# **Co-producing cardiovascular health in Wandsworth:** an evaluation

**Written by:** Juliette Hough and Sarah Lyall

**New Economics Foundation**
www.neweconomics.org
info@neweconomics.org
+44 (0)20 7820 6300
@nef

Registered charity number 1055254

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# Summary


## Introduction

This is an evaluation of three co-produced healthcare projects working with ethnic minority groups at high risk of cardiovascular disease (CVD) in Wandsworth. The projects aimed to explore ways of reducing the risk of CVD through co-production and together made up a pilot to test out Wandsworth's emerging model of co-production in public health. Wandsworth Community Empowerment Network (WCEN) was funded to develop and implement the projects by Wandsworth Council's Public Health Department. WCEN asked the New Economics Foundation (NEF) to evaluate the project.

The three projects included two cook and eat projects for South Asian and Somali women, and an exercise project for African-Caribbean men, which met weekly over a six week period. Community leaders were involved in the project design and delivery, and community members co-produced the projects as they evolved over the six weeks.

## Outcomes

The projects addressed a number of the risk factors associated with CVD, particularly regarding diet, eating habits and physical activity – and some of the underlying issues contributing to health outcomes, such as sense of control and empowerment, mental health and well-being, and social connection.

The three projects were successful in meeting their intended outcomes:

- Individuals said that they and (often) their families were eating more healthily.
- The men taking part in the exercise project said that they had begun exercising regularly and showed (on average) a decrease in weight, body fat percentage and BMI over the project period.
- Participants reported improved mental health and well-being, increased social connection and peer support, and a sense of control and empowerment.
- Participants reported sharing their learning with family members and others in their communties.

It is not clear how sustainable the outcomes will be if the groups do not continue, although all participants said they expect to continue with the changes they have made. Men interviewed seven weeks following the end of the project were still exercising, but less. Women interviwed at a similar time reported continued healthy cooking and eating. All participants and project leaders interviewed were keen for the projects to continue, but required funding for hall hire and to pay the peer and professional experts.

The pilot was less sucessful than had been hoped at influencing systems and processes, such as shared learning between the Public Health team and the

voluntary and community sector, or improved local health policy. The pilot achieved increased participation by communities in the specific CVD projects, but not over local health services or policies more broadly. Closer working between WCEN and the Public Health team might have helped increase impact of the projects on local systems, recognising that policy change was always a longer term aim, to be achieved in the months following the end of the pilot.

### Why and how the projects made a difference

The involvement of community leaders encouraged engagement through feelings of trust and safety. The shared cultural background of experts, peer facilitators and other group members ensured that information, advice and activities were culturally relevant and, therefore, more easily put into practice outside the groups.

The groups facilitated peer support and encouragement, which resulted in a sense of camararderie or togetherness, and a sense of responsibility to others. This motivated people to continue to take part and make positive lifestyle changes.

Community members were closely involved in the design and delivery of the projects as they evolved over the six week period. The project activities evolved in response to the participants' interests, needs and skills. For example, the two cook and eat projects evolved to include (respectively) dancing and exercise sessions led by community members.

Open discussions at the start of each session helped build a shared sense of purpose around the aims of each project and meant that people could talk about more than just cooking, eating and exercise; this helped identify issues of importance to people, some of which the projects began to address.

### The role and process of co-production

The initial project design was co-produced primarily by community leaders and WCEN. Community members played an active role in the ongoing design of the projects, which evolved in response to their interests, needs and skills, and in the project delivery, by sharing recipes, dishes, experiences, ideas and expertise.

The co-production methodology was central to the outcomes achieved. Interim outcomes which helped achieve the overall health outcomes included: feelings of trust and safety; the ability of the projects to identify and begin to address underlying issues; people's sense of ownership and responsibility to others; and increased confidence and feeling valued.

These were enabled by the culturally (and personally) relevant nature of project information and activities, the range of people involved (including both healthcare professionals and community members), the openness of discussion, and the way in which project activities evolved in response to people's needs. WCEN played an important role building relationships (over many years prior to this project),

identifying community leaders and enabling them to connect with Public Health, and supporting the groups.

The Public Health Department were not as involved as they or WCEN would have liked in the project, and this had led to useful learning about differences in working cultures and practices for co-production projects working within public services.

### Possibilities for continuation, expansion and replication

All project participants and group leaders spoken to for this evaluation wanted their project to continue, and a number of people said that they would like to bring friends to future sessions. A number of people involved in the men's group were keen to expand the project by training group members to play a mentoring or facilitative role in new groups.

WCEN stressed that the pilot worked well in a particular local context, and that different contexts might require different models. Key elements for replication include:

- The involvement of community leaders in a central role.
- The existence of an intermediary organisation such as WCEN to build links between public health and communities, and to facilitate and support the projects.
- The understanding, identification and enablement of social networks as a process for community building and project success.
- The flexibility of the projects to evolve in response to community members' interests, needs and skills.

### Recommendations

Continued funding should be made available for the three pilot projects, with the intention of reducing WCEN's input over time so that the projects become self-managing. WCEN should also consider an expansion of the pilot, including training community members to take leadership or facilitative roles in new projects.

For future joint working, WCEN and Public Health should explore together ways in which some of the challenges faced in this pilot could be overcome, particularly in terms of ensuring pro-active, two-way communication and collaboration.

The longer-term outcomes of any continued projects should be monitored so that the sustainability of outcomes can be better understood. Monitoring and evaluation tools can be developed to measure the outcomes and mechanisms of change identified as important by this evaluation.

The Public Health Department, WCEN, community members, voluntary and community sector organisations, and other relevant Local Authority leads and experts, should continue to explore together the preventers of good health among Wandsworth's deprived communities not addressed by this project, and seek ways of addressing these. These include poverty, poor housing, a low sense of control and

self-esteem, and the widespread consumption by children and young people of unhealthy takeaways. They should also continue to explore ways in which health services could better meet the needs of all community members, taking a whole systems approach that recognises the interconnected nature of health, environment and social networks.[1]

Public Health teams in other areas should consider the role of community leaders and peer networks in delivering health outcomes; using co-production as the tried and tested method for doing services *with* people, rather than *to* or *for* them.

# Introduction

This is an evaluation of three co-produced healthcare projects working with ethnic minority groups at high risk of cardiovascular disease (CVD) in Wandsworth. The projects aimed to explore ways of reducing the risk of CVD through co-production. The evaluation was commissioned by WCEN, which was funded to develop and implement the projects by Wandsworth Council's Public Health Department.

## The report structure

This report is in seven sections:

- The *introduction* explains the issue of cardiovascular disease in Wandsworth, the meaning of co-production, and the evaluation methodology.
- *Project design and delivery* describes how the projects were developed and what they entailed.
- *Outcomes for individuals and communities* describes the outcomes that have been achieved.
- *Systems and process outcomes* explores the extent to which desired changes to systems and processes have been made.
- *A theory of change* presents a theory of how the project has achieved its outcomes.
- *The process and role of co-production* discusses how effective the process of co-production was in this project, and the role co-production played in achieving the project outcomes.
- *Possibilities for continuation, expansion and replication* explores future possibilities for the approach.
- *Conclusions and recommendations* discusses the key findings and presents recommendations.

## Cardiovascular disease and health inequalities in Wandsworth

Cardiovascular disease is the leading cause of death in the UK and worldwide. The most common types of CVD are coronary heart disease and stroke. According to the National Health Service, in the UK, "over 1.6 million men and over one million women are affected by chronic heart disease, and it is responsible for more than 88,000 deaths in the UK each year [...] Most deaths caused by cardiovascular disease are premature and could easily be prevented by making lifestyle changes, such as eating a healthy diet and stopping smoking."[2]

CVD is a particular issue in Wandsworth. Data published by the South East Public Health Observatory in 2011 shows that mortality rates from CVD in Wandsworth are significantly higher than the national rate (at 84.8 per 100,000 people under 75 years, compared with an England average of 70.4).[3]

People living in deprived areas in Wandsworth are more likely to experience the risk factors for CVD, and to die from CVD, than those in the least deprived. The

Wandsworth Joint Strategic Needs Assessment 2010 identifies "a strong association between CVD and deprivation as measured by the Index of Multiple Deprivation score. The wards that show a high prevalence of risk factors and CVD mortality were amongst the most deprived in Wandsworth and those with low prevalence and mortality were amongst the least deprived."[4] South East Public Health Observatory data shows that this gap in CVD mortality is increasing.[5]

These health inequalities are particularly experienced by black and minority ethnic groups. Around a third (33.5%) of Wandsworth's residents are from black and minority ethnic groups.[6]

Guidance from the National Institute of Clinical Effectiveness (NICE) on CVD prevention was published in June 2010.[7] This suggests that implementing a comprehensive approach to reducing CVD risk factors at an individual and a population level could have a significant impact on mortality rates and the gap in life expectancy.

In response to the growing health inequalities experienced by people living in Wandsworth's deprived areas, Wandsworth Council's Public Health Department commissioned the WCEN to pilot a co-produced approach to improving cardiovascular health within deprived communities.

## About co-production[8]

Co-production is an approach to service design and delivery that involves equal and reciprocal relationships between professionals and people using services, along with their families and neighbours.

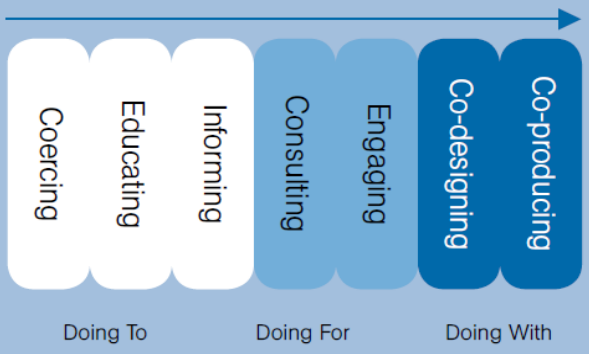
*"Co-production is a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities."*

*National Co-production Critical Friends (2013)[9]*

### *A ladder of participation*

Arnstein's ladder of citizen participation[10] (1969) depicts different levels of involvement. NEF has adapted this to reflect how co-production builds on previous user/professional dynamics.[11] The text below explores how these approaches differ in practice.

**Figure 1. An alternative 'Ladder of Participation'**




**Doing to:** The first stages of the pathway represent traditional services at their most coercive. Here, services are not so much intended to benefit the recipients, but to educate and cure them so that they conform to idealised norms and standards. Recipients are not invited to participate in the design or delivery of the service; they are simply supposed to agree that it will do them good and let the service 'happen to them'.

**Doing for:** As the pathway progresses, it moves away from coercion towards shallow involvement. There is greater participation, but still within clear parameters that are set by professionals. Here, services are often designed by professionals with the recipient's best interests in mind, but people's involvement in the design and delivery of the services is constrained. Professionals might, for example, inform people that a change will be made to how a service is to be run, or they may even consult or engage them to see what they think about these changes. This, however, is as far as it goes. People are only invited to be heard; they are not given the power to make sure that their ideas or opinions shape decision-making.

**Doing with:** The most advanced stages of the pathway represent a much deeper level of service user involvement that shifts power towards people. These types of involvement require a fundamental change in how service workers and professionals work with service users, recognising that positive outcomes cannot be delivered effectively to or for people. They can best be achieved with people, through equal and reciprocal relationships. Co-designing a service involves sharing decision-making power with people. This means that people's voices must be heard, valued, debated, and then – most importantly – acted upon.

**Co-production** goes one step further by enabling people to play roles in delivering the services that they have designed. In practice this can take many forms, from peer support and mentoring to running everyday activities or making decisions about how the organisation is run. What really matters is that people's assets and capabilities are recognised and nurtured, that people share roles and responsibilities

to run the service, and that professionals and services users work together in equal ways, respecting and valuing each other's unique contributions.

### *The underlying principles of co-production*

There are six principles which characterise co-production. Most of the strongest examples of co-production have all of these principles embedded in their day to day activities, but some principles may feature more strongly than others.

1. **Taking an assets-based approach:** transforming the perception of people, so that they are seen not as passive recipients of services and burdens on the system, but as equal partners in designing and delivering services.

2. **Building on people's existing capabilities:** altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively support them to put these to use at an individual and community level.

3. **Reciprocity and mutuality:** offering people a range of incentives to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations.

4. **Peer support networks:** engaging peer and personal networks alongside professionals as the best way of transferring knowledge.

5. **Blurring distinctions:** removing the distinction between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered.

6. **Facilitating rather than delivering:** enabling public service agencies to become catalysts and facilitators rather than being the main providers themselves.

## Evaluation methodology

NEF was asked by WCEN to evaluate this project. The evaluation aimed to identify:

- The outcomes achieved by this project, both for individuals and communities, and in relation to systems and processes.
- The process by which it achieved these outcomes, including the role of co-production.
- The potential for further development of these co-produced projects.

NEF employed the following methods:

- Three workshops facilitated by NEF:
    - **Outcomes workshop:** at the start of the project, WCEN, community leaders and representatives from public health and Wandsworth Clinical Commissioning Group created a theory of change. This identified the issues, barriers and enablers to change, existing services, activities and interventions locally, desired outcomes, and possible activities to achieve these.
    - **Indicators workshop:** following the design of the three pilot projects, WCEN, community leaders and representatives from public health identified possible ways of measuring change in the three projects.
    - **Reflective workshop:** following the interventions, a group of three community leaders and four community members who had participated in the projects (including at least one of each from each project) reflected on the projects.
- **A short questionnaire** completed by all project participants at the start and end of the projects, measuring knowledge about selected health issues, eating and exercise behaviour, well-being, and (in the end-of-project questionnaire) the differences the project had made. This enabled us to assess how common the views and experiences described in interviews were across all participants.
- **In-depth interviews** with ten participants and four people involved in running the projects at the end of the projects.
- **In-depth individual and group interviews** with representatives from public health and WCEN at the start and end of the projects.
- **Attending and observing** at the first and last sessions of each project.
- **Health measures** of weight, body mass index (BMI), body fat percentage and visceral fat collected at the men's project.
- **A review of project information**, including notes from meetings, emails between project partners and commissioners, and photographs from the projects.

Names used in case studies throughout the report have been changed, and some details have been changed to protect people's identities.

# Project design and delivery

This section explains how the projects were developed with input from WCEN, community leaders and public health professionals. It outlines WCEN's staged model of co-production, the 'theory of change'[12] which was produced during the early co-design phase, and the format of the three projects the pilot delivered.

## The stages of co-production in this pilot

WCEN identify several stages to the co-production they have practiced in this pilot and in other projects. Here, we describe these stages and discuss the type of co-production practiced at each stage. The extent to which co-production was effectively practiced, and its role in achieving project outcomes, are evaluated later under the heading '*The process and role of co-production'*.

### *'Pre-co-production'*

WCEN stress that, before co-production can take place, a 'pre-co-production' stage is needed. Central to this is relationship building, which requires an intermediary organisation. WCEN has spent several years building relationships with both the Public Health team and voluntary and community organisations, ensuring that it was trusted and closely linked-in with both.

Alongside this, WCEN has facilitated dialogue between community representatives and Public Health. At the commencement of the project, this took place in a number of workshops, which enabled the development of a degree of mutual understanding, the identification of core issues, and the development of shared solutions.

Community leaders agreed that the strong relationship they had with WCEN was important to the success of this project.

*"We already had a good relationship with [WCEN] so that trusting relationship, I think that's key." – Community leader*

### *Co-production*

WCEN saw the pilot projects themselves as co-production in practice. These can be seen to have three elements: the initial design, the evolving design, and the delivery.

1. **Design (initial)**: The project design was initially informed by (i) three workshops with community leaders facilitated by WCEN, at which issues relating to CVD within local communities, and possible solutions were discussed; and (ii) two workshops involving WCEN, members of the Public Health team, and community leaders, facilitated by NEF. Following these, the design of the projects was led by WCEN in discussion with the three selected host organisations.
2. **Design (evolving)**: Although community members were not directly involved in the initial project design, they were very involved with the design of the projects as it evolved throughout the delivery phase. For example, invited

experts, areas to focus on, and project activities were greatly informed by participants' suggestions and requests.

3. **Delivery**: The delivery of interventions was facilitated by voluntary and community groups, with speakers from the community, healthcare and fitness professionals, and with support from WCEN. A number of community members were involved in project delivery, and participants had the opportunity to share their knowledge and skills with the groups.

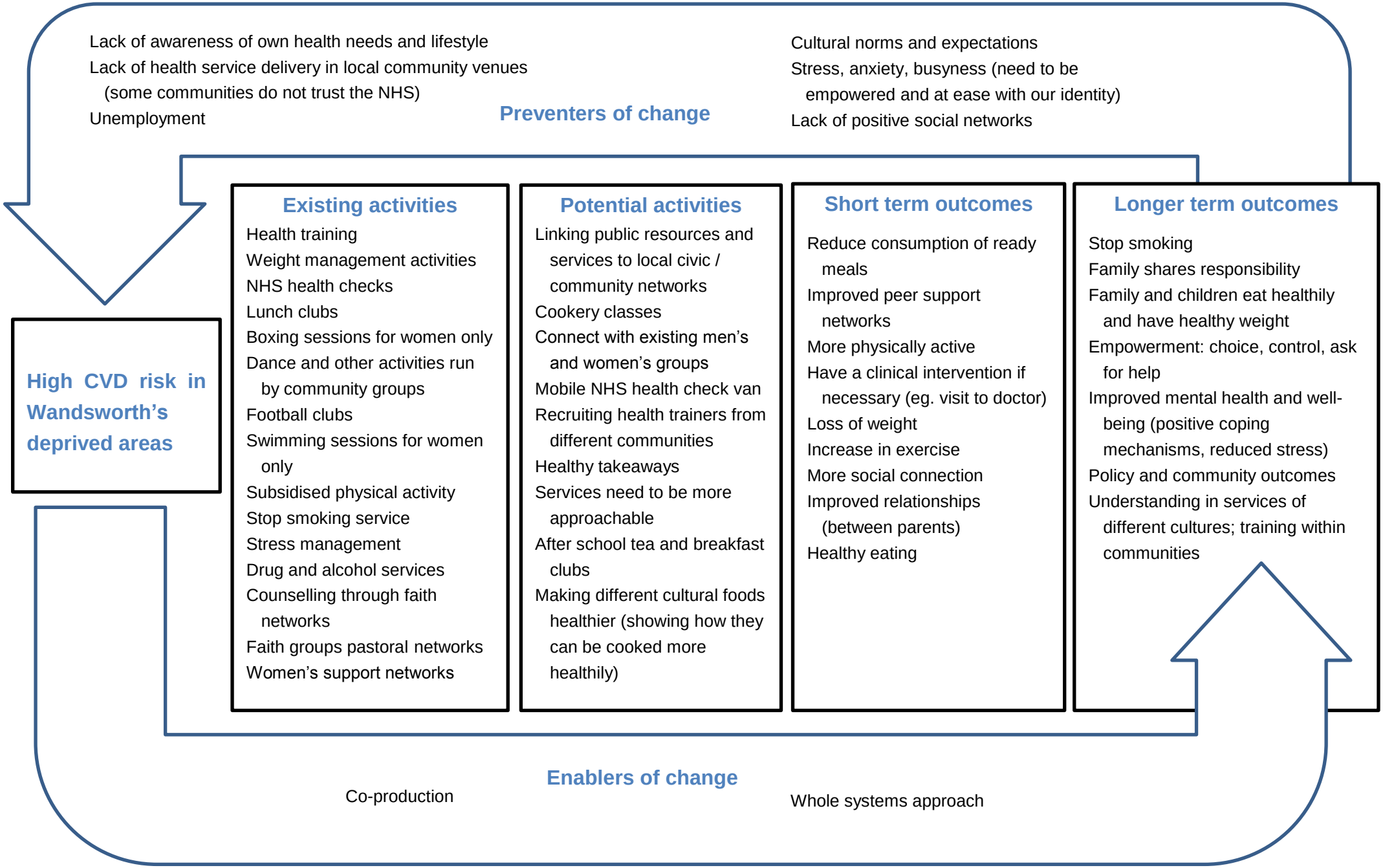
### *Systemic change*

WCEN's ultimate vision is that systemic change is achieved. When this happens, co-production will be the standard way of doing things within public health, the public health workforce will be more reflective of communities, and there will be regular discussion and shared learning between public health professionals and community members. They believe that this will lead to greater trust in public services, more resources and stronger skills in the community, more meaningful measures of change, and equality in health and in other areas of life. Ultimately they believe that this will result in a better settlement between citizens and state, and that more will be achieved with fewer resources.

## Co-designing the projects

Figure (a) shows an initial theory of change created by community leaders, public health professionals, representatives from Wandsworth Clinical Commissioning Group and WCEN in a group workshop. This identifies the preventers and enablers of good health in Wandsworth's deprived areas, the desired outcomes for people at risk of poor cardiovascular health, and some activities that might help people achieve better health, alongside some existing activities. This informed the design of the three pilot projects for co-producing cardiovascular health in Wandsworth.

**Figure (a) The beginnings of a theory of change for addressing cardiovascular disease in Wandsworth's deprived areas**



## The three pilot projects

Three projects were piloted. Each project was hosted and facilitated by a local community group, in order to bring together people known to be members of groups at high risk of cardiovascular disease. Each project lasted for six to seven weeks, and entailed participants meeting once a week in a local venue, for 2-3 hours. WCEN co-facilitated each of the groups, and took notes.

A loose plan was created for each of the groups, but specific intended outcomes and activities were not set out at the start. Each of the groups started with an open discussion in the first week about health and well-being, the barriers and facilitators to healthy eating, cooking and/or exercise, what group members would like to be different, and what would be learnt and done in the project. Although the plan for each group was broadly followed, project activities and the experts invited varied to some extent depending on the questions and concerns raised by group members.

Each of the sessions followed the same basic format:

1. An open discussion of issues relating to health, cooking, diet and/or exercise, including progress and challenges in practicing at home what has been learnt in the group.
2. Project activities, including experts providing information and answering questions; cooking and eating; and/or exercise.
3. Group discussion (sometimes informal) until the end of the session.

The three projects are outlined below.

### *Project 1: Healthy cooking and eating in the Somali community*

**Host organisations:** The Association of Somali Women and Children, and Elays Network (two charities)

**Participants:** Somali women aged 40-75. At least 21 women attended over the period.

**Leaders and professionals:** A community member facilitated the discussion and led the cooking. Other professionals attended to give advice on nutrition, stress management, and dental care.

**Activities:** Cooking and eating, and discussions and advice about a range of issues experienced.

*Project 2: Healthy cooking and eating in the South Asian community*

**Host organisation:** Mushkil Aasaan (charity)

**Participants:** South Asian women aged 40-75. At least 24 women attended over the period.

**Leaders and professionals:** A community member (who had a food blog and some experience of teaching cooking) led the cooking. A second community member led an exercise session.

**Activities:** Originally designed as a cook and eat project, a weekly exercise session was soon added.

*Project 3: Exercise and health awareness in the African-Caribbean male community*

**Host organisation:** New Testament Assembly (church)

**Participants:** Black Caribbean men aged 40-75. 7 men, aged between 46 and 80, attended over the period.

**Leaders and professionals:** A fitness instructor (who was a member of a neighbouring church) led the exercises, and a nutritionist (who was a church member) provided information and advice.

**Activities:** Exercise and nutritional advice.

## Resources required

The project cost £45,125 to deliver. The resources required are shown in figure (b):

**Figure (b) Resources**

| Item | Cost |
|---|---|
| Staff costs (including on costs) | £26,755 |
| Nutritionist and trainer fees | £2,740 |
| Media and dissemination | £2,450 |
| Facilitator fees | £2,310 |
| Beneficiary reimbursements* | £1,380 |
| Hall hire | £960 |
| Refreshments | £769 |
| Childcare | £160 |
| Overheads | £7,601 |
| **Total** | **£45,125** |

*Beneficiary reimbursements include reimbursed costs for contributed dishes, bottled homemade smoothies, diaries, healthy oils, volunteer expenses (travel and lunch), and end-of-project gifts.

# Outcomes for individuals and communities

This section explores how far outcomes were achieved for individuals, their families, and their broader communities. It outlines the extent to which outcomes were achieved, and discusses how sustainable any changes might be.

## Achieved outcomes

Within a short (six week) time period, many of the project participants described a number of changes that their participation in the projects had led them to make. Of the outcomes identified as desirable at the outset by community leaders and public health professionals, the pilot projects began to address almost all of them. The following outcomes were commonly experienced by project participants:

- Learning and understanding about healthy eating, cooking and/or exercise
- Healthier eating for individuals and their families
- Improved fitness and weight loss
- Improved mental health and well-being
- Social connection and peer support
- Sense of control and empowerment
- Improved family relationships and support
- Sharing learning with others in the community

Each achieved outcome is discussed in more detail below.

### *Learning and understanding about healthy eating, cooking and/or exercise*

Many people, from each of the three projects, described learning about healthy cooking and eating through the projects. People described learning:

- which foods were healthy and which were unhealthy (for example learning about the high fat content of meat or the high sugar content of many breakfast cereals, and learning how to interpret nutritional information on food packets);
- how to cook healthy meals (for example by cutting down on unhealthy foods such as fats and increasing healthy foods such as vegetables in cooking);
- how to eat healthily and ensure their family eats healthily (for example by not skipping meals, and giving children a healthy breakfast);
- that healthy meals can still be tasty;
- ways in which they can influence their families to eat more healthily.

  *"We've been educated about how to eat healthily. Now I don't eat after 9pm. I'm not eating heavy portions in the evenings […. Nutritionist] told us how to eat the right amount of carbs, fats, protein, nutrients." – Men's group participant*

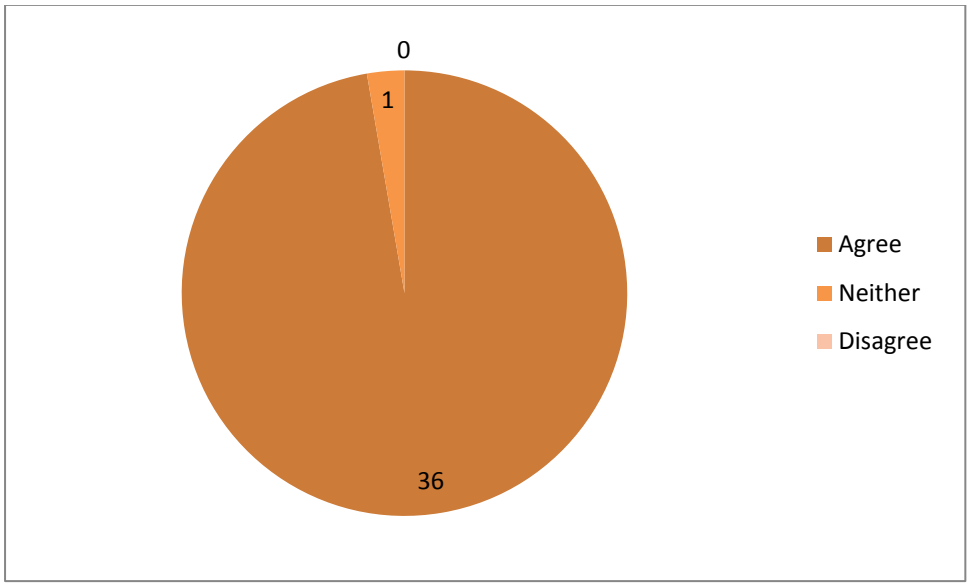
  *"I learnt the difference of ingredients, how to eat healthy and make it delicious." – Somali women's group participant*

*"I've started eating Weetabix and porridge instead of cornflakes because I found out they have sugar in them." – South Asian women's group participant*

*"Here they told us that breakfast is "fuel for the day". I never thought you can have proper meals in the morning, but you can, and my children like it." – Somali women's group participant*

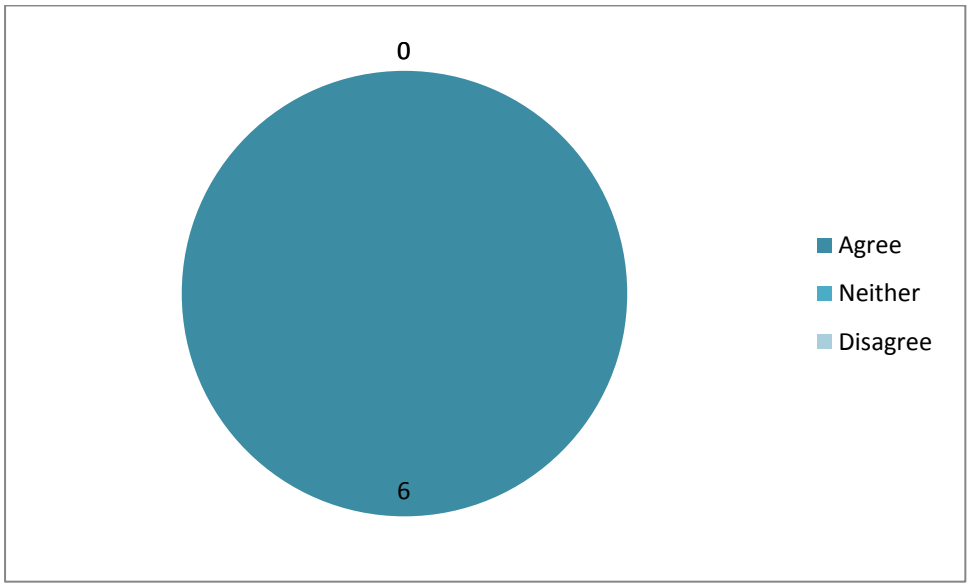
Learning about exercise was less commonly described, although some of the men described learning about how to exercise. It might be that knowledge about how to exercise was less of a barrier to exercise than opportunity or motivation.

**Figure (c) 'I have learnt new things about how to cook and eat healthily'**




Base: total number of people from all projects responding to question in questionnaire completed at final project session.

**Figure (d) 'I have learnt new things about how to keep fit and healthy through exercise'**




Base: total number of people from men's project responding to question in questionnaire completed at final project session.

### *Healthier eating for individuals and their families*

Many people in all of the groups reported eating more healthily. Common changes reported included eating more vegetables and fruit, using less fat in cooking, reducing sugary snacks and the amount of sugar put in tea, eating smaller portions, drinking more water and fewer sugary drinks, eating more regularly and earlier in the evening, and not skipping meals (the Somali women had frequently skipped breakfast).

> *"I stopped using oil. I used to put 2 tablespoons with meat and potatoes, but meat has oil in it so you don't need it." – South Asian women's group participant*

> *"No more sweets – I bought mango instead." – South Asian women's group participant*

> *"We roast and steam instead of frying now." – Men's group participant*

Several people described the impact their change in lifestyle was having on their families. The Somali women in particular were cooking healthier breakfasts for their children; the Asian women were cooking healthier meals for their families; and some of the men said that their families were eating more healthily.

> *"Sometimes my children used to eat chocolate at breakfast. With the coco pops, it was difficult at first, my children had to get used to it. I realised it is best not to buy coco pops so they don't see them in the house. I've swapped them for porridge, Weetabix, or bread and cheese." – Somali women's group participant*

> *"My wife also benefits: I eat differently, she eats differently. Today she's gone to Zumba [exercise class]! She's looking at me: "your stomach is going down!", I think that motivates her." – Men's group participant*

However, people commonly found that influencing family members' eating habits could be difficult, especially with teenage children and elderly parents. Several people described family members picking vegetables out of meals and leaving them on the side of the plate. Groups shared ideas about how to respond to these challenges, such as stopping buying unhealthy food so that it was not in the cupboard, and modelling healthy eating themselves.

***Case study: influencing family eating***

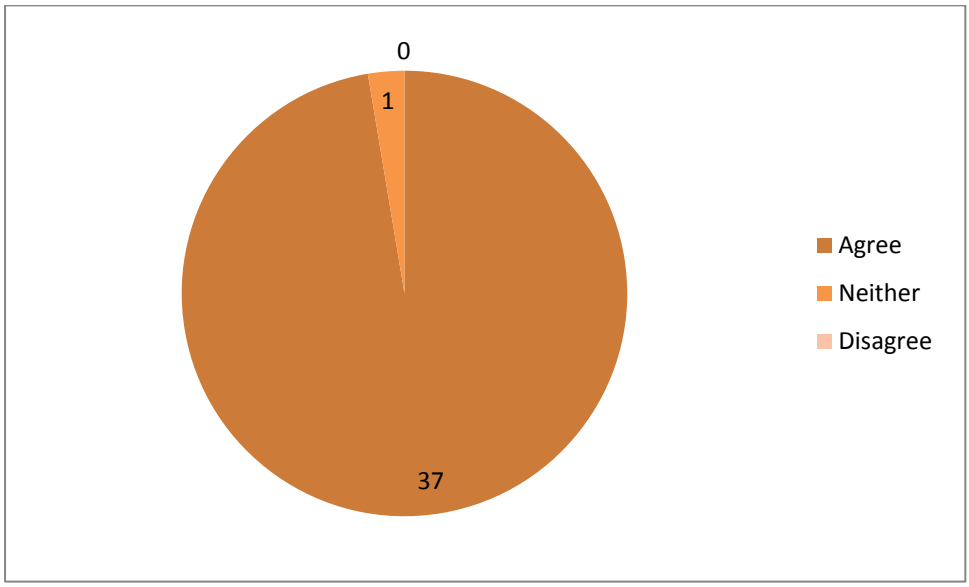
Zaynab and Isha are a mother and daughter-in-law attending the South Asian women's session together, who have changed the way they are cooking for their family:

*Zaynab: "We're eating more fruit. The family love biscuits, cakes and chocolate, but we stopped buying them about 3 or 4 weeks ago. My son searches through the cupboard for them!"*

*Isha: "I find it hard – I used to eat one pack of biscuits just for myself. I stopped because of my health – I have high blood pressure. Everyone was talking, saying "I've stopped this", "I've stopped this", and I thought, "why can't I?""*

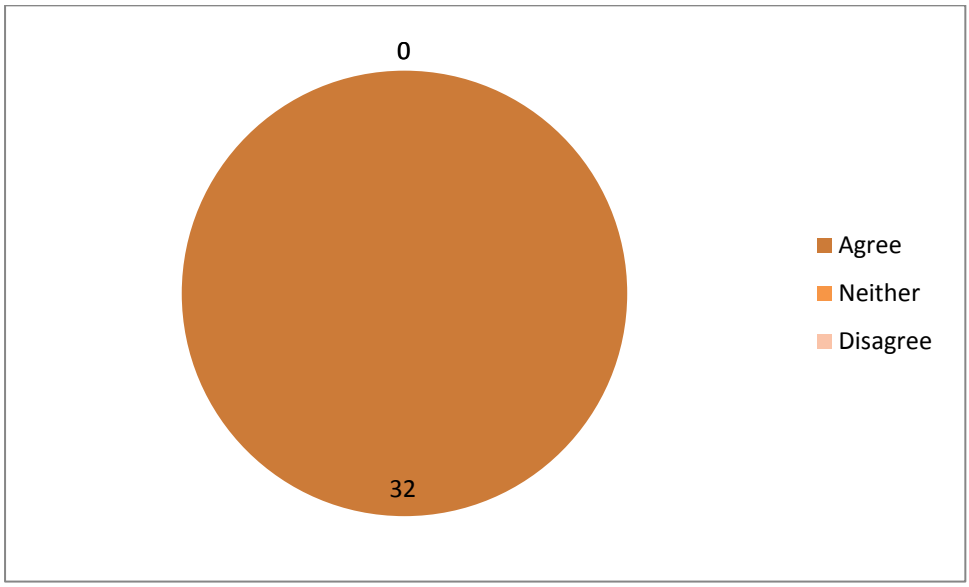
*Zaynab: "And we have small portions. We've started having vegetables and a salad with every meal. Before, we used to have salad but not vegetables."*

**Figure (e) 'I have started to eat more healthily'**




Base: total number of people from all projects responding to question in questionnaire completed at final project session.

**Figure (f) 'I am cooking more healthy meals for my family'**




Base: total number of people from women's projects responding to question in questionnaire completed at final project session.

### *Improved fitness and weight loss*

Most of the men attending the exercise group had previously been doing very little exercise. All of them said that they were exercising more, and all said they exercised regularly in between classes.

> *"I'm maintaining a regime of 1.5 hours a day of exercise. Before, I wasn't doing anything." – Men's group participant*

> *"I had to give away some clothes – they don't fit!" – Men's group participant*

Health measurements collected by the group facilitators summarised in figure (g) showed that, over the six weeks of the project, all four of the participants who had attended both the first and the last sessions achieved a reduction in both weight and BMI (body mass index). Three experienced a reduction in body fat, and two in visceral fat. The average weight, body fat and BMI of the four participants who had attended both the first and the last sessions decreased.

**Figure (g): Changes in average health measurements over the six week men's project**

| | Weight (kg) | Body fat (%) | BMI |
|---|---|---|---|
| Average at start of project | 92.15 | 26 | 29.6 |
| Average at end of project | 89.525 | 24.175 | 28.775 |
| Average loss (-)/ gain (+)over the project | -2.625 | -1.825 | -0.825 |

The South Asian women agreed at an early session that they would like to include an element of exercise. The women described enjoying the exercise, and some said that the group had encouraged them to walk more outside the class.

> *"The exercise was amazing … I can't do exercise because of [health problem] but I just took a chair and held onto it, and did whatever I could." – South Asian women's group participant*

> *"I've started walking and swimming, in the last couple of weeks. I went to ladies swimming at the leisure centre, I'm having lessons." – South Asian women's group participant*

The Somali women did not do any exercise, although there was energetic dancing in the last session. However, a number of women said that the project had encouraged them to exercise more:

> *"A lot has changed [in] my life. I walk to this project and I get out of my house - I get a little bit of exercise, I eat better." – Somali women's group participant*

The Somali group said that they would like the project to continue as an exercise class.

**Case study: A U-turn in my life**

Louis attended all of the men's exercise sessions. He is eating more healthily and has lost 3.6kg in weight over six weeks.

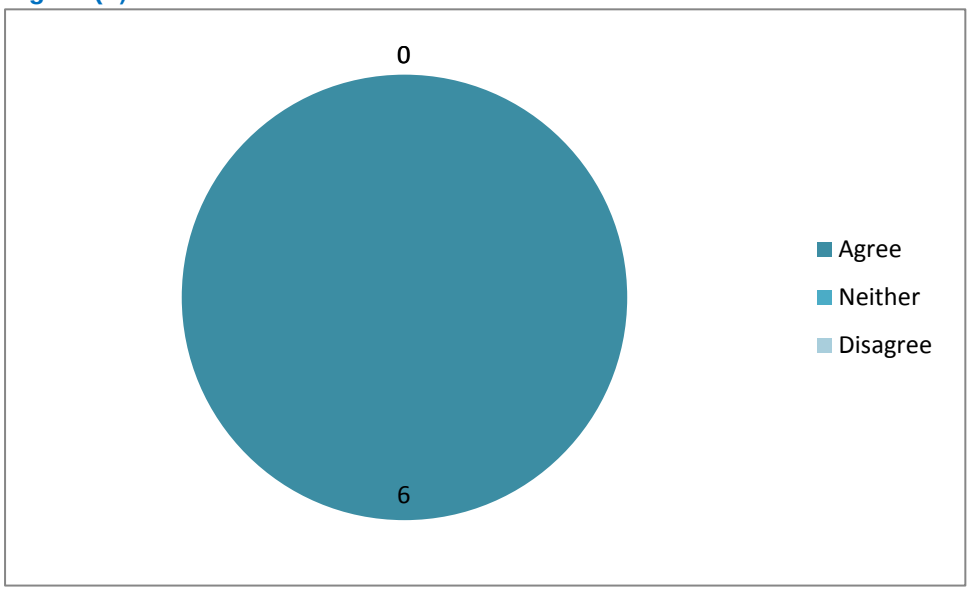
*"Before I had vegetables once a week, now I have them 3-4 times a week, and more quantity. I used to eat at 10pm, now I eat between 6 and 7pm: I find it gives me more time to digest what I eat. I've cut out completely sweet juices; before I'd drink a carton and think nothing of it, I'd buy a fizzy drink every day; now I have water instead.*

*My wife tends to be more cautious of the things she gives me to eat: half a cup of rice instead of a cup, more vegetables. My salad intake has gone through the roof!*

*My energy levels have gone up. It makes a difference in my life […] I'm feeling good, and my body fat has gone down.*

*It's like a U-turn in my life. The things I'm doing now, like this workout, if it was left down to me, I don't think it would have happened. The group helped me to help myself."*

**Figure (h) 'I have started to do more exercise'**




Base: total number of people from men's project responding to question in questionnaire completed at final project session.

### *Improved mental health and well-being*

Many participants described increased well-being as a result of taking part in the projects. Several of the men described feeling healthier and more energetic, and several of the women described feeling calmer and happier.

People attributed this increase in well-being to a number of factors, including increased exercise and healthier eating, and to the social connection and peer support the groups provided. People in all three groups also said that they were getting more sleep, which they saw as central to their well-being.

> *"I see the change in myself: becoming kinder, controlling myself, not always getting annoyed with the children." – Somali women's group participant*

> *"It's made me more happy and relaxed. You feel togetherness and you feel free to talk about anything." – Men's group participant*

> *"The benefits to my mental health have been staggering. I would do the program again just for the sharpness; edge; expanded capacity; clarity and confidence that I can cope, when under pressure." – Men's group participant (letter)*

Mental health emerged in interviews with the South Asian women as a central issue faced by this group of women. A number of women talked about their own experiences of depression, both in interviews, and (to some extent) in the group, and said that the group had helped their mental health and well-being:

> *"In our community, 95% of ladies this age are depressed. Our lives revolve around our husband and children. When we lose that, it's like we've lost everything, we don't know how to live." – South Asian women's group participant*

> *"I was stuck indoors for three or four years after an operation. Now I've started to come out. I feel much better than before. I'm coming back, slowly." – South Asian women's group participant*

### *Social connection and peer support*

In the end-of-project workshop with group leaders and participants, 'more social connection' was the one outcome that everyone agreed had been strongly achieved. One woman said she believed that all the other outcomes achieved had been enabled by greater social connection. Some of the participants described being relatively isolated: of the people attending the first two sessions, about one in three socialised with friends or family twice a month or less (4 out of 12 Somali women, 5 out of 17 South Asian women, and 1 out of 4 men).[13] Coming together with others to socialise was enjoyable and enhanced people's well-being. Members of both of the women's groups referred to the groups as being 'like a family', and the men's group talked about 'camaraderie'.

> *"Instead of sitting in watching TV, you can come out and meet other people and talk about plenty of things." – Men's group participant*

The peer support provided by the groups was clear during sessions, with discussions full of questions, advice and encouragement between group members.

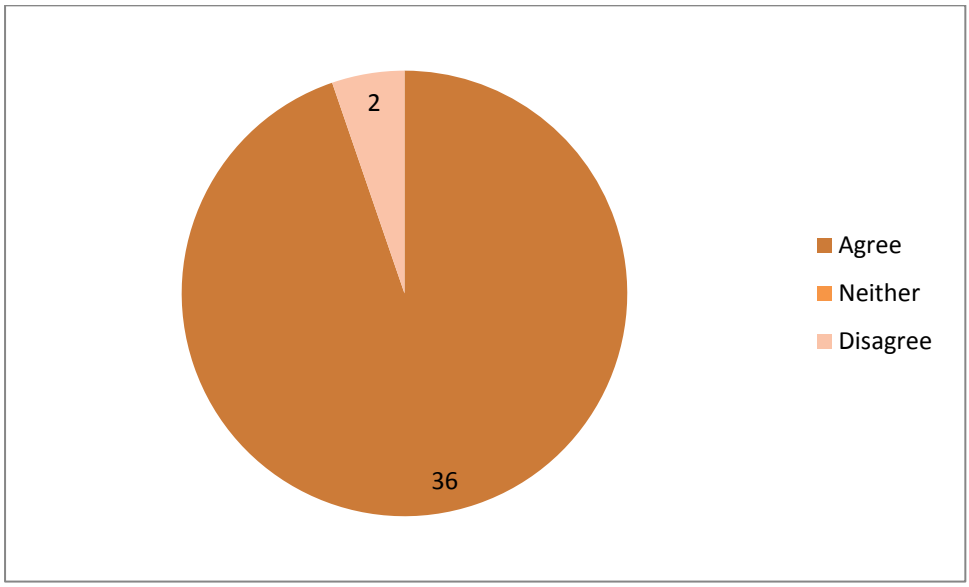
> *"The applause, the encouragement, it sounds like 20 men cheering!" – Men's group exercise coach*

The support and connection provided by the groups was exemplified in the last session of the South Asian women's project. An older woman whose husband had recently died attended the group and said that she felt lonely and depressed. One of the other women who had personal experience of depression spoke to her after the session, told her about a local support group, and arranged to take her there:

> *"I could tell she was depressed when she spoke, she was about to cry. I've taken her phone number. It's helping others, a sense of satisfaction." – South Asian women's group participant*

Nearly all of the participants in the three projects said they had made new friends through the groups.

**Figure (i) 'I have made new friends here'**




Base: total number of people from all projects responding to question in questionnaire completed at final project session.

### *Sense of control and empowerment*

Members of all of the groups described an increased sense of control and empowerment. Several people described how, by achieving small changes, their confidence increased, and they began to take increased personal responsibility for their own health. For some, this sense of confidence and control also began to have an impact on other aspects of their lives.

> *"It's been a boost to my self-confidence. You might look at yourself in the mirror and think "oh no!" Now I look at myself and think "yeah!" I think I'm doing something positive. It has a lot of benefits, self-discipline too, mental discipline: I'm going to continue even though it's hard." – Men's group participant*

> *"We try ourselves. There's no magic thinking [that can make you make changes] – **you** need to try to change." – South Asian women's group participant*

> *"It's also had an effect on personal motivation: you think "if one can do that, what else is possible?". Whatever ideas you might have about accomplishing something – starting a new business, planning for a holiday, getting your finances in order, getting in touch with long lost friends – I see, if I'm clear about what I want to do […] it's likely I'll get results." – Men's group participant*

### *Improved family relationships and support*

Several people said that their participation in the projects had led to improved family relationships. For some, this was because they felt calmer or happier themselves.

*"I find the children are quieter now they've had a healthy breakfast." – Somali women's group participant*

*"Before, I was very angry, because I've not eaten anything. [Now] my children say to me: "Mum, you've calmed down!"" – Somali women's group participant*

Others described receiving encouragement and support from family members, such as spouses or children, for example making decisions together to change family food purchasing habits or meals.

### *Sharing learning with others in the community*

Several Somali women talked about 'spreading the word' to other Somali women, for example when they meet at their children's school:

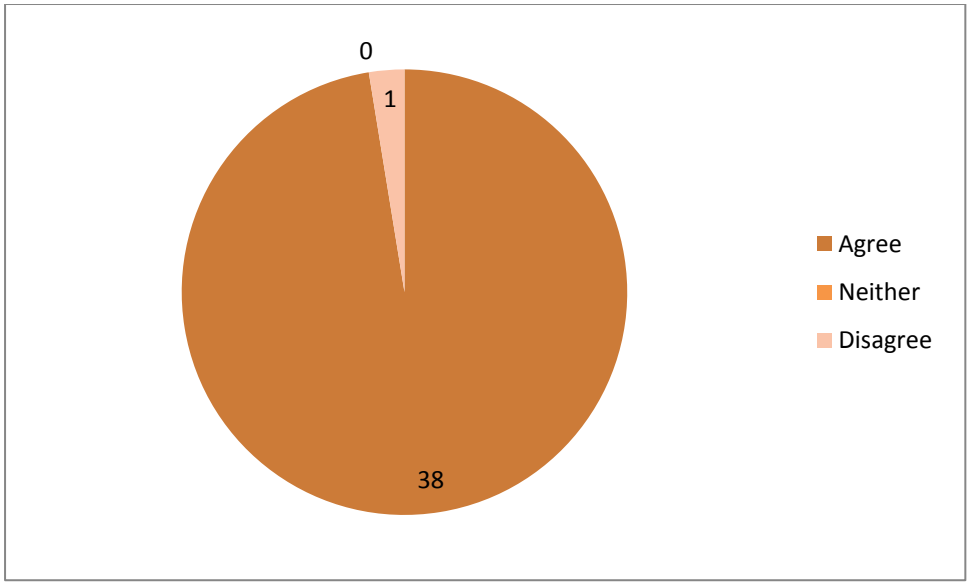
*"I have been telling my friends about fat and salt. Leave the soup for two to three hours and you see the fat on top. I tell my friends: "your children are eating that fat!"" – Somali women's group participant*

Members of the men's group said that they had talked to friends both in and outside the community:

*"I've talked to a few friends, some promised they'll come. I've talked to other people, beyond the church Brothers." – Men's group participant*

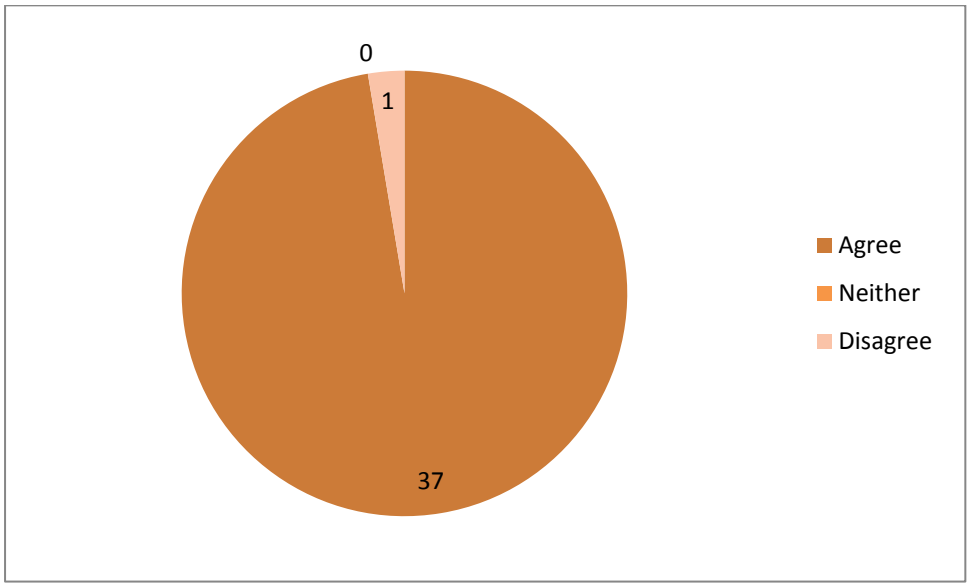
*"I've talked to different friends from different churches about it [the group]: it's importance and its benefits." – Men's group participant*

**Figure (j) 'I've talked to people in my family about what I've learnt here'**




Base: total number of people from all projects responding to question in questionnaire completed at final project session.

**Figure (k) 'I've talked to friends about what I've learnt here'**




Base: total number of people from all projects responding to question in questionnaire completed at final project session.

## Sustainability of outcomes

The projects were only six weeks in duration. Although participants made a number of changes as a result of taking part in the projects, it is not possible to judge how sustainable these changes will be.

All of the participants interviewed during the last session of each project said that they strongly wished to continue the changes they had made in cooking, eating and exercise, and intended to do so.

> *"I have been doing it for five weeks now. I hope it will be part of my life." – Somali women's group participant*

> *"We're going to have an hour's walk after we drop the children at school. I want to lose weight." – South Asian women's group participant*

Participants from across the groups who attended the end-of-project workshop around one month later reported sustaining changes in their cooking and diets, but follow-up is needed to explore how far these changes endure.

However, all of the groups wanted the projects to continue; they did not necessarily believe that they could sustain the changes alone. The social connections and peer support provided by the groups were not only important enablers to the changes that people had made, but were, for most people, in themselves a valuable outcome which people related to improved mental health and well-being.

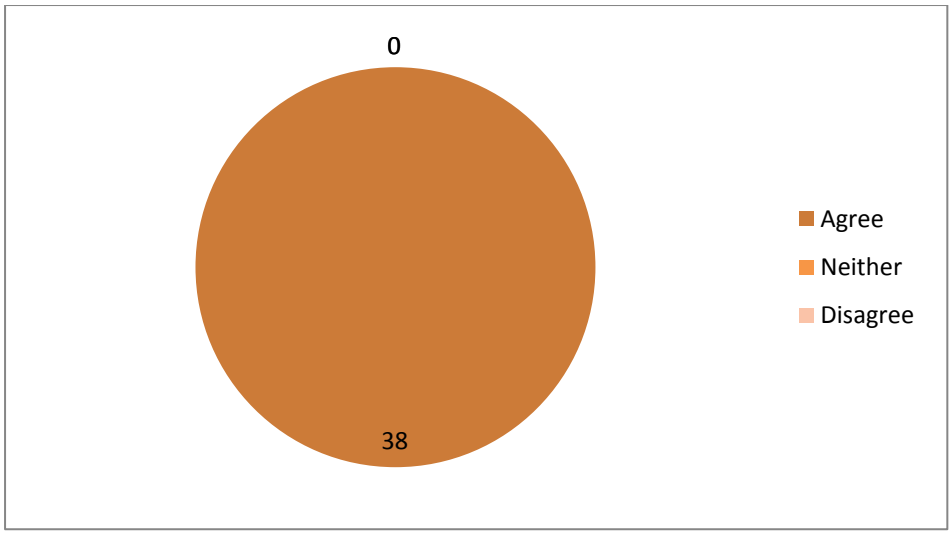
The men's group were very clear that they could not sustain the changes they had made without the group: the structured exercise class and the mutual support of the group were an essential element of the new healthier lifestyle they envisaged.

> *"I'm hoping to keep it up […] I'm hoping the group will carry on. I think it will. We can't just let it go after this, after what we've achieved." – Men's group participant*

During the last group meeting, the men agreed to self-fund their exercise group, but at the time of the end-of-project workshop, around a month later, they had not met again and participants said that, although they were still exercising alone, they were doing less exercise than they had been. The group still intended to resume their meetings because without the group to motivate and support them, it is unlikely that the majority of participants will continue to exercise so much.

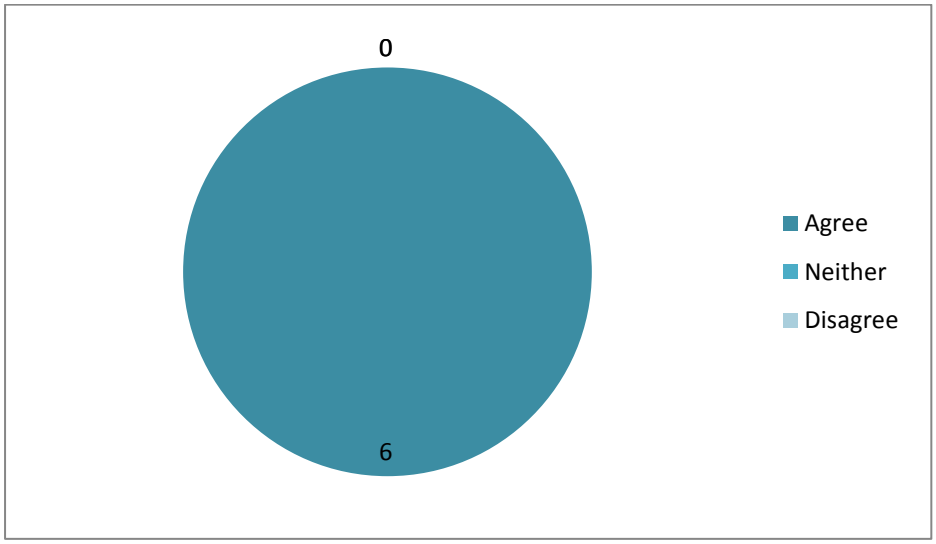
The potential for continuing the projects is explored further in *Possibilities for continuation, expansion and replication* below.

**Figure (l) 'I expect I will eat more healthily from now on'**




Base: total number of people from all projects responding to question in questionnaire completed at final project session.

**Figure (m) 'I expect I will carry on exercising more than I used to from now on'**




Base: total number of people from men's project responding to question in questionnaire completed at final project session.

# Systems and process outcomes

A number of desired outcomes relating to systems and processes were identified during the design phase of the project; this section explores how far these were achieved.

## Desired systems and process outcomes

It was hoped that this relatively small-scale pilot might, through its co-production methodology, lead to some changes in systems and processes. The following outcomes were agreed by stakeholders following discussions in a workshop with public health professionals (including the project's commissioners), community leaders, and WCEN:

- Public health professionals understand more about communities and their needs, learning from the expertise of Voluntary and Community Sector (VCS) and community members.
- VCS and community members have learnt from public health professionals.
- Better communication between public health and VCS.
- Improved local health policy.
- Understanding of different cultures within existing services.
- 'Hard to reach' groups meaningfully engage in health interventions.
- Communities have ownership over health interventions locally.

## The extent to which systems and processes were changed

In practice, the three projects focused on making changes at the individual and community level, rather than on changing systems and processes. This was to some extent because of the way in which co-production was understood and practiced within this project, and to some extent because of the short duration of the interventions and the exploratory nature of the project.

### *Improved communication and learning between public health professionals and the VCS*

- Public health professionals understand more about communities and their needs, learning from the expertise of VCS and community members.
- VCS and community members have learnt from public health professionals.
- Better communication between public health and VCS.

These outcomes were achieved to a limited extent, because of the limited involvement of public health professionals in the projects. The public health commissioner who was involved in the project said that she had gained several insights into the needs of the community through the initial workshop and attending two of the group sessions:

> *"I gained a couple of insights about CVD prevention whilst attending that I was able to feed back [to colleagues]… For example, listening to discussions and*

*realising a lot of barriers the women face are not specific to this community – what teenagers eat, not having time to exercise." – Public health professional*

This evaluation, which is sharing the voices and experiences of community members, might also contribute to this outcome following its publication. However, the limited involvement of public health professionals in the project constrained the opportunity for increased mutual understanding.

### *Changes to policy and services*

- Improved local health policy.
- Understanding of different cultures within existing services.

As described above, public health professionals had limited involvement in the pilot, and this, together with the short duration of the projects, means that changes to policy and services did not take place. However, it is possible that the pilot will contribute to changes over the longer term, for example following the publication of this evaluation report.

### *Engagement and ownership of health outcomes by marginalised communities*

- 'Hard to reach' groups meaningfully engage in health interventions.
- Communities have ownership over health interventions locally.

These outcomes were achieved to some extent. The three groups were well attended by members of groups who did not often access equivalent mainstream health interventions. The communities involved in the three projects had a reasonable amount of ownership over the project that they were involved in, which were co-designed and co-delivered by group leaders and community members (in partnership with WCEN). These outcomes did not extend beyond the three funded projects to a greater engagement in or ownership over mainstream health interventions.

# A theory of change

This section presents NEF's analysis of how the projects achieved their outcomes, and the ways in which the activities in this pilot differed from mainstream services.

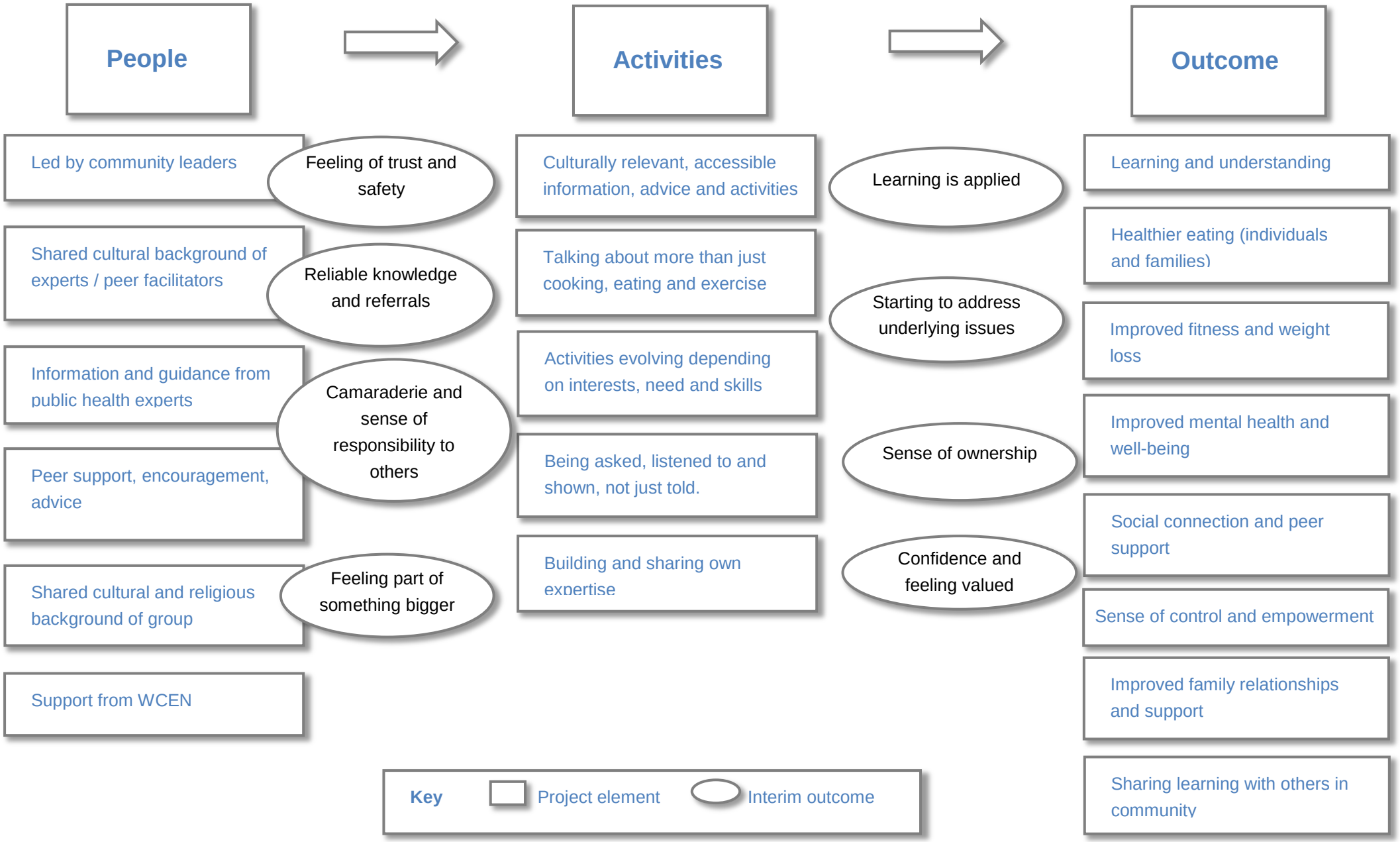
The theory of change[xi] presented in figure (n) is a simplified model of the roles, activities, and outcomes, and mechanisms of change in operation in the projects. It shows how, in these projects, the people created the activities, which in turn led to the outcomes. The boxes show the key elements of the project, and the ovals show the interim outcomes which worked as mechanisms of change. It is based on the views and experiences that participants described in workshops, interviews and questionnaires.

## Barriers to health

The barriers to health that participants described included:

- Distrust of health services
- Health services are inaccessible
- Personal health not a priority, compared to other concerns in life
- Community expertise is untapped
- For some: feeling a lack of control over their lives

Figure (n): A theory of change for Wandsworth CVD co-production pilot projects



## People

Valuing the strengths that different people can bring, and ensuring that they are able to make use of these, is central to co-production. In our interviews and workshops we explored the different roles that different people involved in the projects played, asking what they brought to the projects. We identified five groups who played a part in the project: community members, community leaders, experts from the community, experts from outside the community (including public health professionals), and WCEN. Below, we outline the strengths that participants and leaders said each group brought to the projects:

### *Led by community leaders*

Each of the projects was co-facilitated by a community leader: someone known and respected in the community. This included a Pastor in the men's project, and women employed by the host organisations for the two women's projects. Participants said that they motivated and inspired people to get involved and make changes; that they helped to create links between the community and professionals; that their involvement inspired trust and a sense of safety:

> *"Community leaders can verbalise and remind us of our own shared vision. They can say: "guys, you know you're getting on in age, you need to do something!"" – Men's group participant*

> *"By virtue of being a community, you draw people together and enable trust." – Community leader*

### *Shared cultural background of peer facilitators and peer experts*

The shared cultural background of group facilitators and peers was seen as an important reason for the projects' success. People found it helpful that the facilitators could talk from personal experience of facing and overcoming the challenges being addressed. For example, the woman who led the cooking in the South Asian women's project had had personal experience of CVD-related health problems in her family, and had found ways of cooking healthily and encouraging her family to eat healthily. This ensured that the information and advice given was both trusted and culturally relevant, and, therefore, more easily applied at home; it also showed that change was possible.

> *"Learning from someone who was in a similar situation that I was in a few years back. Saying "it was hard at the beginning but I managed it."" – South Asian women's group participant*

> *'Trust. She knows the food we eat: halal, and healthy. She has an understanding of the culture, the difficulties people face, how to meet people's needs in a professional way. If we bring a professional from outside it will take time to explain to them what we need.' – Somali women's group participant*

The common religion of group members was also thought to be important, with discussions of the ways in which religious texts and teaching emphasised the importance of health.

Community experts were also valued for challenging people, but in a respectful way:

> *"[He] didn't come in as a know-it-all expert. He was perceptive and respectful of us as older men. And he brought challenge." – Men's group participant*

The community leaders said that, by placing community members in leadership roles, they had unlocked skills and abilities that even they had not expected:

> *"They brought professionalism which we didn't expect, running the sessions – we've seen new skills from a member of the community. That proves the community have the expertise we need to continue the work." – Community leader*

### *Information and guidance from public health experts*

Some of the public health experts were community members, and some were not. Both provided reliable information and (where appropriate) referrals for more help, although it was stressed that it was important that they invested time in the group in order for trust to be built.

> *"When we bring in experts, there's always added value. In future, we could get professionals to come every other week, learn something new or seek help." – Group leader*

Experts from outside the community were valued. As outsiders, they could ask questions, or reflect back to the group, from a different perspective.

### *Peer support, encouragement, advice, and the shared cultural background of the group*

Participants said that the shared cultural background of the group facilitated a sense of togetherness and made it easier to be open. It meant that information and advice could be tailored to people's cultures and religions.

> *"If groups like this would take place among professionals and non-Asian people, I don't think people would go. They wouldn't feel very comfortable and would feel the link is not there. For example, we have a shared concept of food – hot foods and cold foods. During the summer we don't encourage children to have eggs, but in the winter we do." – South Asian women's group participant*

Community members exchanged experiences, knowledge and ideas with the group, and encouraged each other. As people practiced changed, their own expertise grew, and they shared their progress and learning.

### *Support from WCEN*

The key elements of WCEN's role were facilitating links between communities and health professionals (for example finding experts to attend the sessions), enabling community leaders to connect with Public Health, and providing support and reassurance to the groups (through 'being with us' through the process). They initially motivated community leaders to take part, introducing the idea of the projects and explaining the broader vision. They provided administrative support, information and materials. They also attended each group, co-facilitating group discussions to draw out experiences and learning, and taking notes. Community leaders said that WCEN staff 'led by example', including taking part in activities, and community members stressed that they treated them as equals, which they greatly valued.

> *"Observing the projects and being with us through the process gave us reassurance." - Community leader*

> *"[WCEN staff member] brings links with professionals. This brings credibility, trust. It gives us reassurance – he knows a range of organisations behind us that can facilitate, like a professional from mental health." – Community leader*

> *"[WCEN staff member] helped so much. You see she cares, she's interested in your opinion, you can try to explain. She's friendly, she treats us as equals, she was with us. She says 'I have the same problem'. Her questions help to emphasise the learning." – Group participant*

### *Blurring distinctions*

An underlying principle of co-production is that the distinction between professionals and recipients is removed, by reconfiguring the way services are developed and delivered. This happened in several ways in these projects. Community members were leaders and facilitators in the projects, and people described participants becoming experts. For example, in one project, a participant began teaching exercise in each session, after she told the group she had experience of doing so. WCEN also 'led by example' (as a community leader described it), participating as far as possible as equals in the projects: *"[WCEN staff member] was one of the brothers."*

## Interim outcomes achieved through people

### *Trust and safety*

People said that the involvement of community leaders resulted in a sense of trust and safety which was an important reason for their involvement.

> *"A sense of trust and safety that you won't bring us to something that could be harmful to us." – Group participant*

> *"If not for [community leader and WCEN staff], I guarantee you I wouldn't have gone for the 6 weeks anywhere else. It's about trust." – Group participant*

### *Reliable knowledge and referrals*

The involvement of experts (from both within and outside the community) was important in ensuring that the knowledge shared was reliable, and ensuring that people who needed further support knew where to go for this.

### *Camaraderie and sense of responsibility to others*

The peer support, encouragement and advice facilitated by the group, together with the shared cultural background of the group members, led to a sense of 'camaraderie' or 'togetherness'. In observing the sessions, the importance of this camaraderie was clear. The groups regularly fed back on their experiences of trying to make changes over the previous week, and comments such as 'well done', and 'how are you getting on?' were common. Instead of a professional telling people how they should be behaving, people's successes were celebrated, and they had the opportunity to ask for advice or share difficulties if they wished to.

> *"Everyone was making mistakes [during exercise session], all laughing, it was fun. [The exercise teacher] said "one more, one more!" You look at someone even older than you trying to do it, and you have an incentive. It's not someone looking down on you." – South Asian women's group participant*

The men texted each other regularly between classes to compare progress and encourage each other, and several people said that these texts were important in motivating them to make change:

> *"This [change] is all from this group, and by getting texts from the brothers encouraging me to carry on. It motivates you to keep going." – Men's group participant*

As people began to make changes, seeing others change became an important motivator for change:

> *"I already knew some of the things. But now I have the encouragement to put it into practice, in my diet and also regular exercise. I've reduced quite a lot of things in my diet, and I walk. You see others, and think "they're doing it, why can't I do it?"". – South Asian women's group participant*

> *"Once you're involved in a group and see the way the group is progressing, that motivates you. Not just yourself but others: you see the way their body is changing and feel the way your body is changing and think: we're doing something good." – Men's group participant*

People also described an increasing sense of responsibility to others in the group, which motivated them to stay engaged and make difficult changes. The personal trainer of the men's group said that the group was more persistent and determined than other groups he trained. He thought this was due to:

> *"The support network, accountability. The phone call saying "are you coming?" Knowing everyone will expect to see you there." – Men's group exercise coach*

He said that people felt both responsible to each other and inspired by each other:

> *"The applause, the encouragement, it sounds like 20 men cheering! The men think "I can do it myself."" – Men's group exercise coach*

Someone else in the men's group said that the group talked about a lack of sleep because of staying up late:

> *"A couple [of the men] have started ringing each other saying: "go to bed!"' 'Doing it with others helps. Some days I feel I don't want to do anything, but I have to give feedback [to the others]. Doing it as a team, you're accountable. It's kind of competitive too!" – Men's group participant*

### *Feeling part of something bigger*

Several people described feeling part of something bigger, and said that this motivated them to stay engaged. WCEN played an important role in this by communicating a greater vision for change with project leaders:

> *"[WCEN staff member] enabled us to understand why it was important – that this is about more than just us – we can share it with our communities." – Community leader*

## Activities

### *Culturally relevant and accessible activities*

Participants said that, because the community leaders, group members and (in most cases) experts in the group were from a shared cultural background, this ensured that the information, advice and activities were culturally relevant. Facilitators and experts from different cultural backgrounds were also valued by the groups for the specialist knowledge they brought, in particular when they tailored their information and activities to the group's interests and needs.

> *"She [group leader] knew this is how we're brought up to cook and then how to do this but in a healthier way."– South Asian women's group participant*

### *Talking about more than just cooking, eating and exercise*

Although the projects were initially designed as cook and eat / exercise projects, in practice they were able to help address far broader issues than cooking, eating and exercise. The conversations at the start of each session were open enough to enable people to raise any issues of concern to them:

> *"We discussed everything together here: cooking, children, saving money." – Somali women's group participant*

> *"We were doing it for the heart [CVD], but it was amazing how much we talked not to do with that." – South Asian women's group participant*

> *"It was a cook and eat project, but people were more interested in social isolation and exercise. It was a richer process because it worked in a way that spoke to communities from where they were at." – WCEN*

The issues discussed all related to CVD in some ways, and included several that had been identified as preventers of good health at the initial project outcomes workshop (see the theory of change for CVD in Wandsworth in figure (a)).

This approach was particularly helpful in encouraging people to attend who might not have attended a service or project specifically for (for example) mental health issues or isolation:

> *"I had bad depression. If the GP says you have to go to counselling, you won't go. In our culture, if it's a mental problem, it's not visible, and it's shame. Especially for older people." – South Asian women's group participant*

However, some facilitation was needed to ensure that people were aware of the limitations of this six week project:

> *"People wanted information on welfare benefits and we had to say that's not for this group, because resources and time are limited." – WCEN*

### *Activities evolving depending on interests, need and skills*

The open discussions, which covered cooking, eating and exercise, but also other issues such as family relationships, stress, and money, helped to shape the content of future sessions. For example, a dental health specialist and a mental health counsellor attended and ran sessions at the Somali group after people raised dental health and stress as issues. Likewise, the groups were shaped by participants' skills. The South Asian group was initially conceived as a cook and eat project; however, when the women said that they wanted the opportunity to exercise, and it became apparent that one of them was able to teach exercise, the project was quickly adapted so that the first half focused on cooking and the second involved an exercise session.

### *Being asked, listened to and shown, not just told*

Participants valued being asked and listened to, which enabled them to raise important issues, and ensured that these were responded to as far as possible in the sessions. They also said that being shown how to cook, or given visual information, was helpful:

> *"If someone else tells you these things [how to cook healthy, tasty food], you'd never believe, but when someone shows you…" – South Asian women's group participant*

### *Building and sharing own expertise*

It was common for group members to share their own experiences, ideas and expertise. This ranged from recipe ideas, to tips about how to encourage family members to eat more vegetables, to a man agreeing to share produce from his allotment in return for help with it. Groups discussed difficulties, such as receiving cake as a gift, and came to ideas for solutions, such as how to have a conversation with the person who is giving a gift and ask for flowers or fruit instead.

> *"We teach each other. My friend she told me about [healthy] breakfasts and that the children like it." – Somali women's group participant*

> *"Before we start the session we talk about what we've been doing. That helps us to share our knowledge. For example, I told them you don't have to do all the exercises in one go – you can do them in sets." – Men's group participant*

> *"I try to tell people about my prostate cancer. West Indians don't like going to the doctor because of the test you have to do for prostate cancer. I tell them about my symptoms and say they should go to the doctor." – Men's group participant*

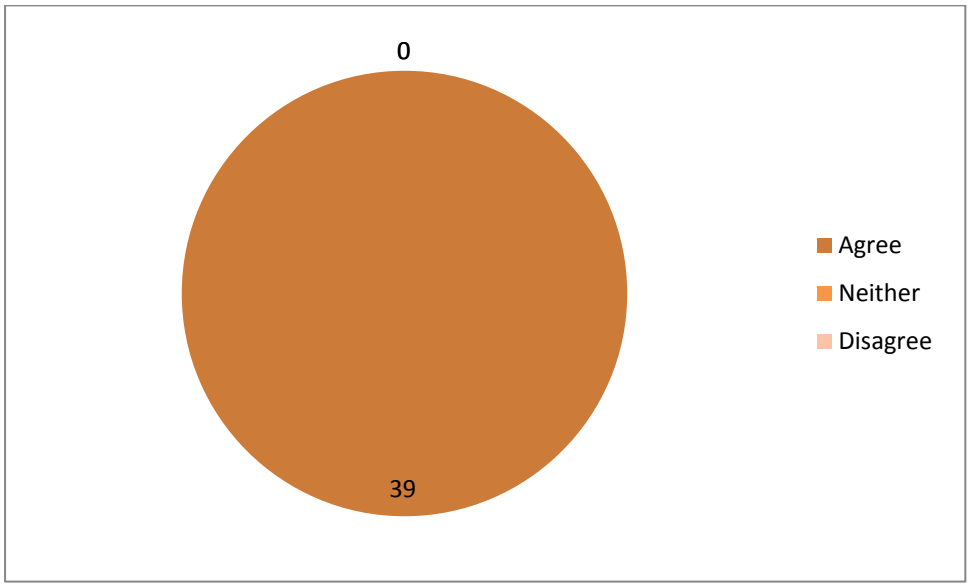
> *"It was amazing, hearing that knowledge from Malawi women [about herbal medicines]. All those tips!" – South Asian women's group participant*

A number of group members were found to have expertise that had not been known (such as the participant in the South Asian group who took on a regular role of leading the group in exercises). The community members who led the groups were also described by the community leaders as flourishing – building on their existing skills. WCEN use the term 'unlocking' the skills already in the community to describe this.

> *"Some community members also qualify as experts. They were implementing things being said; everyone developed an expertise. One guy was previously an amateur boxer and a lot of his training came through in information-sharing with the group – how to train, how to not injure yourself. A few guys had done martial arts and they shared how to hold the position, speaking words of encouragement." – WCEN*

The projects also allowed community members to develop new knowledge and skills, and they described sharing this both within and beyond the group.

**Figure (o) 'I have shared my ideas, skills or knowledge with other people in the group'**




Base: total number of people from all projects responding to question in questionnaire completed at final project session.

## Interim outcomes achieved through project activities

The interim outcomes shown in ovals on the theory of change figure (figure n) were those outcomes that people said were important in leading to change.

### *Learning is applied*

The shared cultural and religious background of ground members helped to ensure that learning in the group was culturally relevant, and therefore more easily applicable in people's everyday lives outside the group.

### *Starting to address underlying issues*

The facilitation of open discussion meant that issues underlying poor health and preventing good health could be identified and potentially addressed. Some issues raised, such as a lack of knowledge about different kinds of fats, could be addressed within the group. Other issues could be addressed to some extent in the group, for example by inviting a stress counsellor to talk about stress management. Others, such as children eating unhealthy takeaways, poverty and housing issues, are likely to need different approaches. Capturing the learning from the groups about these issues is important in order to help identify different ways of addressing them.

### *Sense of ownership*

Being listened to, having a say over what the group did and discussed, and meaningfully contributing ideas and experiences to the group, helped people to feel a sense of ownership over the project. This was demonstrated for example in the men's group when the trainer was unable to attend one week. The men decided to run the session themselves, each taking a lead on one exercise. At the end of the project, they decided to pay between them for the personal trainer to continue with them (although this had not transpired at the time of the final project workshop, seven weeks later).

### *Confidence and feeling valued*

Many people described an increased sense of confidence, which resulted from both feeling valued for their contribution to the group, and from achieving positive changes.

> *"Instantly you feel like you're doing something good for yourself. So mentally you feel… a pat on the back." – South Asian women's group participant*

## The difference from mainstream health services

We asked people how this project was different from other health services available to them. They said:

- **Being based within local community venues** makes the project more accessible.
- **The project was culturally specific**: *"Our project led up to Ramadan which was a good preparation for healthy Ramadan food which the NHS would have struggled to achieve."*
- **The projects were accessible for people who would struggle to access mainstream services for cultural reasons.** For example, one South Asian woman was referred for hydrotherapy, but was not able to find out when there were no men in the pool, so did not go: *"I wouldn't go somewhere I have to take my headscarf off."*
- **The project enabled trust to be built up**, in comparison with GPs who only see people briefly. People said that GPs often sent people with mental health issues away with medication rather than other support. *"If you go to the doctor you have 5 minutes, you struggle to explain." "How many people go to the GP just with depressive symptoms and go away with tranquilisers."*
- **The consistency** of a project based within a local community organisation: *"People parachuted in from NHS will come to 3 or 4 meetings then they will leave, be sacked or moved in the organisation, and I will wonder why I made that connection."*

**Case study: The difference from mainstream health services**

Amina (in her 50s) has a number of health problems. She does not exercise and finds that mainstream health services do not meet her needs.

*"I was sent by my GP to the leisure centre. I went for a few weeks, but you feel out of place. The person who showed me [how to use the equipment] was too busy teaching the young people. I have to walk with a stick, there's no provision for me, it's for an able person.*

*If you go to the doctor, you know [they say] "you should do that, do this, not eat this". It's medical advice. But here, it's set in an environment of all of us, saying "I made this effort", "I tried to use less oil" and in the back of your mind you think "if this person can, I can too."*

*The exercise was amazing! … For six weeks I didn't miss a single one because, you know, I didn't want to."*

## Challenges and learning

Most participants could not identify any areas for improvement, although the Somali women wanted an exercise class. The main areas for improvement that WCEN identified were:

- **Childcare.** The presence of their children made it difficult for some Somali women to concentrate and participate fully. Although a crèche was provided in later sessions, it was in the same room, which was noisy. This would be resolved by the provision of a fully equipped crèche in a separate room.
- **Translation.** The presence of WCEN, NEF and professionals from outside the community meant that translation was sometimes needed. This could be a burden on group leaders, and a distraction from their role of facilitation or teaching. This issue could be resolved by ensuring that a dedicated translator was available.

# The process and role of co-production

Here we discuss how effective the process of co-production was in this project, and the role co-production played in achieving the project outcomes.

## The role of co-production in achieving project outcomes

Many of the project elements and interim outcomes that resulted in the project outcomes (such as healthier eating, improved well-being and social connection), as outlined in the theory of change in figure (n), are intrinsically related to the co-produced nature of the project. Most of the key mechanisms of change worked through co-production. Interim outcomes which worked as mechanisms of change included feelings of trust and safety; the ability of the projects to identify and begin to address underlying issues; people's sense of ownership and responsibility to others; and increased confidence and feeling valued. These were enabled by the culturally (and personally) relevant nature of project information and activities, the range of people involved (including both healthcare professionals and community members), the openness of discussion, and the way in which project activities evolved in response to people's needs. WCEN played an important role building relationships and supporting the groups.

## Effectiveness of the process

### *'Pre-co-production'*

WCEN effectively built relationships with community leaders and with senior members of the Local Authority's Public Health Department over many years, and this proved a strong foundation for this project. Community leaders and public health professionals were also effectively brought together in two workshops facilitated by NEF as part of the evaluation, which stakeholders said they found a valuable means of engaging in dialogue and created shared solutions.

### *Initial design*

The co-production of the initial project design took place primarily between WCEN and community leaders. Community members were not involved at this stage, and were represented by community leaders. WCEN acknowledged that there remained a power imbalance between community leader and community members, and discussed this with the community members they worked with. The absence of community members had some consequences:

> *"In the women's group, their views on cooking and the control they had varied substantially to what men had told us in the original scoping sessions. A gentleman told us about what women's needs are, but then [when this was mentioned in the later pilot project session] the women in the group were laughing and saying "these are the problems"." – Public health professional*

However, this was quickly resolved as the community members began to take ownership over the topics discussed in the group.

The Local Authority Public Health team had very little involvement with project design, except for their involvement in the initial workshops. Public Health professionals felt they could have been more involved, had communication between them and WCEN been more pro-active and regular. On occasion they were told about planning meetings with only one day to one week's notice, which was too late for them to be able to attend.

### *Evolving design*

Community members became much more involved in the evolving design and delivery of the project, as discussed in previous sections. Although the broad project structure was adhered to, there was a great deal of scope for participants to shape the design of the project. For example, an exercise session was incorporated into the South Asian women's project; and experts attended the Somali women in response to issues raised, and there was traditional dancing during the last two sessions.

Only one of the participants thought that there was scope for more co-production:

> *"Instead of spoon-feeding, you should encourage participants to take more of an active part. It should be more interactive." – South Asian women's group participant*

### *Delivery*

Community members were significantly involved in project delivery. This ranged from community leaders co-facilitating the sessions, and community health and fitness experts leading sessions, to project participants sharing their experiences, skills and ideas. Most notably, in the South Asian project, a project participant began to teach an exercise session. Other women brought in recipes and dishes, and shared their experiences of cooking new food for their families. The men texted and telephoned each other between sessions, and shared their learning and experiences of exercising and eating healthily.

### *Challenges in the co-production process*

The Local Authority Public Health team had very little involvement with either project design or delivery, following their involvement in the initial workshops. Neither the Public Health team nor WCEN felt that Public Health had been able to fully contribute their strengths, knowledge and skills to this project, and both felt that this impeded the full effectiveness of the pilot.

This was partly because of a reduced capacity in the Public Health team during the pilot. However, differences in working cultures and practices also emerged as a key challenge in this project. One central challenge was that it did not prove possible to

commission public health professionals to take part in the project: the commissioning process required a project plan and, most importantly, took time. The projects required professionals who could respond immediately to the needs that people raised: for example, in the Somali group, a dental expert attended, and an IAPT (Improving Access to Psychological Therapies) practitioner talked about stress management. WCEN secured these professionals through their own networks. As mentioned above, Public Health professionals needed to be given more advance notice of meetings when they were scheduled, in order to ensure they could attend.

Other differences in working practices were also experienced. For example, it is good professional practice in the healthcare and other sectors that projects are planned and evidence-based, have intended outcomes, and that roles are clearly delineated. In contrast, this co-production pilot had less clearly articulated plans and procedures, the link to existing evidence was not formally set out, and roles were fluid. These are not necessarily features of co-production, but co-production does involve challenging existing ways of working, and an openness to evolution in project activities and outcomes is likely to mean a less structured or formal overall approach.

The challenge of adapting to a new way of working was also experienced by professionals who were community members. One person described the challenge of:

> "…*not knowing where we were going or how we were going there … They weren't clear giving me a spec of what they wanted … That was me being "we've only got six weeks, we need to do this, what are we going to do, how will we spend the two hours, you need to account for this time" – that's me, that's the way I work."*

However, this person said that a less planned approach, although challenging, had some benefits:

> *"[Participants] were more relaxed. Anyone could chip in to talk about what they wanted to talk about. The freedom was beneficial."*

An important consequence of the more limited involvement of the Public Health team was that the project was not able to influence policy, commissioning practice or service delivery as strongly as it might have been able to. It was also not able to draw on the knowledge and skills of the Public Health Department.

Ideas for overcoming these challenges include:

- More pro-active, regular communication about the project, and more thorough discussions about roles, would have made working together easier and would have ensured that Public Health were able to play a more active role in the project.
- Mutual appreciation that co-production involves bringing together professionals, charities and communities – each of which have their own

working cultures which can evolve over time but need to be understood and discussed.

- Post-pilot discussions between Public Health and WCEN about ways of better combining their strengths. In particular, the codified health knowledge of Public Health, and the relational approach to learning of WCEN.
- Continue to explore together the preventers of good health among Wandsworth's deprived communities, and seek ways of addressing these, taking a whole systems approach.[14] Local preventers of good health include poverty, poor housing, a low sense of control and self-esteem, and the common use by children and young people of unhealthy takeaways.
- Ongoing collaboration to build the case for change – recognising that changes in policy and practice are likely to take time, but also that this pilot has been a significant step forward in making that case.

# Possibilities for continuation, expansion and replication

## Continuation

The enthusiasm of all participants and group leaders spoken to for this evaluation for continuing the projects, and for bringing friends, suggests that the projects would continue to be well-attended if they continued.

> *"I just want the group to keep going. I would love it to continue, I'd like more people to attend, we could advertise it more." – Men's group participant*

> *"I hope projects like this will be funded … We need Wandsworth and the NHS to have trust in us with public money." – Community leader*

The men's project said that they needed a personal trainer and nutritionist in order to continue; the Somali women's project needed money for rent for hiring the hall the sessions took place in, and a trainer. Both the men's group and the Somali women's group had discussed paying a personal trainer themselves as group members for the projects to continue. However neither had yet for a number of reasons, including that Ramadan and the school holidays made it difficult for the women to attend. This perhaps supports WCEN's view that their role is important in organising, supporting and facilitating the groups until they are more well-established.

Required costs would include:

- Hall hire – even those community groups with community spaces were losing the rental income they usually made from those spaces when they held groups there.
- Facilitators including health professionals (such as trainers and nutritionists) (or training for local people to take these roles).

## Expansion

WCEN would like to run the project on a much larger scale across Wandsworth, for example by training the participants in the pilot projects to become exercise leaders or nutritionists and co-lead other groups.

Several participants believed there was scope for expansion of the project on a greater scale:

> *"We need a continuation of this in our communities, NHS would have their bills drop." – South Asian women's group participant*

> *"We would like to make it not six weeks but a lifestyle … WCEN have also come in with a future vision – training men as facilitators. We'd like to be self-propelling, to take ownership, so it's not that, if someone is running it and their*

> *life changes and they stop, then it all falls down. We could formalise the training with [WCEN's] help." – Men's group community leader*

It is important that WCEN continues to monitor the future of the groups, including whether plans to continue on a self-managed and self-funded basis come to fruition and, if they do not, what the obstacles to this are.

### Replication

WCEN believe that these projects could be replicated with other community groups within Wandsworth, although – as co-produced projects – the replication should be of the model for co-production rather than the content of the sessions. Key elements for replication include:

- The involvement of community leaders in a central role.
- The existence of an intermediary organisation such as WCEN to build links between public health and communities, and to facilitate and support the projects.
- The understanding, identification and enablement of social networks as a process for community building and project success.
- The flexibility of the projects to evolve in response to community members' interests, needs and skills.

WCEN stressed that co-production would operate differently in another area. In WCEN's view, relationships are central to co-production, so the relationships in any local context would need to be mapped in order to determine the best model for co-production. Outside Wandsworth, the role that WCEN plays might not be necessary, or could potentially be filled by a community group, for example.

# Conclusions and recommendations

The three pilot projects were successful in supporting individuals within Wandsworth's deprived communities to cook, eat and (for the exercise projects) exercise more healthily. Many project participants said that their families were eating more healthily as a result, and almost all had spoken to friends about what they had learnt. The projects addressed a number of the risk factors associated with CVD, particularly regarding diet, eating habits and physical activity. It also addressed some of the underlying issues contributing to health outcomes, such as sense of control and empowerment, mental health and well-being, and social connection.

The co-production methodology was central to achievement of these outcomes. Interim outcomes which worked as mechanisms of change included feelings of trust and safety; the ability of the projects to identify and begin to address underlying issues; people's sense of ownership and responsibility to others; and increased confidence and feeling valued. These were enabled by the culturally (and personally) relevant nature of project information and activities, the range of people involved (including both healthcare professionals and community members), the openness of discussion, and the way in which project activities evolved in response to people's needs. WCEN played an important role building relationships and supporting the groups.

Continued funding should be made available for the three pilot projects, with the intention of reducing WCEN's input over time so that the projects become self-managing. WCEN should also consider piloting an expansion of the project, including by training community members to take leadership or facilitative roles in new projects.

For future joint working, WCEN and Public Health should explore together ways in which some of the challenges faced in this project can be overcome. More regular and pro-active communication would help, along with mutual understanding of the different working cultures of Public Health, WCEN and community groups. It is anticipated that over time and through collaboration, partners will learn to adapt to each other's needs and build the case for change together.

The longer-term outcomes of any continued projects should be monitored so that the sustainability of outcomes can be better understood. Monitoring and evaluation tools can be developed to measure the outcomes and mechanisms of change identified as important by this evaluation.

The Public Health Department, WCEN, community members, voluntary and community sector organisations, and other relevant Local Authority leads and experts, should continue to explore together the preventers of good health among Wandsworth's deprived communities, and seek ways of addressing these through a whole systems approach that influences local and national policy.[15] Local preventers of good health include poverty, poor housing, a low sense of control and self-esteem, and the common use by children and young people of unhealthy takeaways. They

should also continue to explore ways in which health services could better meet the needs of all community members.

Public Health teams in other areas should consider the role of community leaders and peer networks in delivering health outcomes as demonstrated in Wandsworth; using co-production as the tried and tested method for doing services *with* people, rather than *to* or *for* them.

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# Endnotes

[1] Whole systems approaches involve identifying the various components of a system and assessing the nature of the links and relationships between each of them. This is the approach recommended in Marmot, M. (2010) *Fair Society, Healthy Lives: The Marmot Review,* pp.90-91.

[2] NHS Choices (page updated 3/7/2012) *Cardiovascular disease* www.nhs.uk/conditions/cardiovascular-disease/pages/introduction.aspx

[3] South East Public Health Observatory (2011) *Cardiovascular disease CVD health profile: Wandsworth* www.sepho.org.uk/NationalCVD/Archive/2011/docs/5LG_CVD%20Profile.pdf

[4] Wandsworth Borough Council and NHS Wandsworth (2010) *Wandsworth Joint Strategic Needs Assessment 2010*

[5] The absolute gap in CVD mortality for persons under 75 years between the most deprived and least deprived local areas increased by 59.7% between 2001 and 2009. The relative gap has increased from 72.4% to 550.7% respectively.[5] [5] South East Public Health Observatory (2011) *Cardiovascular disease CVD health profile: Wandsworth* www.sepho.org.uk/NationalCVD/Archive/2011/docs/5LG_CVD%20Profile.pdf

[6] South East Public Health Observatory (2011) *Cardiovascular disease CVD health profile: Wandsworth* www.sepho.org.uk/NationalCVD/Archive/2011/docs/5LG_CVD%20Profile.pdf

[7] National Institute for Health and Care Excellence (2010) *Prevention of cardiovascular disease*. NICE public health guidance 25. www.nice.org.uk/guidance/ph25/resources/guidance-prevention-of-cardiovascular-disease-pdf

[8] The text in this section is adapted from New Economics Foundation (2013) *Co-Production in Mental Health: A literature review*.

[9] This is the shared definition of co-production, produced in January 2013 by the National Co-production Critical Friends. For more information, see: http://coproductionnetwork.com/page/national-coproduction-critical-friends-briefings

[10] Arnstein, Sherry R. "A Ladder of Citizen Participation," JAIP, Vol. 35, No. 4, July 1969, pp. 216-224.

[11] Slay, J. and Stevens, L. (2013) *Co-Production in Mental Health*, New Economics Foundation.

[12] A Theory of Change defines the building blocks required to bring about a long-term goal. It is linked to a policy or programme logic model, but moves beyond articulating the links between inputs, outputs and outcomes; to include 'how' and 'why' change is expected. For more information, see: www.theoryofchange.org/what-is-theory-of-change/#1

[13] Totals represent the number of people answering this question on the questionnaire.

[14] Whole systems approaches involve identifying the various components of a system and assessing the nature of the links and relationships between each of them. This is the approach recommended in Marmot, M. (2010) *Fair Society, Healthy Lives: The Marmot Review,* pp.90-91.

[15] Ibid.