways we get people to drive community change are not maybe the best ways and if we use the structures that we are used to, to expect people from a community to bubble up as a driver – meetings etc. – is not necessarily the way that will we work we might be used to those ways but they wont be helpful to them, so we were talking about
The idea of a CD project that is <u>with</u> rather than <u>to</u> a community – we ended up deciding that the community would be on the bus and that they would be driving the bus and certainly navigating where it would be going and there is a clear direction and the direction is flexible and could change depending on the needs of community over time
we (stakeholders from organisations – public and third sector) were outside or alongside of the bus, we were giving a push or facilitating or supporting when needed but not in control and not on the bus driving
third sector maybe helping with navigation or with the other services
we would be mending the tyres, putting air in and making sure the tread on the tyre have enough grip etc
stretching the metaphor
– wheels have funding on one and trust and commitment on another
– we have flexible and adaptable drivers
– not necessarily just the one driver on the bus

- Working with existing groups and communities, we have to be looking at what is already existing and working and we have a starting point of assets.

– what the community itself think are what's working in that community, not what we see from outside but what they think… that's really important.

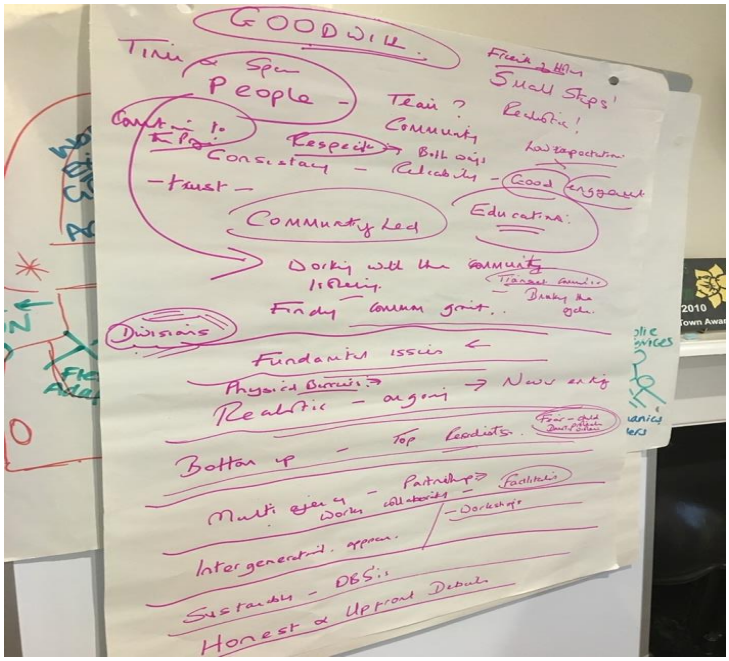
- Assets starting points what people in that community already thinks is working.

These are invisible to us from outside – not that we and go and say 'there is a lovely park - don't forget you have a lovely park aren't you pleased you have a lovely park or whatever' it's more about what the community values about living there, we find out what's of value already to them living there – such as the neighbours are really good and reliable if they are stuck for child care etc whatever it might be
So what's good already so that it can be grown rather than what's wrong with it and what can we change for you!

‘Open and resilient networks, so these are often hidden, so that was about finding out what social networks are working for those people in/with their understanding ‘engagement and support to invest and open up access to networks’ … we had a conversation about that the reality of those social networks is that often they are very closed - that often these networks in reality are very closed and its very difficult if you are outside to feel included so we had a chat about maybe investing in and supporting on those networks to open them up a bit and make them more accessible.
There are networks in there but not necessarily healthy to all of the residents
It links to the green person at the back who is the conductor, so this links to ‘Rachel’ isn’t she the errm the lady who left recently –‘Vicky’ oh yes Vicky she provided that really valuable link and now they have lost that
who was that? Was she from the public sector – yes, she was neighbourhood warden, and she had been there for years – informally worked as a ***community connector***, that wasn’t her work role so no-one else could come in and take that over its just it’s what she brought and what she did. It wasn’t her primary role it was informal, so it has now been lost its just something she did. She will be part of this group though in future so can input.
But her job role can be replaced but her replacement wont do the same thing but it takes years to grow this experience and skills and trust, relationships and knowledge. it wont be part of that job description
Big up the good stuff! But again not from the outside and not on behalf of people to make them think that something crap its great because that doesn’t work!
Its an open back bus so people can just jump on and access it – the door is already open and conversation events ideas interests – that door being open allows all those things.

Jumping on also to opportunities that are also outside – e.g. on a Saturday morning when the football is on just by being there and having a coffee you might find out about stuff that’s working – because this idea of what’s working is really powerful – and a lot of that just happens, we talked about families that have been in the area a long time and are very established from the outside are often seen as a barrier to that healthy development in that community but they are part of that community too – like it or not they are on that bus and they are entitled to be on that bus, perhaps they occupy the whole of the back seat but we do still need to find out from them what works – why do they feel the need to occupy all the back seats, they are on there too and you cant improve a community that contains them without involving them and without taking them with you
These tyres by the way have chains, snow tyres and chains because that hill is bloody steep

1.2) Rich picture and feedback (audio recorded) Group Two



We didn't get into the nitty gritty about money or about who does what or anything this is from the heart because we, the play development team, have been leading on a play development scheme in the Holway for some time probably about the last six months and we do have a lot to say about some significant small steps changes s we do have a lot to say but we will try not to dominate this section but we have a lot of passion and we do have a lot to say

We have a lot of passion in this so I am going to read this through – we feel for the Holway we get it and now we've been there we get a little bit more than we did and its important stuff

We are in there on goodwill at the moment. Even if you are a paid officer you don't get anywhere working with the community without good will – you've got to have that – you need to want to be there, you are interested, you can't be tokenistic, if you haven't anything to give, nothing to bring to the table, don't come, don't get involved from the start, don't do it.

How do you get that goodwill? Its your approach, it's the people that you have to do this work, its goodwill coming back too, it's a two-way street isn't it? And we are having a lot of good will back from that community. Its saying we want to be here – you are making things better because you are helping me do my job and its so fantastic to do this work – it goes round – it doesn't go one way 'we are making you better, they are making my life better in this job' it goes round they are making us better too, we are enjoying the work and it is fantastic the working we are doing

Very small steps are required.

Being realistic, engagement, consistency, trust, respect these are huge words in terms of changing attitudes and that's what you have to have and you are never going to fix a community, how are you going to know when can you say yes this communities fixed its good? We have done our job that's a community development model and that's worked – NO! not in my lifetime is this going to be sorted, its not, but hopefully life will be better that's what we are after.

So good engagement community led, we are on a task group here – that's up here the corporate task group but what is going on is what's down here! How are you communicating between these – everyone in the senior management should be in

that community centre every Saturday morning have a cup of tea with that community if you want to know what's going on – can't do that from county hall Community led. We know the community has been consulted with consulted with consulted with for months. Those consultations shouldn't have been done of there aren't realistic expectations that something would done, acted upon. Shouldn't be done. Don't do it!
If you haven't something in mind when you consult with them don't ask them. Don't raise expectations and then not act. That's what's happened here for thirty or forty years don't do it

Ok so small steps and small results. We are involved in recreation and play and leisure, sports and kicks for kids we are about the poverty agenda. there are some fundamental issues on there that you need to be aware of - safeguarding, child protection, domestic violence, people rehoused, under witness protection, transient communities, people who have always been here all their lives, isolated. now that's a huge melting pot and we are going in making things better?! No, no we are not. We make small steps, agencies who work together and work together and we care and we are down there so the cd model we have we know we won't do all of that easily, it's not easy but if we are going to do anything we do need to get down there – over the next couple of weeks come down there and have a cup of tea with the residents and kids and young people. Or don't – and then don't get involved!
Question – so the first group said that their vision was a bus – what was your vision here?
We get the bus idea, but we think what's important here is the drive, and, you have to know the route, to be the bus driver you have to know the route,
…they are still going to need some direction and guidance aren't they
The challenge is how to get the residents to do the bottom up bit aligned with the top down bit.
That the work isn't it – no one said it was going to be easy.

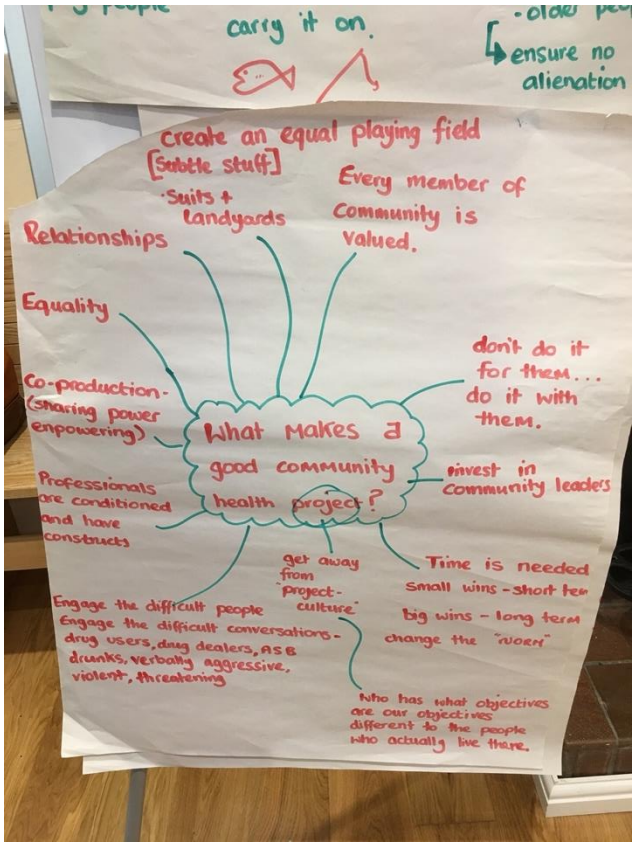
That is the big challenge, how are you going to enable the residents to be the drivers of their own bus, for them to decide what the bus is, where it is going to be going, what route is it going to take? How that journey is inclusive? Especially when it's a very challenging community, communities are not homogenous lumps and Holway is a very small but challenging and very complex set of communities and divided not only geographically because of its divide from Holywell but also within itself because of the road structure and its various territories and histories, so it's all that, and so how you enable the residents to take on board that empowerment.
… but we are doing that empowerment through small steps and that approach of get in – get stuck in – and do the job that is needed here, not just the job that's on paper.
And your challenge is how do we bring in the different agencies appropriately at the right time to add value to what is going on.
How do we build on the building blocks that we have already got? But we are all here and this is all corporate stuff – we are all here – this shouldn't be rocket science.
There are core challenges – but we do need to do more than scrabble for resource and scrabble from event to event to event – we do need to plan for the longer term and co-ordinate resources.
What we are doing here as a group is recognising that there is good progress at the moment around – there are some people emerging that might be drivers and we are trying to decide on how we capitalise on that and move forward … there are definite

things we need to achieve in this project and that's why we look at physical regeneration, environmental aspects, we are looking at the data that informs us what we need to do, the decision making and the monitoring etc.
There is something about the Holway that is having a significant impact upon all public services in Flintshire – we all have an incentive to be here because there is a drain on your resource or service or you recognise there are significant problems in this community that need to be solved BUT this work has been going on since the 1980s so despite the fact we have been doing all this something is still not quite hitting the mark. If we have that sort of resource on the estate, can we start to look at how we try to remodel and consider different models, so we get a larger impact? For example, should we develop an early help hub / a Holway early help hub?
So it is about how we use community development help build the trust relationships to facilitate that, help them gain the ability to drive it themselves definitely, but then also how the services can listen to what comes out of the community development work and say actually 'if these are the big problems coming out of this community, how can we deliver services differently, that you feel will be more helpful to you than previously'

1.3)

1.4) Rich picture and feedback (audio recorded) Group Three

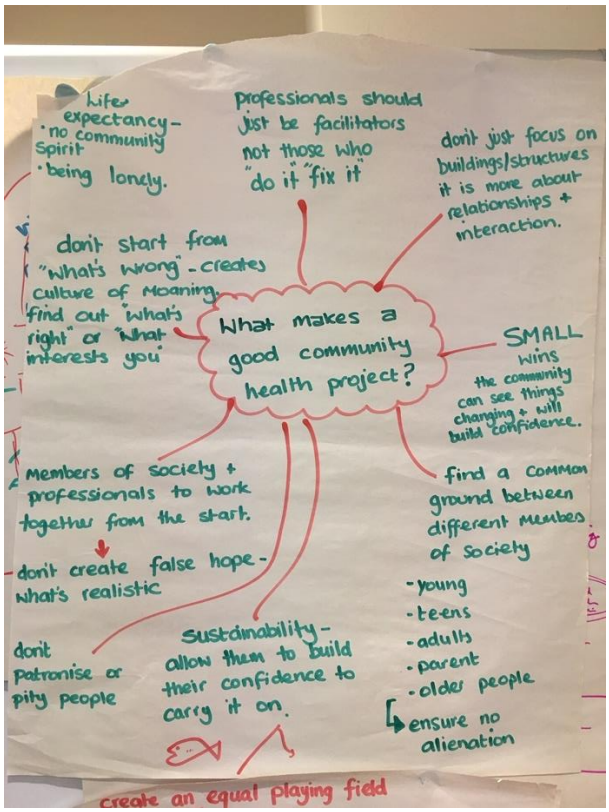
- Give a man a fish feed him for today, teach a man to fish feed himself into the future – build in sustainability and build skills/empowerment
- Remove professional distance, community barriers and hierarchy
- Value each and every member of communities – equity and recognition



Basically everything is here in words but our vision is holding our hands outwards and trying to bring everyone together – so like stickle bricks – attaching people together and we are looking for some small wins

Being realistic and not promising the world, because the small wins will breed confidence in the community that what we ant to do from an expectation point of view
Within the community the biggest thing is yes they have to drive this, they have to be involved right from the very beginning
We are all here because as agencies we are passionate about this and wanting to help but they have to be at the beginning, we need to then find the common ground between everybody – and then understanding the stories – understanding the complexities and acknowledge that we are all people, yes we have a position we have our role but we are all people – there's something about our id badges and our lanyards that means they separate us from the communities and we are seen immediately as from outside coming in, parachuting in and we need to get rid of that
We do also need to drop the project idea because these timescales aren't enough – this takes years to do it properly and become sustainable.
Also if it comes from the bottom it doesn't need to have that set end point – this date when we need to have that done! so we need to give this community the time they need
We need to invest in community leaders – that's the biggest thing
We need to change the norm – the norm being that we go in and do things **for** but that has to change we need to flip that over to really facilitate and not do, we need to find facilitators for community leadership – to empower and to give confidence – if they are going to pick up the challenge of leadership, to make a difference and drive we need to give them confidence that they can do that and they can make those relationships.
And we need to ensure every member of that community is valid and they are valued community member no matters what their background is or what trouble they may have caused, they all bring worth, and they are all valued.
And it's about co-production. yes, these are all buzzwords ha-ha!
But seriously don't patronise people, or pity them, don't judge them, again we all know that we to have treat people in the right manner whoever they are or have done – take the barriers down, from a professional point of view we have to open up, we have to forget we have come in with certain aims and objectives and stuff – we do have to keep them at the back because we do have to work to them but we do have to somehow remove them when working here .
And the big thing is to look at assets – you know we always start by looking at what's going wrong, and we have to now start by looking at what's strong and build on that
The vision of the fish? Sustainability and the parable of the fish – don't give a fish teach them how to fish.
The other thing we did discuss is that whilst we all (three groups) talked of doing things with and not to the community, if we look around the room there isn't anyone here from the community!!!
Nb – one person was, but she did also have a formal agency role. The conversation then went on to question how someone would manage in this type of workshop/group as it currently operates
It interesting that all this looks like a project plan but in the content a number of times its been said drop the plans its more important to engage the community and go with their ideas
How do we shift these plans so that they do get people involved?

The project framework need to be there to support our agencies and chief officers to secure resources but maybe that's what we co=ordinate in the background to ensure legitimacy and transparency and access resources and monitor progress but it should be invisible at the community development delivery level
We did think about that because we asked who has what objectives and are we starting from our objectives or starting from this is what people think is working well? And from the things that they think they need our support from and with to help them change – so it was a different way for us to think about these things
We need to do this really useful exercise again but with the community and a number of times with different communities but without so many of us, and demonstrate to them what and why we are doing this – help them to understand us as well and that we are trying to change the way we do things – be explicit about our plans and restrictions.
But you can – just come to the coffee morning come and have a cup of tea and talk to people – we have the small wins we have that already – that small win though needs supporting you need to give support from this group to that so it doesn't fade away again
Anyone who wants to work in the Holway– go and have a cup of tea with them.
But I have a frustration that everyone says about the Holway community – which community its not one community. Different issues from family interventions and older people communities. Each community has its own unique issues.
So we have to look at communities not Holway community – what we need is a common way of working across these communities between our agencies – a clear overall vision of how we are going to do that, because in the past we have done things to them and we are now looking to a different type of conversation and thoughts about a different approach



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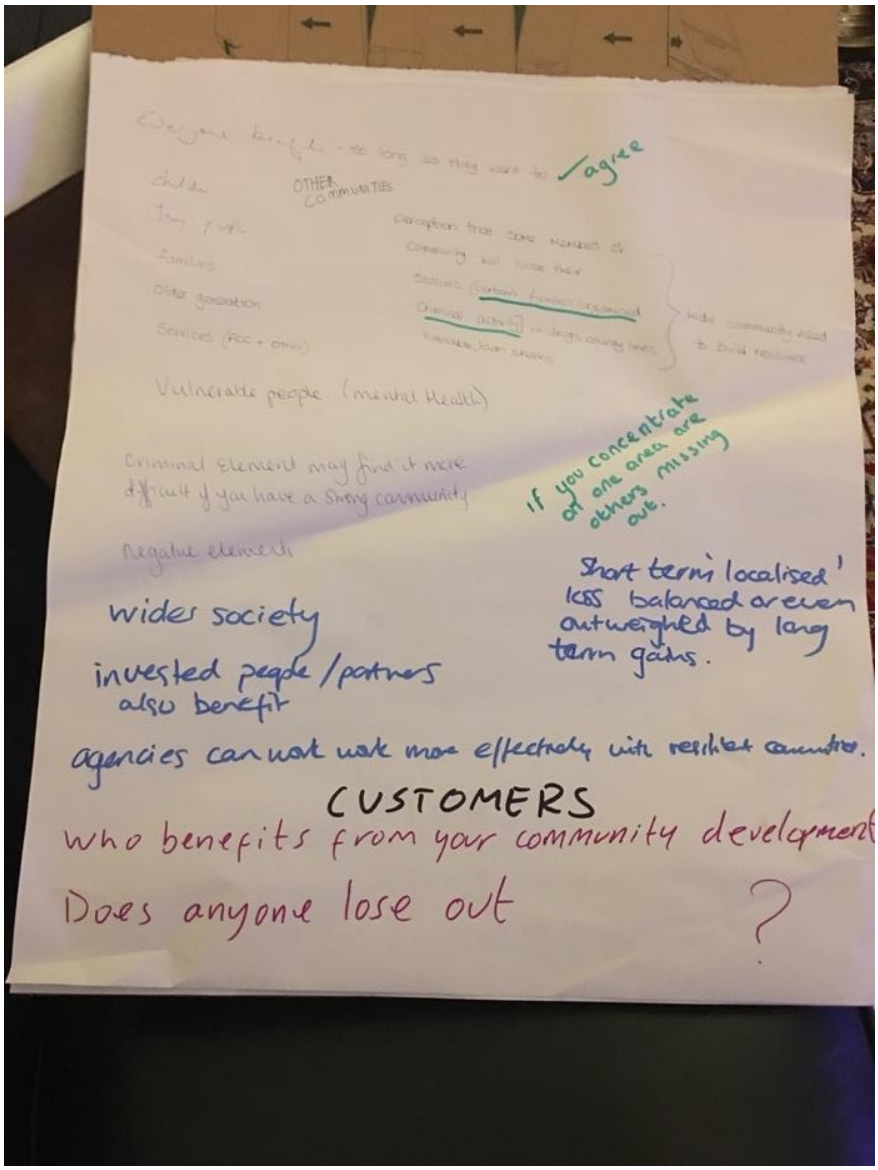


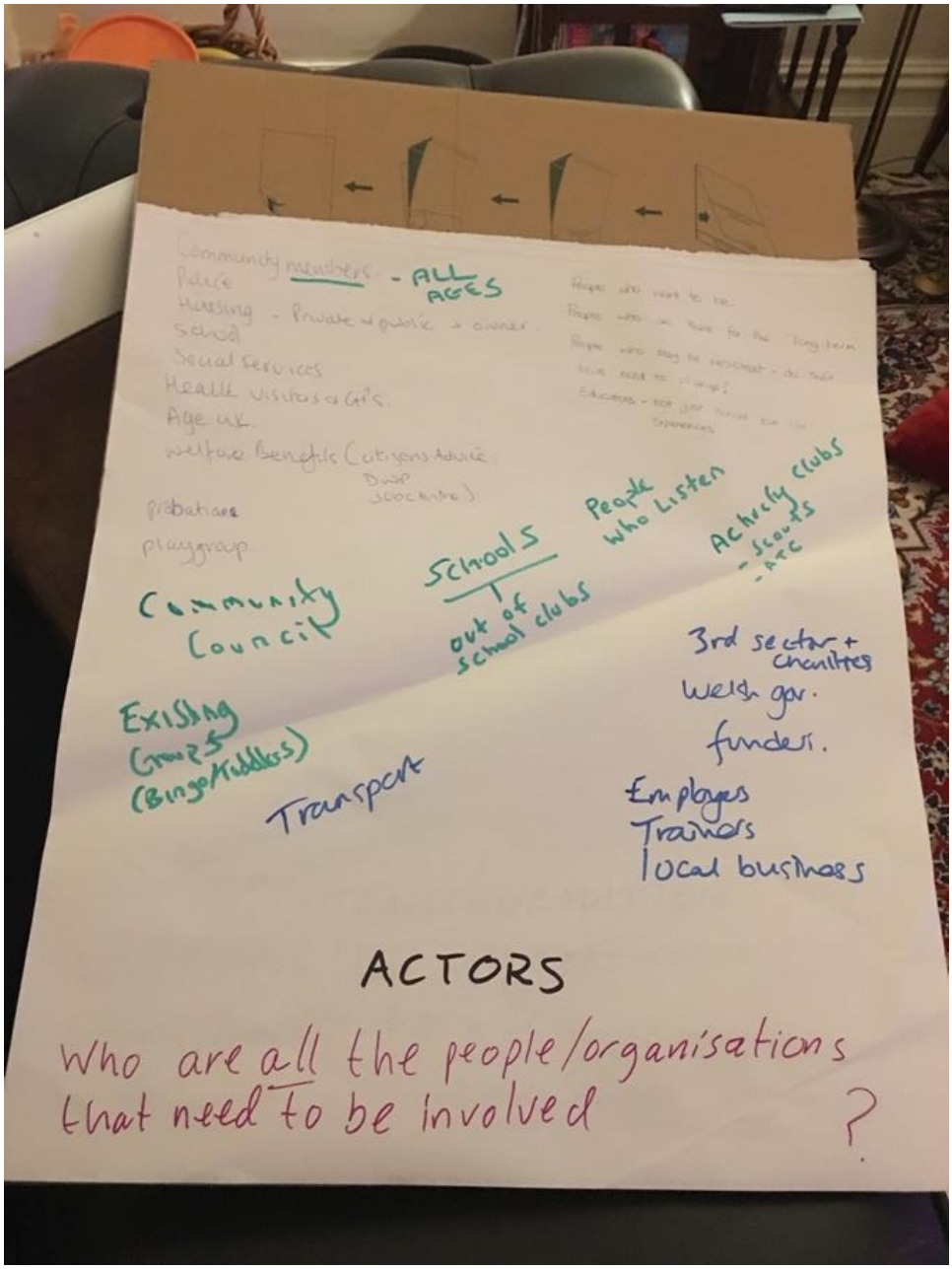
CATWOE

Customers

- Everyone benefits – if they want to and are open to benefitting.
- However criminal elements may find it more difficult if the community becomes stronger and more resilient.
- These elements do have an impact on the wider communities, and they need to be facilitated to be more resilient.
- There are many communities hidden within the community – age groups and service-related communities.
- If you concentrate on one area you may miss out others in need
- Short term localises losses can be balanced out by long term gains.
- Wider society benefits from change here.
- Invested partners also benefit.

- Agencies can work more effectively with communities that are more resilient
- community members themselves – all ages
- Housing -all sectors
- School

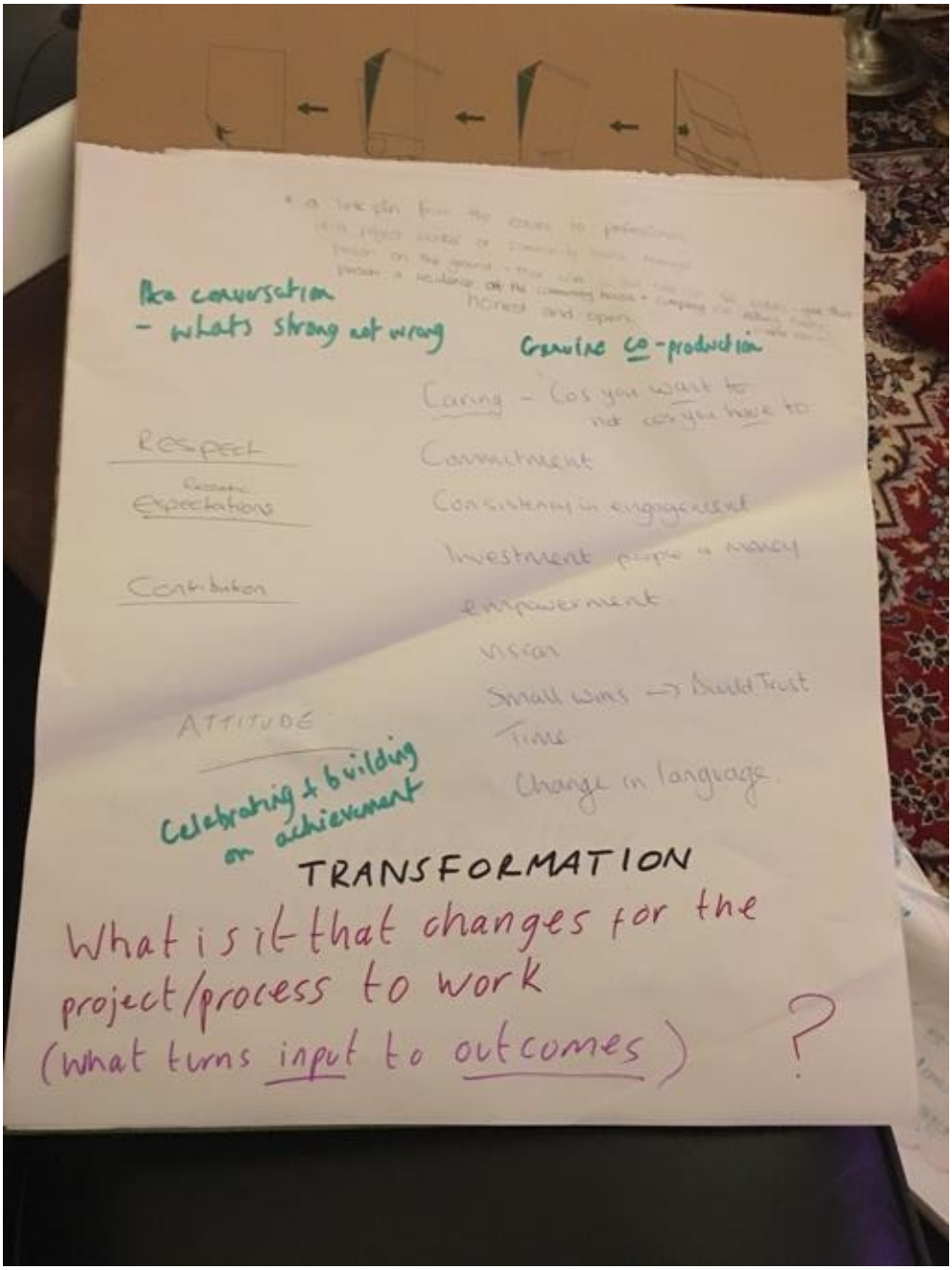
Actors



- Social services
- HVs and GPs
- Age UK
- Welfare Benefits
- Citizen's Advice
- DWP
- Job centre
- Probation

- Playgroup
- Community Council
- Existing group – bingo/toddlers
- Transport
- People who listen.
- Activity clubs – scouts ATC
- 3rd sector and charities
- Welsh gov
- Funders
- People who want to be
- People who are there for the long term
- People who may be resistant – do their views need to be changed?
- Educators – not just school – but life experience

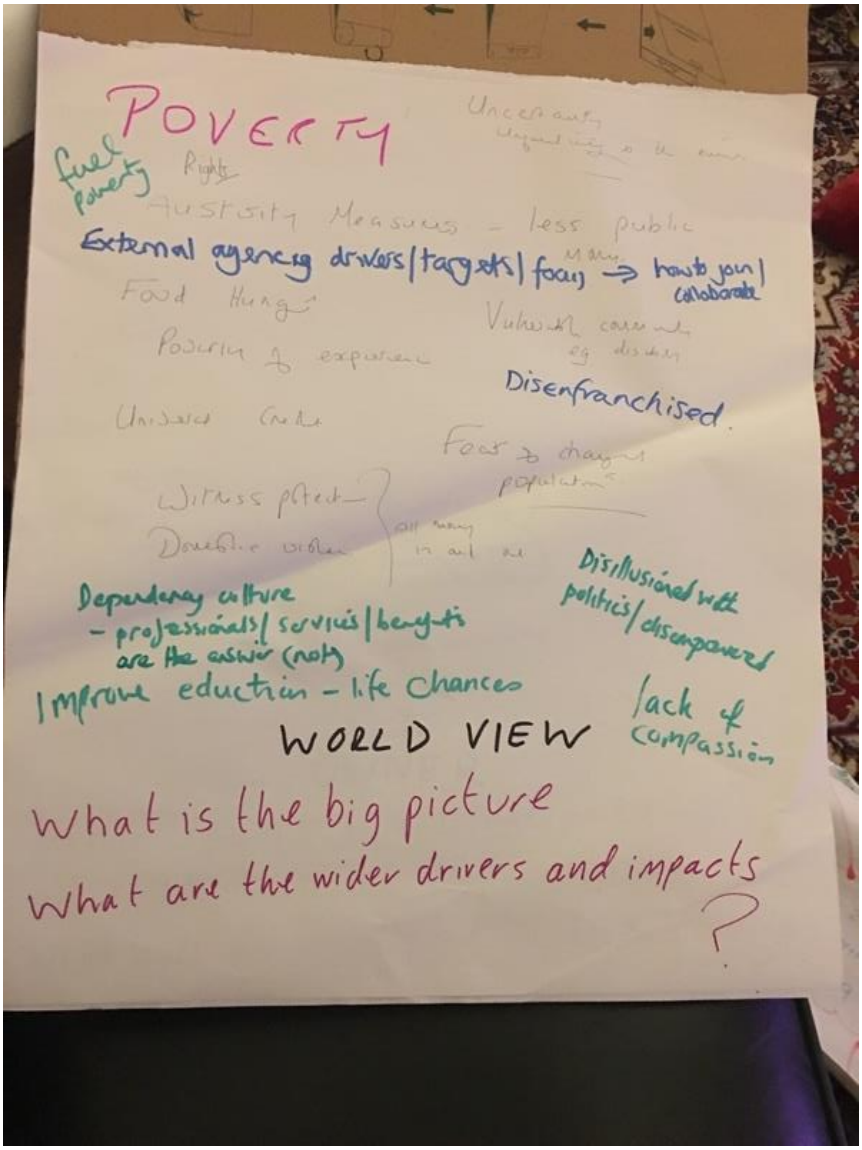
Transformation



- Genuine co-production
- Genuine caring and commitment (because you want to not because you have to)
- Consistency in engagement
- Investment people and money
- Empowerment
- Vision
- Small wins build trust
- Time
- Change in language
- Celebration and building on achievement
- Attitude

- Respect
- Realistic expectations
- Assets conversation – what's strong not wrong
- A lynch pin – a link - from the estate to professions i.e. a project worker or community house manager, person on the ground – their work is full time on the estate – give this person a residence at the community house and a company car but nothing flashy
- Honest and open

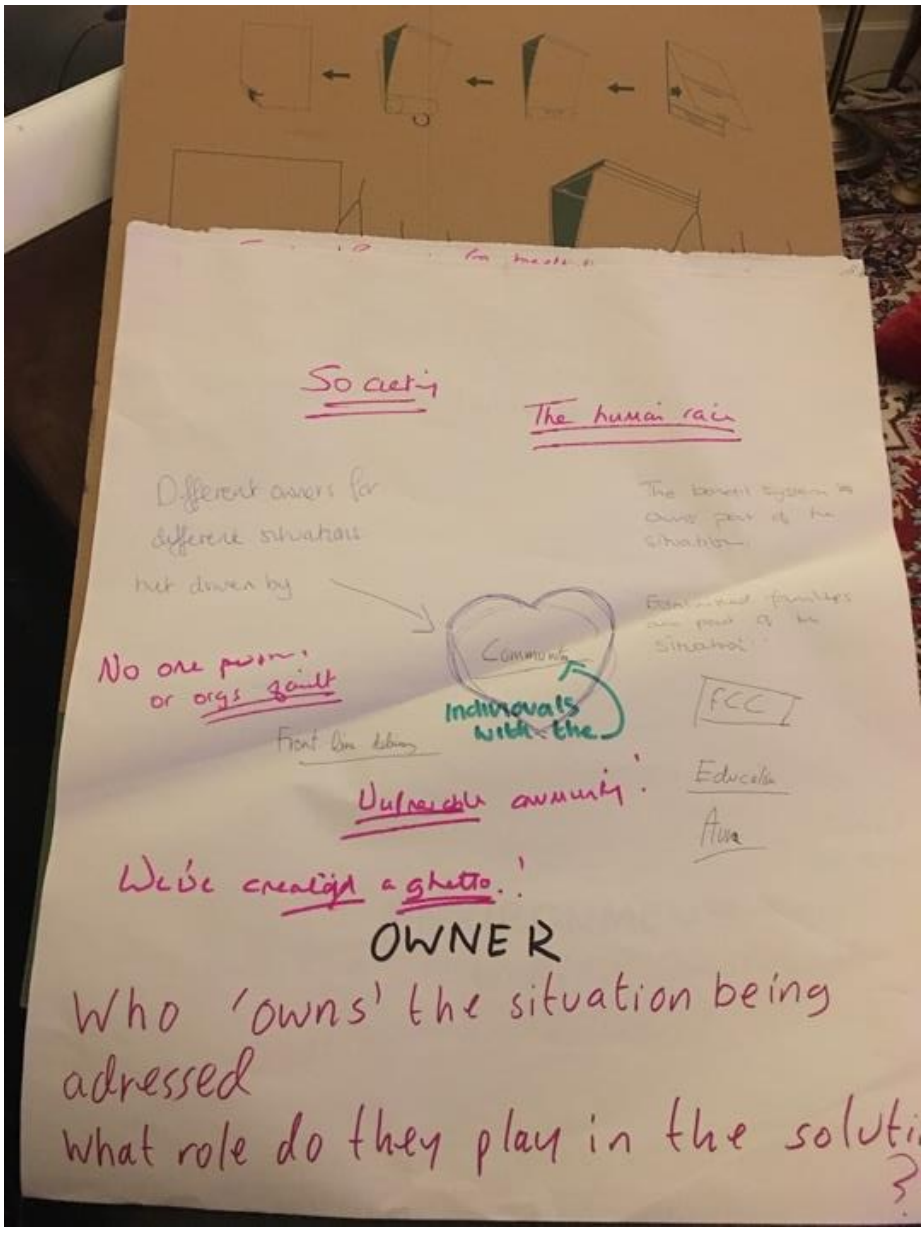
World view



- Uncertainty and unfamiliarity with the issues
- Rights
- Fuel poverty
- Austerity measures – less public
- External agency drivers/targets/focus – how to join/collaborate
- Food and hunger
- Vulnerable community e.g. disability
- Poverty of experience

- Universal credit
- Fear of changing population
- Disenfranchised
- Witness protection and domestic violence – all moving in and out
- Dependency culture – professionals/services/benefits are the answer(not)
- Improve education – life chances.
- Disillusioned with politics/disempowered
- Lack of compassion

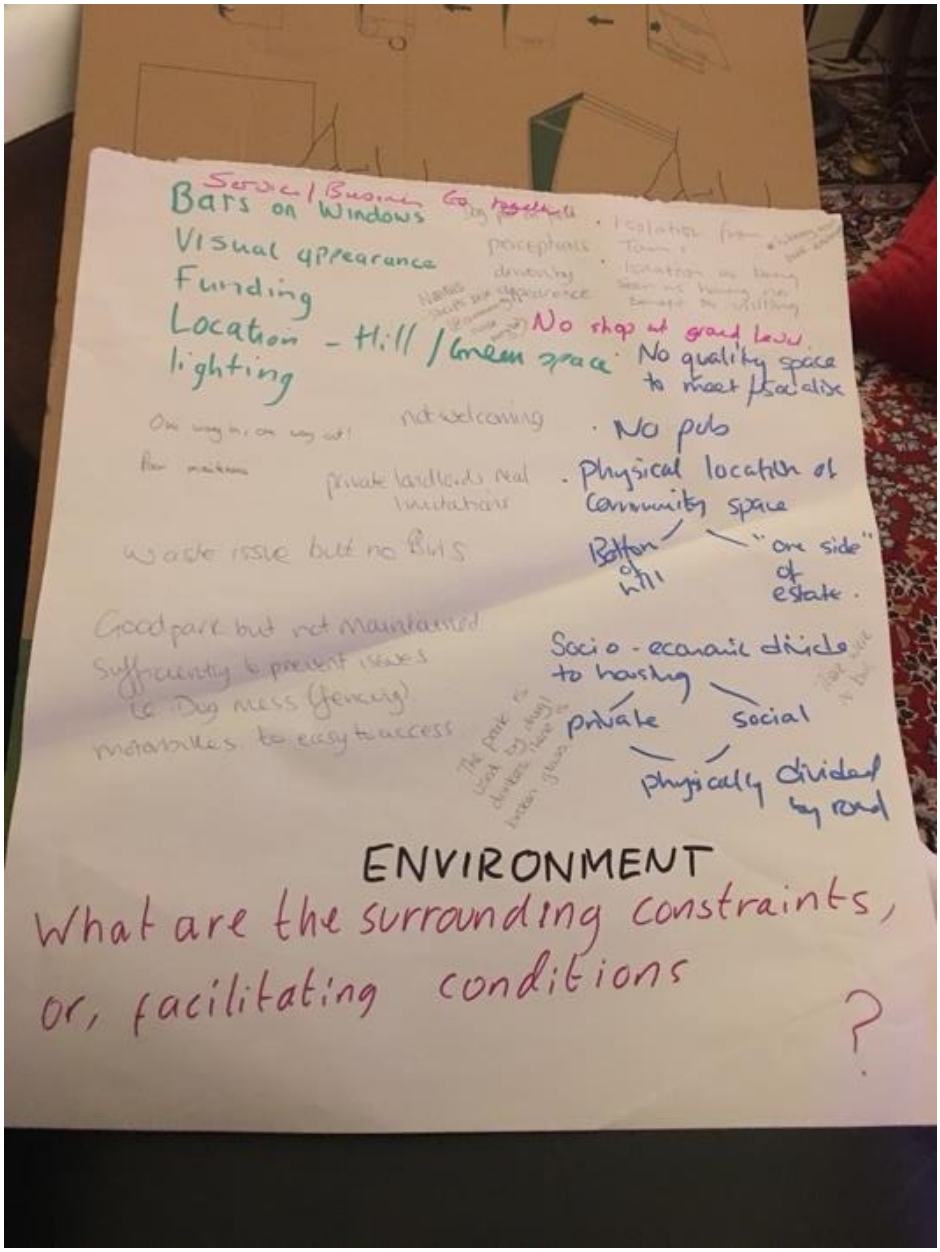
Owner



- Society
- The human race
- Different owners for different situations but driven by COMMUNITY
- The benefits system owns part of the situation
- Established families are part of the situation

- Flintshire County Council
- Education
- Front line delivery
- No one person or organisation's fault
- Individuals within the community
- Vulnerable community
- We've created a ghetto

Environment



- bars on windows
- Visual appearance
- Funding
- Location – hill/green space

- Lighting
- Dog poo on field
- Perceptions driven by experience.
- Isolation from town
- Isolation as being seen as having no benefit in visiting.
- No shops at ground level
- Needles – sharps box at community house maybe?
- No quality space to meet/socialise.
- No pub
- Physical location of community space – bottom of the hill – one side of the estate
- Socio-economic divide to housing – private/social/physically divided by road.
- One way in one way out
- Poor maintenance
- Private landlords, real limitations
- Waste issue but no bins
- Good park but not maintained sufficiently to prevent issues i.e., dog mess (fencing)
- Motorbikes too easy to access
- The park is used by drug/drinkers. There is broken glass.
- There were no bins

Summary

Discussions between participants as they worked through the CATWOE exercise revealed three main positions held on community development for the Holway, some individuals holding more than one at once

- Deficit based community development as bottom up (community) driven change
- Asset based community development focussing on what's strong not wrong and empowering change building in what is already good
- Joined up provision co-ordinating services with a shared perspective of the communities in Holway and integrated programme delivery to build wellbeing (involving communities in co-production)