MOBILISING COMMUNITY ASSETS TO TACKLE HEALTH INEQUALITIES

A synthesis and review of Phase 2 case studies

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FOREWORD

Our experience of community life – where we live, the strength of our social connections and how identity and heritage are valued – has a profound impact on our health and wellbeing. While these social determinants are well recognised, more needs to be known about the most effective ways of mobilising community assets for better health, and how to build sustainable and equal partnerships with the least advantaged communities in order to have a lasting impact on health inequalities. It is frustrating that despite much promising practise, there are limited opportunities to scale and disseminate asset-based approaches. That is why it is so exciting to see this case study synthesis pull together learning across a series of projects, all of which were funded by the Arts and Humanities Research Council as part of their 'Mobilising Community Assets to Tackle Health Inequalities' programme.

Anyone reading the report will be struck by the creativity shown in the choice of methods across all projects. There are fresh ideas, new models and growing understandings of alternative pathways to connect better with communities facing the worst inequalities. All of this linked by an assumption that cultural, community and nature-based assets can be of benefit to a wide range of people if we make the connections easier in communities and maintain investment in the social infrastructure.

The synthesis provides insight into the thorny issues around scale and integration at the same time as recognising that each project was unique, delivered in a specific context and using community assets in different ways. Achievements gained through collaboration between academic teams and community-based organisations are discussed. Working across sectors with different organisational cultures can be challenging, but some of the essential ingredients for successful collaborations are highlighted here. Adaptation is a key theme, building on the notion that asset-based approaches start with the intrinsic strengths of a community.

Rich stories from practice reveal deeper understandings of the realities of implementation. Here, we see how new evidence was generated and how participatory methods worked in different contexts. The case study synthesis itself is a relatively new method that helps researchers distill common factors from practice-based evidence. The result is a nuanced view of how cultural, community and nature-based assets can be mobilised, with plenty of practical pointers for anyone wishing to grow and scale these approaches to tackle health inequalities.

Jane South,
Professor of Healthy Communities, Leeds Beckett University

1. SCOPE OF THIS WORK

This synthesis brings together insights generated by 16 community-university partnerships funded by the Arts and Humanities Research Council (AHRC), part of UK Research and Innovation, in partnership with the National Centre for Creative Health (NCCH). Phase 2 projects ran throughout 2023 [1] with the aim to build cross-sectoral community research consortia to address health inequalities. The synthesis presented in this report followed the methodology outlined in A Guide to Synthesising Case Studies [2].

Completed Phase 1 projects, which began in January 2022, consisted of 12-month pilot projects. These focused on how to scale up small, local approaches to addressing health inequalities. For further detail, please consult: Mughal, R., Schrerer, I.A., Smithson, J., Bagnall, A.M., South, J. & Chatterjee, H.J. (2024). Mobilising Community Assets to Tackle Health Inequalities: A Case Studies Synthesis and Review. London: University College London. Available at: https://ncch.org.uk/uploads/MCA-Case-Study-Synthesis.pdf

Phase 2 projects researched the establishment of consortia incorporating academic, health, local authority, community and lived experience partners across a range of settings, working in some of the poorest areas of the UK. The aims, reach and participant groups were broad and heterogenous, but generally the overarching aims were to use cross-sectoral consortia and community assets to:

- **Enhance integrated care and collaboration**
- **Strengthen community engagement and co-production**
- **Support health equity and access**
- **Develop sustainable and scalable solutions for integrating community health assets into health systems**
- **Underscore evidence-based practice and research**
- **Improve outcomes in population health and healthcare**
- **Tackle inequalities in outcomes and access to services**
- **Enhance productivity and value for money**
- **Contribute to the wider goal of preventative care in the community**
- **Support the NHS in its broader objective of social and economic development [4].**

SYNTHESIS OF KEY THEMES

Project Overview

Phase 2 objectives:

- Enhance integrated care and collaboration;
- Strengthen community engagement and co-production;
- Support health equity and access;
- Develop sustainable and scalable solutions for integrating community assets into health systems.

Purpose and Aims	Methods	Participants	Impact and Outputs	Barriers	Enablers
Integrated care and collaboration	Build intentional relationships via health assets	Co-production, diversity, reach	Capacity building	Logistics and funding	Alignment, funding, and attitude
Community engagement	Health asset mapping	Outreach and diverse programmes	Mapping and joining-up existing health assets	Funding	Funding
Equity and access	Relationship building	Demographic diversity	Establish collaborations and build capacity	Logistics and scheduling	Collaboration
Sustainable and scalable	Collaboration and applied evidence	Co-production and collaboration	Created conditions for success	Sustainability challenges due to engagement and participant recruitment	Strategic alignments for data, policy and logistics
Evidence based research and practice	Intentionally making health assets human and equity centred		Broad range of outputs in form/focus		Enthusiasm and building on existing relationships
			New strategies and evidence		
			Orientation for future collaboration		

KEY TAKEAWAY: Mapping community assets for health along with collaborative practices that prioritise co-design and co-production, generate positive conditions for health asset creation (capacity building) and scalable improvements in access to health resources in communities by diverse demographics; logistical and funding barriers exist as future threats

2. METHODOLOGY

2.1 Research Question

How can cross-sectoral consortia be built to address health inequalities?

2.2 Materials

Project data was collected using a practice-based case study template. The template was a modified version of a measurement tool devised for What Works Wellbeing by Leeds Beckett University and the University of Liverpool [2,3]. Case study reports derived from practical experience are a good tool for presenting practical intervention findings. Typically, such case studies offer a narrative detailing the development and outcomes of an intervention in a specific context, shedding light on insights gained from those actively engaged in its creation and implementation. Practice-based case studies can highlight key aspects of implementation and outcomes in real-life settings. The contextual information can be beneficial for practitioners, policy makers, and funders seeking insights into the application and adaptation of various approaches in diverse contexts. Offering a glimpse into the 'how' and 'why' of projects or programmes in intricate settings, practice-based case studies often incorporate community perspectives [2]. Evaluative techniques, particularly with creative and community organisations, are known to be problematic due to a host of reasons: from asking projects to ‘mark their own homework' to expecting non-academics to engage in sometimes complex statistical analysis [5]. The methodology devised by the What Works Centre for Wellbeing allows for charities, small enterprises and community groups to tell the story of the activity or project in a structured manner applicable for evaluation, building a business case, funding application, or strategy [2,3].

Towards the end of their funding, each project was asked to complete a practice-based case study. Questions within the tool asked for summaries of the project, its settings, methodology and reasons for its use, participants, data collection, impact and outcomes, enablers and barriers, key learning, sustainability and outputs (Table 1). See Appendix 1 for a full version of the questionnaire used.

Table 1: Main headings used within questionnaire

Heading	Description
Overview	Summary of case study
Setting	Geographic area and organisations involved
Purpose	Aims; goals and objectives
Description	Description of what the project is/does
Methodology	Why this approach was taken: evidence base
Participants	Demographics and numbers taking part
Data collection	What data was collected, by whom
Impact and outcomes	Measurable impact record; list of outcomes
Enablers and barriers	Factors supporting and developing project delivery
Key learning	Including project delivery and the challenges and successes of the project itself
Next steps	Sustainability and continuity of the project
Further information	Links to supporting materials, e.g. website or evaluation report

2. METHODOLOGY

The original measurement tool was slightly amended: two questions were changed to reflect lived experience and community research (Questions 9 and 10 – see Appendix 1). These additions were made to reflect the projects' goals of community research and lived experience; items not originally included in the case study template.

The measurement tool was uploaded as a Microsoft Form in April 2023 and sent out to projects for completion over the summer of 2023. The programme comprised twelve funded projects, however one project did not complete a case study due to insufficient data having been collected.

2.3 Data extraction

Once the case studies were received from all projects, a four-step thematic analysis was performed on the raw data. A data extraction template was developed to systematically extract relevant data fields from each case study. Topics for consideration were based on the need for the current synthesis to produce insights around system delivery, since these were the topics that addressed the research question. The topics for consideration were chosen as:

- Overview of project;
- Purpose and aims;
- Settings;
- Methodology, participants, enablers and barriers; and
- Key learning.

Although the synthesis methodology suggested a quality criteria checklist, one was not included within this work. To enable us to understand the broad spectrum of insights, an emphasis was placed on strengths, weaknesses, barriers and enablers, with the view of delineating inherent bias within answers using a thematic analysis approach as set out within the synthesis methodology [2,3]. Answers given by projects were taken at face value.

- **Step 1 is denoted throughout pages 8-14.**
- **Step 2 is denoted by a lime green box with text inside it.**
- **Steps 3 and 4 are outlined on page 5.**

A four-step thematic analysis was conducted as follows:

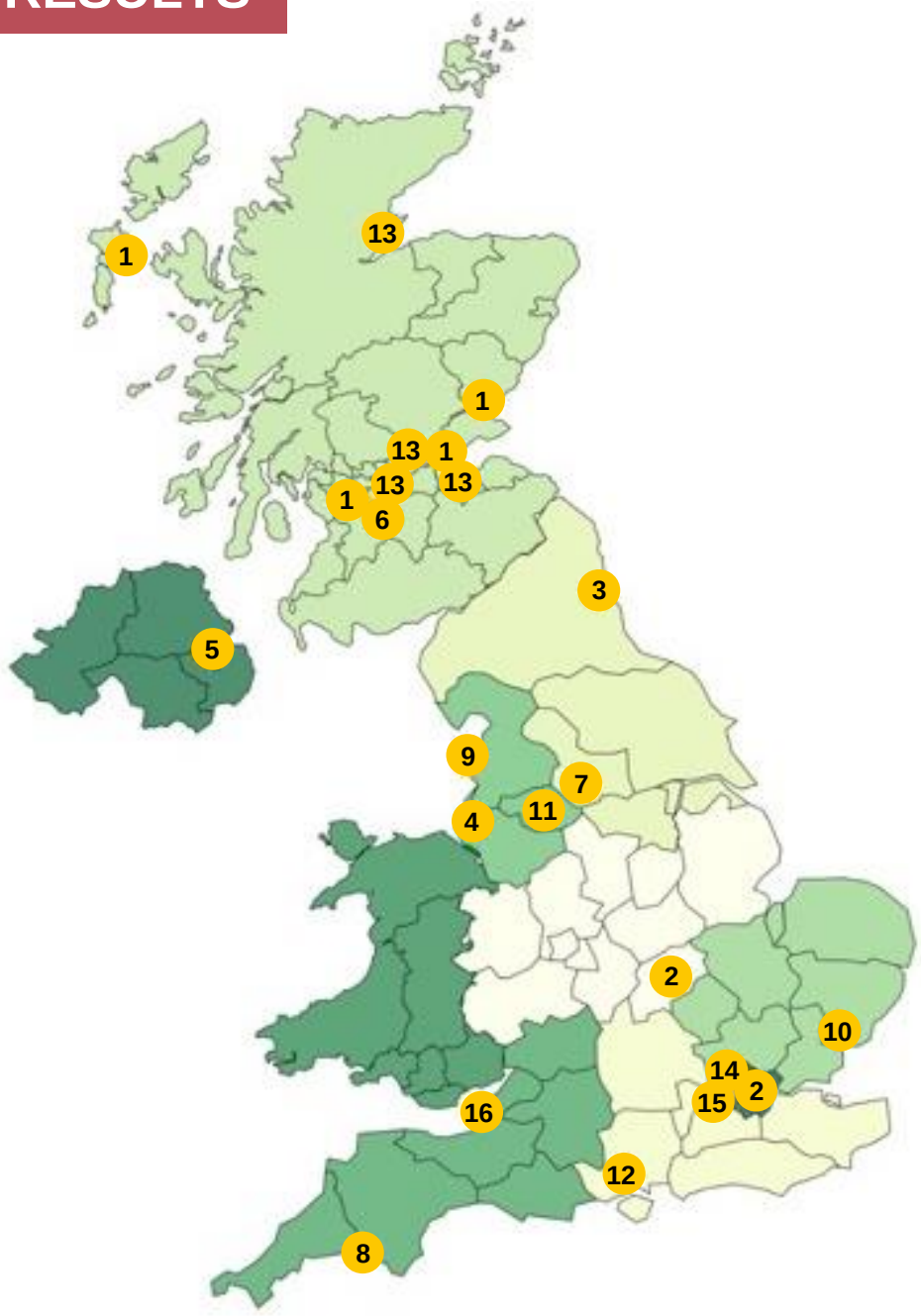
Step 1: Answers from each key heading were summarised within the data extraction template. All answers were made uniform in order to extract data easily for synthesis (i.e. summarised with key points in the same order, same tense, each part summarised within a sentence).

Step 2: Themes were identified from the summary sections from each key heading. Themes were identified as similar or repetitive answers given by projects that provide an insight (for example if several projects identified "collaboration" as a barrier or enabler, "collaboration" was identified as a theme).

Step 3: Themes from all summary sections were collated. General themes were then identified from those that developed from several summary sections (for example, if "collaboration" appeared as a barrier or enabler and, also, as within impact and key learning, it was identified as a general theme).

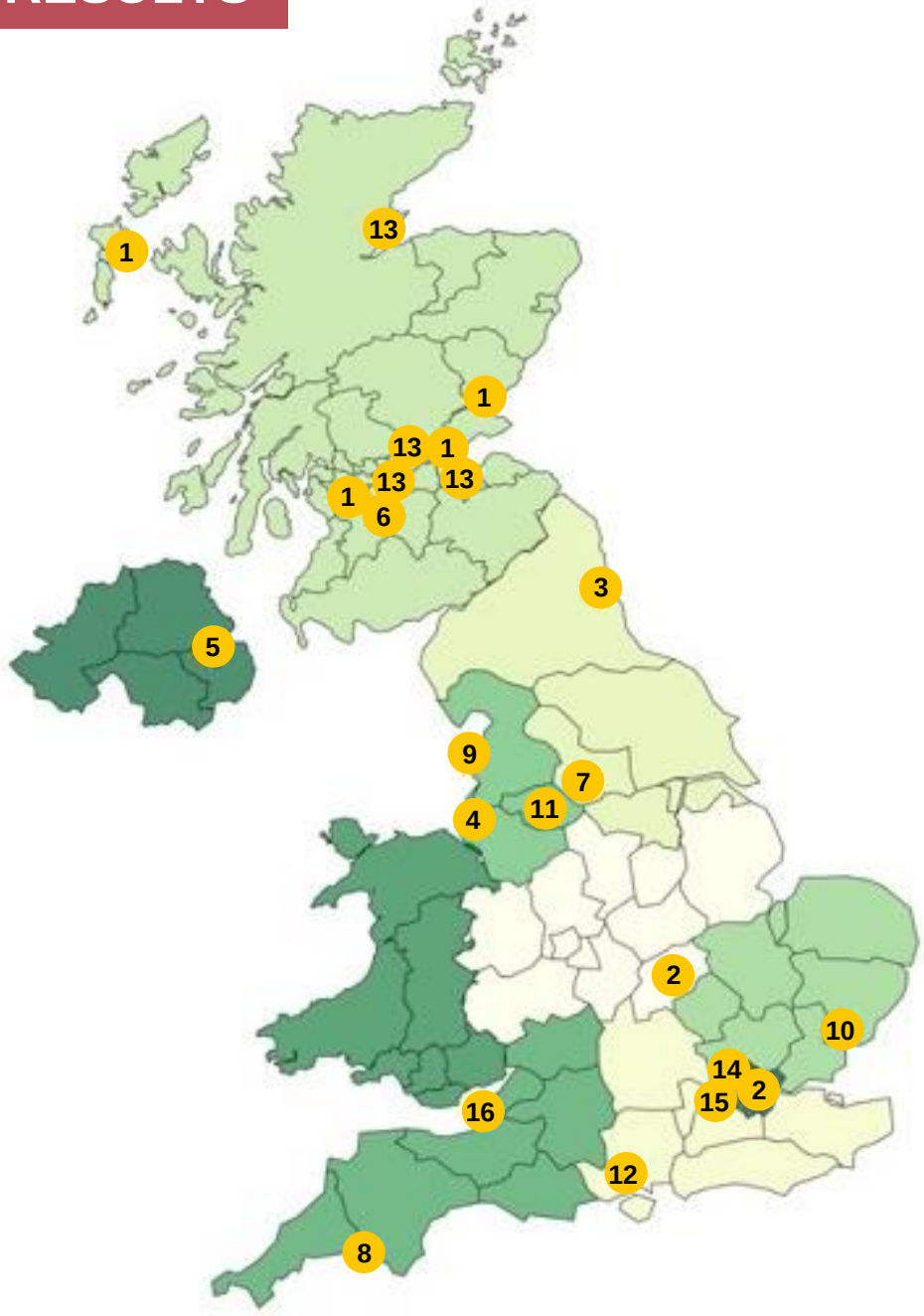
Step 4: All general themes were collated. Any repetitive themes found within the general themes were further identified and refined.

3. RESULTS



1. Art at the Start - Phase 2 (University of Dundee) - Dundee; Glasgow; North Uist, Fife
2. Building a Well Communities Research Consortium to address health disparities through Integrated Care Systems (City, University of London) - East London; Northamptonshire
3. Building and evidencing community asset partnerships in housing and health to address health disparities in North-East and North Cumbria (Northumbria University) - North East and North Cumbria
4. Building REsearch by Communities to address Inequities Through Expression (ReCITE) Consortium (Liverpool School of Tropical Medicine) - Merseyside
5. Challenging Health Outcomes and Integrating Care Environments (CHOICE): a community consortium to tackle health disparities for people living with mental illness (Ulster University) Northern Ireland
6. Common Health Catalyst: developing a community research consortium to address health disparities (Glasgow Caledonian University) - Lanarkshire
7. Creating Change: a collaborative action inquiry approach for integrating creativity and community assets into integrated care system responses to health disparities (University of Huddersfield) - West Yorkshire
8. Devon Community Assets Research Collaborative (CAN-DO): developing, understanding and linking within integrated care systems (University of Plymouth) - Devon
9. FYLDE Coast Research Consortium (Lancaster University) - Lancaster

3. RESULTS



10. INtersectional Network Of community and stakeholder Voices, And research to Tackle (in)Equities (INNOVATE) in mental health and wellbeing (University of Essex) - Essex

11. Organisations of Hope: building a creative consortium for health equity in Greater Manchester (University of Manchester) - Greater Manchester

12. Pathways to health through cultures of neighbourhoods (University of Southampton) - Southampton

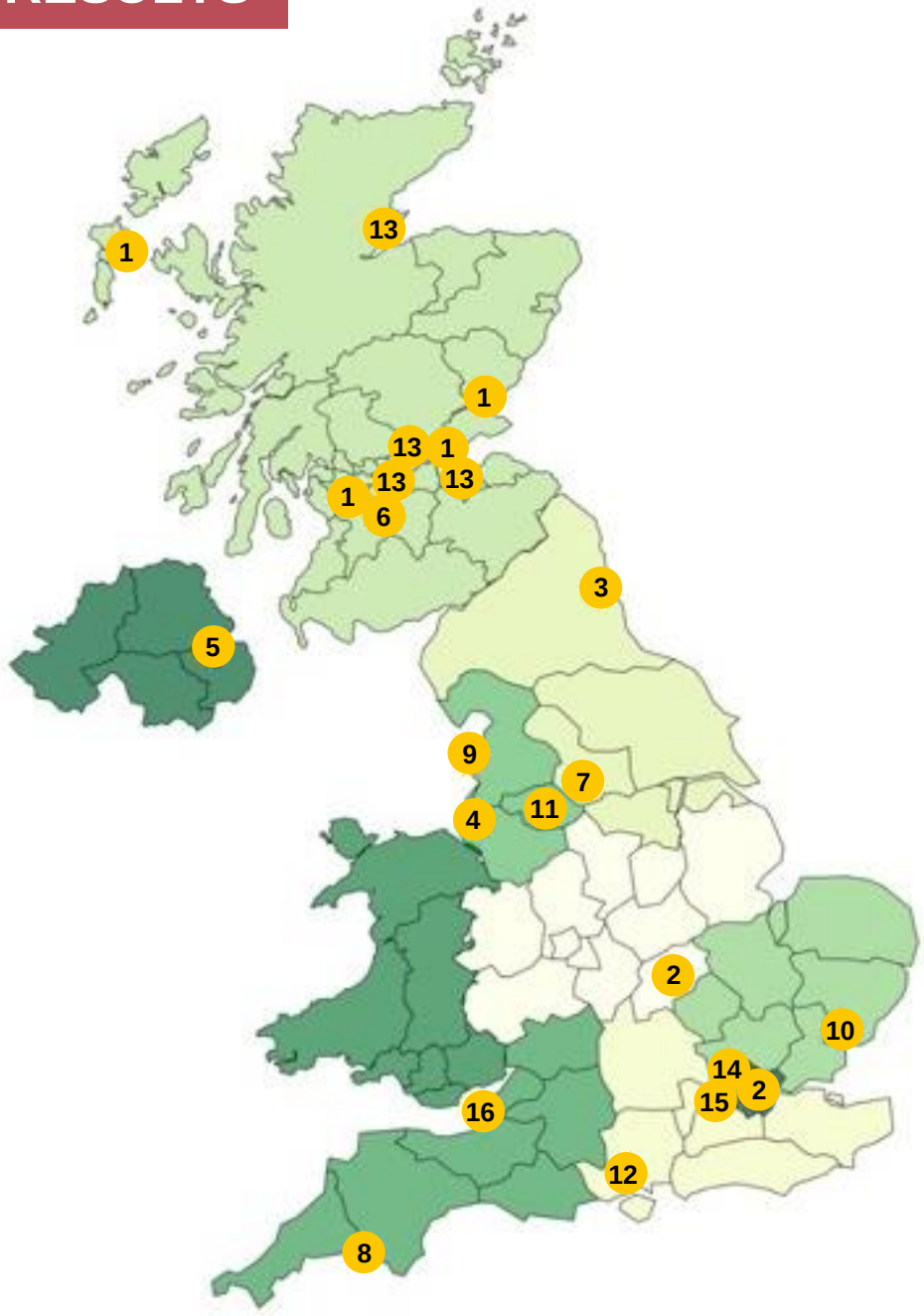
13. REALITIES in Health Disparities: researching evidence-based alternatives in living, imaginative, traumatised, integrated, embodied systems (University of Edinburgh) - North Lanarkshire; Clackmannanshire; Easter Ross

14. Tackling health disparities through social innovation: a multi-stakeholder coalition for inclusive health in Brent (University College London) - Brent, London

15. The Living Roots Project: building a community asset and research consortium in Ealing, west London to address health equity (Institute of Development Studies) - Ealing

16. Weston-super-Mare consortium: harnessing community assets to tackle inequities and reduce social isolation in end-of-life care and bereavement (University of Bristol) Weston-super-Mare

3. RESULTS



Sections 3.1-3.6 set out the summaries (3.1) and derived themes of project aims (3.2), methodology (3.3), participants (3.4), impact (3.5), and enablers and barriers (3.6). The first level of thematic analysis is outlined at the end of each results section. Sections 4 and 5 include a discussion of findings and concluding remarks.

3.1 Project Summary

Art at the Start; Dundee, Scotland. Provides arts therapy for parents and infants in Scotland to promote mental health and wellbeing, leveraging community assets and interdisciplinary partnerships.

Building a Well Communities Research Consortium; East London and Northamptonshire. Addressing health disparities through Integrated Care Systems.

Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria; North East and North Cumbria. Focuses on housing and health partnerships to address health disparities.

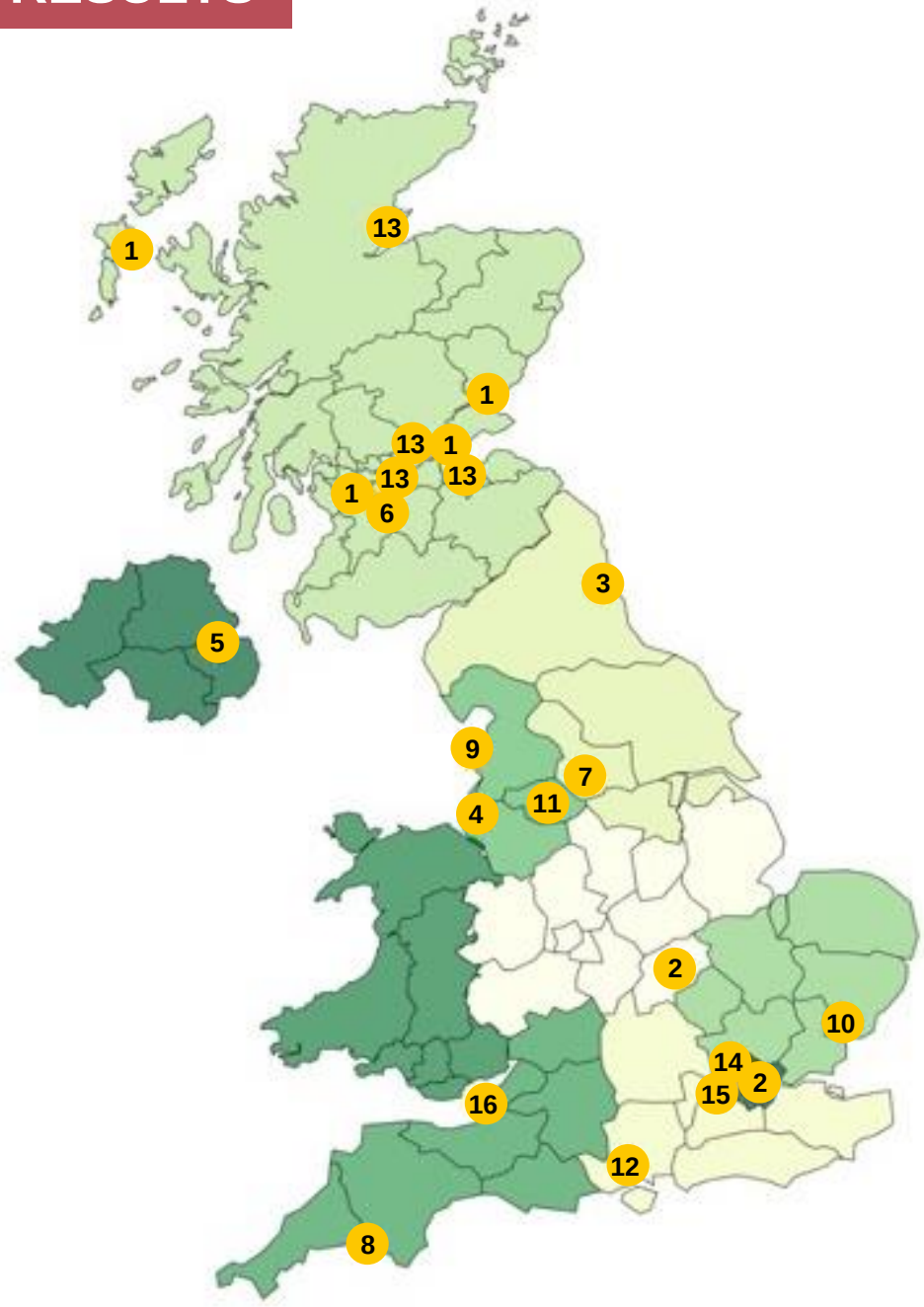
Building REsearch by Communities to address inequities through expression ReCITE; Anfield and Everton, Liverpool. Integrates storytelling into health systems in Liverpool to increase breast cancer screening engagement, resulting in significant reductions in missed appointments.

CHOICE; Northern Ireland: Establishes community partnerships to create arts-based approaches to combat social exclusion and reduce health inequalities for those with mental health problems, envisioning a flourishing life for them.

Common Health Catalyst: Lanarkshire. Developing a community research consortium to address health disparities.

Creating Change: West Yorkshire. Integrating creativity and community assets into integrated care system responses to health disparities using a collaborative action inquiry approach.

3. RESULTS



3.1 Project Summary

Devon Community Asset Network – addressing Disparities in Outcomes (CAN-DO); Devon, Southwest England: Exploring how community assets can be valued, mapped and linked as part of the integrated care system.

Fylde Coast Research Consortium; Fylde Coast, Blackpool. Builds partnerships among public and community stakeholders to address health disparities, with plans for future coastal community collaborations.

INtersectional Network Of community and stakeholder Voices, And research to Tackle (in)Equities (INNOVATE) in mental health and wellbeing; Essex

Organisations of Hope; Greater Manchester. Mapping creative health assets and exploring factors affecting access to these resources, from choirs to parks.

Pathways to health through cultures of neighbourhoods; Southampton, Southern England. Involving young people to reimagine cultural engagement to reduce health challenges, integrating these insights into local health systems.

REALITIES in Health Disparities; Clackmannanshire, Easter Ross, North Lanarkshire, Scotland. Taking a human-systems approach to co-produce a model addressing health disparities through diverse knowledge bases and community engagement.

Tackling health disparities through social innovation; Brent, London. A multi-stakeholder coalition for inclusive health.

The Living Roots Project; Ealing, London. Uses participatory and creative health methods to address health inequities, engages peer researchers to understand local views on health equity.

Weston-super-Mare Consortium; South West England. Tackling inequity in end-of-life care and social isolation by leveraging community assets.

3. RESULTS

3.2 Aims and purpose of projects

Art at the Start: To map and reflect on art-based interventions for early years relationships, evaluate family experiences and needs, and co-produce research plans to reshape cultural assets for public health benefits. The project aims to establish a research hub to promote early intervention through art and cultural engagement.

Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria: To reduce health disparities by developing integrated, community-focused approaches. The project aims to engage marginalised groups through participatory methods, create a database of evidence for decision-making, establish a physical integrated care hub, and develop a virtual consortium to improve health outcomes and facilitate collaborative work across different systems.

Building REsearch by Communities to address inequities through expression - ReCITE: To improve breast cancer screening uptake among women in deprived areas of Liverpool. The project involves understanding barriers to attendance, such as convenience, knowledge gaps, and anxieties, and developing targeted interventions to increase screening rates and improve early detection and outcomes.

CHOICE: To address the high premature mortality rates among people with severe mental illness (SMI) due to modifiable medical risk factors and physical multimorbidity. The project focuses on improving health outcomes through the integration of mental and physical health services and the involvement of voluntary sector organisations (VSOs) in providing health interventions and social prescribing, thereby overcoming social exclusion and improving overall health and wellbeing.

Community Asset Network – addressing Disparities in Outcomes (CAN-DO): To address health disparities by understanding and enhancing community assets' engagement, adaptation, and integration into health systems. The project aims to build a research consortium, map community assets, examine co-production models, and develop sustainable strategies for integrating community assets into health improvement efforts.

Creating Change: To develop sustainable, non-medical approaches to health and wellbeing in West Yorkshire through creative, physical, and nature-based activities. The project engages stakeholders to understand and address social drivers of health disparities, build community capacity, and integrate community assets into health systems to improve health outcomes and reduce disparities.

3. RESULTS

3.2 Aims and purpose of projects

Fylde Coast Research Consortium: To address the drivers of deprivation and improve public health in Blackpool and other coastal communities. The project focuses on understanding local health challenges, enhancing community research capacity, integrating co-production into health systems, and creating sustainable, place-based health models through collaborative efforts

Organisations of Hope: To build a creative health coalition in Greater Manchester that leverages community assets to improve health and wellbeing through creativity, culture, and heritage. The project seeks to understand the current creative health landscape, identify gaps and barriers, and integrate these assets into the Greater Manchester Integrated Care System to reduce health inequalities.

Pathways to health through cultures of neighbourhoods: To improve the health of young people in Southampton by leveraging cultural engagement as a protective factor. The project seeks to address structural inequalities in cultural access, understand young people's cultural experiences and health choices, and foster collaboration between young people and adults to enhance health and wellbeing.

REALITIES in Health Disparities: To reimagine health and social care systems to better address health disparities. The project involves co-researching and co-creating with communities to explore links between creativity, relationships, nature, and health, and to develop new systems that promote equitable health and wellbeing.

The Living Roots Project: To improve health equity in Ealing by understanding how community organisations perceive and prioritise health inequities and by creating a structure for a community asset and research partnership. The project aims to reduce the burden on overworked staff, establish shared health equity priorities, and explore models for collaboration with the Integrated Care System (ICS).

Weston-super-Mare Consortium: To reduce inequities in end-of-life care, bereavement support, social isolation, and loneliness in Weston and North Somerset. The project brings together health and social care workers, community providers, academics, and people with lived experience to collaboratively tackle these issues, using creative approaches and data analysis to understand and address local needs.

3. RESULTS

3.2.1 Synthesis - derived themes (aims and purpose)

Overall, the projects prioritised the integration of care through various collaborative practices . All of these practices involved engagement of diverse communities through various techniques of knowledge co-production for health. The projects also addressed structural issues and solutions at a local level for challenges presented by equity and access to health resources, the practical and appropriate use of evidence and research in practice and sustainability, and scalability of programmes and projects so that they will meet community needs.

Integrated care and collaboration: Emphasis on the integration of health and social care systems to address health disparities (e.g., NHS England Community Mental Health Framework, regional integrated care systems). Encouraging partnerships between voluntary, community, and statutory organisations to provide cohesive support (e.g., Fylde Coast Research Consortium, Building and Evidencing Community Asset Partnerships in Housing and Health).

Community engagement and co-production: Involving community members and people with lived experience in the design and implementation of health interventions (e.g., Building and Evidencing Community Asset Partnerships in Housing and Health, Pathways to Health Through Cultures of Neighbourhoods). Utilising participatory methods to ensure that services are tailored to the needs and preferences of the community (e.g., CAN-DO, Creating Change).

Health equity and access: Aiming to provide equitable access to healthcare and support services, particularly in disadvantaged communities (e.g., Weston-super-Mare Consortium, ReCITE). Addressing specific health disparities, such as breast cancer screening uptake in deprived areas (e.g., ReCITE).

Sustainable and scalable solutions: Developing sustainable models for integrating community assets into health systems (e.g., Fylde Coast Research Consortium, The Living Roots Project). Creating frameworks and infrastructures that can be scaled up and replicated in other regions (e.g., Pathways to Health Through Cultures of Neighbourhoods, REALITIES in Health Disparities).

Evidence-based practice and research: Emphasising the importance of evidence collection and research to inform policy and practice (e.g., Art at the Start, Building and Evidencing Community Asset Partnerships in Housing and Health). Conducting research to understand the drivers of health inequity and to develop targeted interventions (e.g., Fylde Coast Research Consortium, Creating Change).

3. RESULTS

3.3 Methods employed within projects

Art at the Start: This consortium investigated art-based supports for infant mental health in the UK, exploring families' experiences, accessibility, and desired outcomes. It examined differences in delivery across various settings, the experiences of service providers, and existing partnerships. The project aimed to identify gaps in research, strategy, and policy to support art-based infant mental health practices.

Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria: This project used the Assets-Based Community Development (ABCD) model, focusing on mobilising community strengths and assets rather than a needs-based approach. Equal power was shared with Experts by Experience (EbE), individuals who had faced chronic homelessness, to foster collective action. Four workshops were conducted to develop networks and connections among stakeholders, including academics, health and social practitioners, funders, and policymakers. The project aimed to co-produce and implement an Integrated Care Hub model that could be widely replicated.

Building REsearch by Communities to address inequities through expression – ReCITE: Inspired by a community-led model from East Africa, ReCITE adapted strategies used during COVID-19 in Liverpool to address health inequities. It employed a creative health approach and drew on evidence from previous phases of the project. Activities included a learning event, a final report, and a short film to disseminate the approach and its outcomes.

CHOICE: Employing stakeholder workshops and photovoice sessions, the research team used participatory approaches, data review by experts by experience and community members.

Community Asset Network – addressing Disparities in Outcomes (CAN-DO) Centred experiential learning from rural, coastal, and urban sites, guided by a complex systems approach. It involved co-learning among VCSE groups, public health teams, commissioners, and academics. The project identified local causes of health disparities and assets, aiming to mitigate these through collaborative, bottom-up approaches responsive to local needs.

Creating Change Collaborative action inquiry approach, engaged people with lived experience and practitioners as partners in exploring and addressing health disparities. The project focused on co-inquiry, critical questioning, and reflection to innovate and sustain creative health provision practices.

3. RESULTS

3.3 Methods employed within projects

Fylde Coast Research Consortium: Followed recommendations from the Chief Medical Officer's Annual Report and NHS Long-Term Plan. It aimed to integrate services and enhance community-based health and social care. The project utilised provision mapping and social network analysis for a comprehensive understanding of community support resources. Co-production groups and research capacity-building workshops were conducted, focusing on collaborative and interdisciplinary approaches to address cultural barriers and enhance collective responsibility among stakeholders.

Organisations of Hope: Building on Greater Manchester's tradition of arts in healthcare, this project aimed to deepen understanding of creative health practices. It developed multidisciplinary research teams to explore and innovate methodologies addressing health inequalities. The project drew on existing research and regional strategies, using systems mapping and creative health practices to inform new approaches and collaborations.

Pathways to health through cultures of neighbourhoods: Focusing on young people, this project aimed to understand their needs and experiences to develop culturally engaging health programmes. It involved young people as researchers and community advocates, ensuring their voices were heard in the development of integrated care systems. The consortium adopted a co-ownership model, enabling equal dialogue between young people and decision-makers. The project combined expertise to create a shared theory of change for improving young people's health outcomes.

REALITIES in Health Disparities: Proposed a model for measuring change in complex health and social care systems. It embraced a creative-relational inquiry to integrate diverse methodologies and perspectives, acknowledging both scientific and lived experiences. The approach aimed to reconcile different views and understandings of health disparities, promoting a holistic and inclusive evidence base.

The Living Roots Project: Participatory and iterative approach, developing an emergent theory of change. It used a participatory, action-oriented, and asset-based methodology, centring collaboration and inclusion. The project incorporated a ‘creative health' approach, focusing on promoting wellbeing and flourishing through strength-based strategies. It engaged in a whole systems approach, understanding health inequities through intersecting factors and power relations, beyond just social determinants of health.

Weston-super-Mare Consortium: Established a community network of over 100 members, including health and social care stakeholders, community assets like arts organisations, and community members. The network held several meetings, featuring cross-sector discussions and mapping of community assets using Understory software. They organised the Good Grief Weston festival to open conversations around death and bereavement and created a directory of community assets and a data dashboard in collaboration with North Somerset Council. The project was influenced by the transition to Integrated Care Systems (ICS) and evidence showing the benefits of creative- and arts-engagement activities

3. RESULTS

3.3.1 Synthesis - derived themes (methods)

Programmes typically encompassed validated methodologies within their design, focusing on developing an art intervention but also in collecting evidence for its efficacy. As such programmes reported various evidence syntheses, including collaboration with stakeholders, mixed-method research, community engagement, adaptation based on practical experiences, and the need for further research in the field.

Applied evidence: Many projects used the learning and knowledge produced through their activities to deepen community member engagement with health assets and health awareness (CHOICE; Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria; Weston super-Mare Consortium; The Living Roots Project; Pathways to health through cultures of neighbourhoods; Fylde Coast Research Consortium; Art at the Start; Organisations of Hope; CAN-DO; REALITIES; Creating Change.

Asset and mapping: The majority of the projects described existing assets for health in their communities and affirmed their importance for community members through co-produced and collaborative activities (CHOICE; Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria; Weston Super-Mare Consortium; The Living Roots Project; Pathways to health through cultures of neighbourhoods; Fylde Coast Research Consortium; Organisations of Hope; CAN-DO; REALITIES; Creating Change).

Collaboration: Most projects described the importance of collaboration with stakeholders. (CHOICE; Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria; Weston Super-Mare Consortium; The Living Roots Project; Pathways to health through cultures of neighbourhoods; Fylde Coast Research Consortium; Art at the Start; Organisations of Hope; CAN-DO; REALITIES; Creating Change).

Community and human centred research: Putting people first through interactive and co-produced activities characterised the programme events of most projects (CHOICE; Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria; Weston Super-Mare Consortium; The Living Roots Project; Pathways to health through cultures of neighbourhoods; Fylde Coast Research Consortium; Art at the Start; Organisations of Hope; CAN-DO; REALITIES; Creating Change).

Relationship building for intentional equity production: All projects put making and extending relationships in communities and with community members at the heart of their methods approaches for generating data and evidence.

3. RESULTS

3.4 Participants engaged in projects

Art at the Start Consortium: 7 academics, 6 community co-investigators, a peer researcher. Public engagement: 700 at events, 509 survey participants. Targeted outreach: 256 parents facing health inequalities.

Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria: Participants recruited through networks such as Voluntary Organisations North East and others, with snowball sampling. Specific involvement: 8 Experts by Experience facilitated by Tyne Housing.

Building REsearch by Communities to address inequities through expression – ReCITE: Engaged women: 89 through surveys, over 800 at roadshows. Specific involvement: 20 community innovation team members, extensive outreach via texts, calls and mail.

CHOICE: Hundreds of participants from voluntary, statutory, and academic organisations. Specific involvement: Over 50 service users in workshops, experts by experience on symposia panels and talks.

Community Asset Network – addressing Disparities in Outcomes (CAN-DO): Engaged individuals: Approximately 200 people, including young and older people, community leaders, and volunteers. Approach: Informal relationship building without collecting detailed demographic data.

Creating Change Participants: 80 professionals from 67 organisations, 76 people with lived experience. Specific involvement: Engaged through place-based inquiries and workshops, focusing on creative health experiences.

Fylde Coast Research Consortium Representatives: 49 from community organisations. Co-production groups: 30 co-researchers (11 public, 16 service providers, 3 academic). Workshops: 50 in capacity building, 69 in knowledge exchange events.

Organisations of Hope Overall engagement: 672 people. Specific involvement: 272 in structured research (30 in ethics workshops, 170 in strategy workshops, 75 young people, 85 older adults, 72 in conversations). Diverse group participation: From various organisations.

REALITIES in Health Disparities Participants: Vulnerable community members including prisoners, ex-offenders and refugees. Involvement: Embedded through longstanding local collaborations.

Pathways to health through cultures of neighbourhoods: Young researchers: 20, aged 14-16. Specific involvement: Over 200 young people in creative workshops, and adult community members in asset mapping and interviews. Consortium: Over 30 organisations.

The Living Roots Project: Steering committee Expanded from 8 to 19 members. Peer researchers: 10, youth co-researchers: 3, youth advisory board: 5-7 members. Specific involvement: Consulted over 150 young people, 15 in arts-based research, and over 200 South Asian women in chai and chat sessions.

Weston-super-Mare Consortium Network: Growth from 50 to 100 members. Festival attendance: Approximately 3000, with diverse demographic data from 205 surveys. Specific involvement: 8 public focus group members, an average of 46 participants at network meetings, and well-attended training events.

3. RESULTS

3.4.1 Synthesis - derived themes (methods)

Approximately 7,500 participants took part in phase two of this programme through co-produced community-based events and activities. Because contact occurred with a broad range of people across the life course as well as social, professional and economic boundaries we estimate the impact of these programmes to have been magnified.

We relied on the rough estimates provided by the projects. As such, the reach in terms of direct participation may be slightly higher or lower. We find it difficult to estimate indirect impact which has to include the ongoing existence of the health asset in local communities and the greater awareness community members will have of health assets local to them. This speaks to demand on the one hand and to sustainability on the other.

3.5: Impact and outputs from projects

Art at the Start impact: Mapped arts-based supports for infant mental health across the UK. Outcomes: Trained nursery staff and caregivers, promoting early years art making. Hosted training events for NHS and arts professionals. Engaged in policy discussions and showcased as a best practice in parliamentary groups.

Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria impact: Enhanced public involvement and community engagement in research. Outcomes: Increased confidence and reduced stigma among participants. Positive regional attention, with involvement in major health and care initiatives. No negative outcomes reported, with continued enthusiasm for collaboration.

Building REsearch by Communities to address inequities through expression ReCITE impact: Raised breast cancer awareness and improved attendance at screenings in North Liverpool. Outcomes: Developed a data dashboard for tracking health equity. Built a multi-disciplinary team for creative health approaches. Became finalists for a local culture and creativity award. Developing a toolkit for training and case studies.

Community Asset Network – addressing Disparities in Outcomes (CAN-DO) impact: Established a research consortium to address health inequalities. Outcomes: Produced films, reports, and graphic illustrations to document community work. Developed models for engaging with underrepresented groups. Collaborated on funding applications for further research.

3. RESULTS

3.5 Impact and outputs from projects

CHOICE impact: Successfully united four community-based mental health organisations to tackle health and social inequalities collaboratively. Outcomes: Established collaborative links with major health and social policy-makers in Northern Ireland (NI). Formed an expert-by-experience research group funded by the Bamford Centre. Positive reception of the photo voice project among participants, with interest in continuing arts and other projects. Completed a film about CHOICE for broadcast on community television. Assisted ArtsCare NI in transitioning from hospital to community-based activities. Worked towards enhancing university inclusivity for people with mental health issues.

Creating Change impact: Developed a programme theory and logic model for creative health provision. Outcomes: Generated evidence to challenge existing public health models.

Fylde Coast Research Consortium impact: Enhanced collaboration among health and social care providers through provision mapping and social network analysis. Outcomes: Identified community needs and improved service integration. Organised workshops and knowledge exchange events. Addressed challenges in co-production and service accessibility.

Organisations of Hope impact: Piloted creative health research approaches and built capacity among practitioners. Outcomes: Contributed to Greater Manchester's creative health action plan and strategy. Drafted reports on professional development and funding landscapes. Produced various media outputs to promote creative health.

Pathways to health through cultures of neighbourhoods' impact: Established a research and knowledge exchange architecture influencing policy and strategy in Southampton. Outcomes: Engaged young people in decision-making processes through youth-driven research. Contributed to policy developments in children and young people's health and social care. Developed a young researcher training programme and secured funding for training resources.

REALITIES in Health Disparities impact: Co-produced a systems-level model with deprived communities and stakeholders. Outcomes: Established asset hubs and conducted participatory-action workshops. Contributed to policy changes and engaged international stakeholders. Expanded consortium and secured funding for ongoing phases.

The Living Roots Project impact: Contributed to higher community participation and influence in Ealing, fostering partnerships and understanding community needs. Outcomes: Enhanced community dialogue through arts events and peer researcher programmes. Strengthened partnerships between VCSE organisations and local councils. Currently preparing final reports and project website.

Weston-super-Mare Consortium impact: Produced a wide range of impactful outputs promoting end-of-life care and bereavement support. Outcomes: Presented at international conferences and local stakeholder meetings. Published multiple articles and blogs, influencing policy and practice. Launched an online directory of community assets and a comprehensive data dashboard. Developed a strong, multi-sector network and created new roles. Secured additional funding through collaborations and prepared for further funding applications.

3. RESULTS

3.5.1 Synthesis - derived themes (impact and outputs)

We have described in the foregoing section direct and indirect impacts of the projects. In this section we consider a range of tangible impacts observable in communities from the projects as they delivered a range of activities.

Health asset generation: This theme we infer from the ways in which projects described their activities in terms of impacts and outcomes. Those can be found below, and we stress the importance of this theme as it demonstrates that investment in community assets for health not only identify such resources in communities that already exist but also develop new assets for communities relative to the projects' priority areas.

Relationship building and collaboration: As noted above, all of the funded projects placed building relationships at the centre of their methods of engaging with and in communities. These links then supported collaborations and trust building that aided in delivery of project and learning activities.

Impact

Created conditions for more public involvement and community research (Capacity building) (e.g. Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria; CHOICE; Fylde Fylde Coast Research Consortium; Organisations of Hope).

Established collaborations (e.g., CAN-DO; REALITIES in Health Disparities).

Generated strategies and evidence (eg. Creating Change; Realities CHOICE; Pathways to health through cultures of neighbourhood)**.**

Knitted together existing health assets (e.g., CHOICE; Art at the Start; Organisations of Hope).

Motivated desire for future work (e.g., Fylde Coast Research Consortium; ReCITE; Pathways to health through cultures of neighbourhoods).

Varied impacts through applied research (all of the projects achieved this objective).

Outcomes

Broad Range of outputs oriented towards capacity building - training - and knowledge generation.

Produced evidence of successful collaboration for policy and public engagement with specific groups and with the general public (all of the projects achieved these outcomes successfully).

3. RESULTS

3.6 Enablers and barriers to project delivery

Art at the Start Enablers: Policy Support: Support from Scottish Government initiatives. Network Development: Building powerful cross-disciplinary networks. Proof of Concept: Demonstrated proof of concept for creative health approaches. Barriers: Funding Limitations: Short funding period limiting administrative processes. Knowledge Gaps: Institutional knowledge gaps in sustaining creative approaches. Network Sustainability: Challenges in sustaining network collaboration post-project.

Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria Enablers: Energy and Engagement: Galvanising regional energy and engagement. Short-Term Success: Achieving significant progress in a short period. Workshops Continuity: Commitment to continue funding workshops if unsuccessful. Barriers: Diversity in Engagement: Limited diversity in expert by experience (EbE) group. Funding Uncertainty: Dependency on third-phase funding for continued engagement. Short-Term Funding: Challenges posed by short-term funding streams in health and social care.

Building REsearch by Communities to address inequities through expression - ReCITE Enablers:Team Diversity: Multi-disciplinary team enhancing project strength. Creative Approaches: Use of creative approaches adding value. Community Relationships: Strong community relationships aiding logistics. Barriers: Time Constraints: Primary care staff availability impacting project engagement. Data Quality Issues: Challenges in data quality from GP practices. Financial Mechanisms: Slow subcontracting processes hindering project sustainability.

CHOICE Enablers: Passion and Commitment: Stakeholders' dedication and willingness to collaborate. Data Utilisation: Use of impactful data from ADR-UK studies. Accomplishments: Nearly achieving all project goals despite ambitious aims. Barriers: Governmental Impact: Northern Ireland's lack of government affecting funding. Stakeholder Enthusiasm: Maintaining coalition enthusiasm amid organisational threats. Engagement Challenges: Difficulty in scheduling meetings with experts by experience.

Community Asset Network – addressing Disparities in Outcomes (CAN-DO) Enablers: Partner Diversity: Broad partner base enhancing project inclusivity. Existing Relationships: Leveraging existing relationships for quicker community engagement. Collective Enthusiasm: Collective enthusiasm for addressing health inequalities. Barriers: Short-Term Nature: Short project duration limiting partnership development. Engagement Prioritisation: Competing with other priorities in busy calendars. System Embedding: Need for more time to embed consortium in the system.

Creating Change Enablers: Funding Impact: Instrumental funding supporting systemic change efforts. Lived Experience Involvement: Valuing and paying for lived experience contributions. Network Momentum: Building momentum and clarity with partners. Barriers: Initiative Clarity: Uncertainty in project's differentiation from other health initiatives. Sustainability: Challenges in sustaining creative health infrastructure. Next Phase Funding: Dependency on phase three funding for continuity.

3. RESULTS

3.6 Enablers and barriers to project delivery

Fylde Coast Research Consortium Enablers: Dedicated Team: Large team of dedicated experts and professionals. Engaging Activities: Engaging activities ensuring project progression. Clear Objectives: Clearly defined aims and objectives improving resource utilisation. Barriers: Recruitment Challenges: Difficulty in recruiting from marginalised and underrepresented populations. Project Timelines: Short timelines impacting meaningful engagement. Ownership Challenges: Perception of top-down ideas hindering ownership development.

Organisations of Hope Enablers: Timely Funding: Funding coinciding with relevant policy developments. Infrastructure Support: Support from existing infrastructure partners. Creative Research: Welcoming approach to creative research methods. Barriers: Short Funding Period: Limited time for necessary administrative processes. Scheduling Difficulties: Complex scheduling due to limited lead-in time. Clarity with Partners: Uncertainty in project's relation to other health initiatives.

Pathways to health through cultures of neighbourhoods Enablers: Community Involvement: Extensive community involvement in health and wellbeing. Equitable Framework: Investment in people through equitable frameworks. Logistical Support: Provision of logistics and day-to-day support. Barriers: Institutional Processes: Complex institutional processes hindering participation. Engagement Challenges: Challenges in engaging marginalised populations. Geographical Focus: Difficulty in recruiting from underrepresented regions.

REALITIES in Health Disparities Enablers: Barrier Mitigation: Addressing transport, digital, and mental health barriers. Community Engagement: Engagement through participatory design principles. Support Strategies: Strategies like ‘allying' and ‘resourcing' supporting community needs. Barriers: Complex Needs: Challenges in addressing varied psycho-social barriers. Political Tensions: Potential tensions within and across refugee groups. Iterative Response: Need for iterative responses to community tensions.

The Living Roots Project Enablers: Funding Support: Critical funding enabling project execution. Policy Alignment: Alignment with new Health and Wellbeing Strategy. Steering Committee: Dedicated committee driving project values. Barriers: Sustainability of Involvement: Challenges in sustaining peer researcher involvement. ICS Integration: Difficulties in linking project work with newly formed ICS. Young Researcher Support: Complex institutional processes challenging for young researchers.

Weston-super-Mare Consortium Enablers: Leadership and Vision: Strong leadership driving shared vision. Public Engagement: High engagement levels in community events. Creative Approach: Success in blending creative and health domains. Barriers: Survey Response Rates: Lower-than-expected response rates from surveys and focus groups. Weather Disruption: Event disruptions due to weather necessitating venue changes. Evaluation Challenges: Difficulties in synthesis of evaluation methods due to funder constraints.

3. RESULTS

3.6.1 Synthesis - derived themes (enablers and barriers)

All of the funded projects utilised their funding to build consortia that would identify and establish health assets in local communities. Funding and collaboration emerged as both enablers and barriers for project success. These strategic inputs facilitated projects' objectives and also created challenges for them particularly around logistics and long-term sustainability. Projects used funding in ways relevant to the communities and the objectives they intended to meet. The strategy of co-producing health knowledge and health activities requires co-ordination, partnerships in communities and enthusiasm for the work.

Enablers

Collaboration: Collaboration and partnerships can be both barriers and enablers. Partnerships take time to grow and trusting relationships need to be fostered and made over time. There are different paces of work and different styles of work in different sectors. All of the projects utilised this strategy.

Collective enthusiasm: This qualitative attitude was recognised as a significant input that helped motivate work based in communities. (e.g., CHOICE; Building and evidencing community asset partnerships in housing and health to address health disparities in North-East Cumbria; Pathways to health through cultures of neighbourhoods; Fylde Coast Research Consortium).

Existing relationships: A number of projects recognised the advantage of having existing relationships in communities on which they could build their consortia and project activities. (e.g., Art at the Start; CAN-DO; Pathways to health through cultures of neighbourhoods; Organisations of Hope).

Funding: Funding was described as both a barrier and an enabler, with several projects commenting on how things can slow down or grind to a halt if no further funding is in place. Additionally with funding shortages community organisations might rely on volunteers to staff their projects, which is not always sustainable.

Strategic alignment for data, policy logistics: Broad awareness of context and structural circumstances enabled projects to leverage these insights to achieve project goals. (e.g., Weston-super-Mare Consortium; The Living Roots Project; Pathways to health through cultures of neighbourhoods; Art at the Start; Organisations of Hope; CAN-DO; REALITIES in Health Disparities).

3. RESULTS

3.6.1 Synthesis - derived themes (enablers and barriers)

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Barriers

Collaboration: Collaboration and partnerships can be both barriers and enablers. Partnerships take time to grow and trusting relationships need to be fostered and made over time. There are different paces of work and different styles of work in different sectors. All of the projects utilised this strategy.

Funding: Funding was described as both a barrier and an enabler, with several projects commenting on how things can slow down or grind to a halt if no further funding is in place. Additionally with funding shortages community organisations might rely on volunteers to staff their projects, which is not always sustainable. Projects also mentioned the challenges presented by short-term funding streams.

Logistics and scheduling: Building consortia and partnerships through community-based activities requires co-ordination of multiple people, timelines and organisations which adds complexity to project undertakings (e.g., The Living Roots Project; CHOICE; Building REsearch by Communities to address inequities through expression - ReCITE; Organisations of Hope; CAN-DO; REALITIES in Health Disparities).

Recruitment challenges: Because the broad objective of the community-based projects concerns making health assets in communities more accessible, one of the challenges is reaching people who can benefit from project programmes but who might not immediately step forward for participation. Sustaining contact with those groups as well as maintaining and building relationships after projects have finished remain core activities. (e.g., Weston-super-Mare; The Living Roots Project; Pathways to health through cultures of neighbourhoods; Fylde Coast Research Consortium).

Sustainability of stakeholder engagement: This concerns future orientation and recognising the need to support relationships in communities as well as find sources of ongoing funding and being positioned to respond to existing and emerging community health needs especially post project (e.g., CHOICE; Art at the Start; Creating Change).

4. DISCUSSION

4.1 Introduction

The UK Research and Innovation (UKRI) body funded 16 projects under Phase 2 of the programme “Mobilising Community Assets to Tackle Health Inequalities”. These ran throughout 2023. They took as their goal building cross-sectoral consortia to address health inequalities as experienced in a diverse range of communities and localities from across the UK, including some of the most economically deprived areas.

4.2 Aims

The aims, reach and participant groups of the projects were intentionally broad and heterogenous and had four broad objectives: 1) Enhance integrated care and collaboration; 2) Strengthen community engagement and co-production; 3) Support health equity and access; 4) Develop sustainable and scalable solutions for integrating community health assets into health systems. Phase 2 projects have impacted an estimated 7,500 people across the life course, across genders, classes and ethnicities. Each project actively created conditions for greater public involvement in community research for health, thus helping to build capacity, which generates local community health benefits.

4.3: Priorities and activities

Phase 2 activities prioritised care integration through various collaboration strategies and programmes. These supported stakeholders to actively produce health knowledge relevant to them via consumption of resources people in local communities identified as assets relevant to health and wellbeing. Activities and projects took place in spaces, places and at times accessible for community members. As a result, projects offered local level solutions to some of the challenges presented by equity and access barriers to health resources in communities, especially as experienced by the most vulnerable.

Through mapping and knitting together existing community assets that speak to health needs in various ways, Phase 2 programmes produced new assets for health in communities as an outcome of building consortia via community assets. Appropriate funding levels supported project ambitions to build relationships across organisations, institutions and communities, which helped address structural barriers to healthcare access. The consortia resulting from Phase 2 projects have demonstrated the practical and appropriate use of evidence and applied research in service of sustainable and scalable health services that address community needs.

Relationship building features as central to effective utilisation of community strategies for applying identified asset for health that exist in local areas. Co-design, co-production and participatory methods worked effectively as practice-based strategies that align available service offers to the needs and preferences of community members. Devolved authority and the rooting of programmes in local knowledge helped identify communities and individuals challenged by equitable access to healthcare and support services. Consequently, these projects intentionally build health equity as a feature of new look health systems.

4. DISCUSSION

4.4 Challenges

That collaboration and partnerships can function as both barriers and enablers to community asset access for health and equity emerged as a key finding. Fostering partnerships and trust takes time. Sustaining stakeholder engagement and reaching target communities requires qualitative investment in making and maintaining relationships in communities and with community members. Building relationships for partnering requires a shared focus on planning, logistics and funding.

4.5 Outputs and outcomes

Phase 2 projects generated a broad range of outputs oriented towards capacity building - training - and knowledge generation. They have also produced evidence and modelled successful collaboration for policy and public engagement with specific groups and with the general public.

"Factors that supported the project are predominantly the passion and commitment of the various stakeholders, their willingness to work together and the ideas that emerged from regular meetings and discussions. Maintaining the enthusiasm of the coalition can be a challenge, particularly in the midst of various threats to their own organisations."

"Of enormous help was the use of hard facts - data that we gathered from our ADR-UK studies on physical health of people with SMI - which demonstrates the issues in stark terms and is often the only information to which the government and policy makers will pay attention."

"We developed really productive relationships with our EbE, who we consider part of our team and are looking forward to continue engaging with (in the shape of a co-authored article, currently) however, in order to achieve this, we spent a substantial amount of time getting to know them as people, and vice versa."

"We were delighted and humbled by the amount of interest that we have attracted from practice and policy partners, highlighting the fact that this is an issue many organisations are grappling with across the system. This could not be led 'just' as a research project but needed the genuine commitment of all involved."

4. DISCUSSION

4.6 What do the results mean?

The range of successful Phase 2 projects demonstrates the capacity to develop and enact sustainable models for integrating community assets into health systems. Since health issues manifest in integrated communities of people, so too do the assets that can effectively address many of the health challenges people in local communities face. Funded projects evidenced why and how they meet the needs of local stakeholders and reach target groups and communities, especially the most vulnerable. The qualitative factors of building on existing relationships, and harnessing enthusiasm mattered for creating successful programmes in Phase 2 as much if not more than strategic alignments for data and evidence generation. None the less, building effective response and feedback channels for policy and implementation remain a core activity for success.

4.7 Why do the results matter?

Phase 2 projects helped create the conditions for their own success and acceptance by stakeholders. By mapping and building on existing community assets for health, new community grounded health resources that prioritise accessibility and community needs can be built. Effective economic investment in model programmes can generate sustainable, scalable and acceptable health infrastructure for and with communities that will help reduce health inequities. Capacity building results in learning about and being responsive to community health needs. This work requires energy and willingness to practice care and to build equitable structures.

"First, we point to the power of involving young people in research in thoughtful ways, listening to what they have to say, and bringing them together with decision makers on equal terms… Young people are agents for change in their communities."

"Second, placing equity at the centre of research, whether through flat hierarchies, compensation, or participant skills development positively influences knowledge exchange dynamics, establishes an environment for co-ownership, and provides example and opportunity for the reduction of health inequalities."

4. DISCUSSION

4.8 Limitations

The range of successful Phase 2 projects demonstrates the capacity to develop and enact sustainable models for integrating community assets into health systems. Since health issues manifest in integrated communities of people, so too do the assets that can effectively address many of the health challenges people in local communities face. Funded projects evidenced why and how they meet the needs of local stakeholders and reach target groups and communities, especially the most vulnerable. The qualitative factors of building on existing relationships, and harnessing enthusiasm mattered for creating successful programmes in Phase 2 as much if not more than strategic alignments for data and evidence generation. None the less, building effective response and feedback channels for policy and implementation remain a core activity for success.

4.9 Recommendations

Further field research ought to be undertaken to describe and analyse project methods and assumptions since projects reported a broad range of approaches to consortia building and how community assets respond to health needs and potentially produce new health assets. Given that a number of projects identified the issue of maintaining their collaborations as a key challenge, further work could explore how this is addressed in an ongoing, sustainable way.

5 Conclusions

The 12 Phase 2 funded projects discussed here have reached more than 7,500 people directly. The economic investment in these projects has resulted in the active creation of positive conditions for greater public involvement in community research for health. Projects have helped identify and strengthen existing assets in communities that can address health needs and inequalities through a broad range of successfully co-designed and co-produced activities. Consortia have generated new knowledge on how to build scalable health programmes with communities that, taken collectively, generate health knowledge across broad age ranges, genders, classes and ethnicities.

By building effective consortia, they have enhanced collaboration, shown a commitment to community engagement, improved health equity by enhancing access to community assets and public health resources which are better integrated into communities and responsive to community members' needs. Logistical and funding challenges remain, and these must be addressed to sustain the integration of community health assets into health systems rationally through evidence and experience, and in diverse and creative ways.

KEY TAKEAWAY: Future research should ensure enough time is built into the project to build trusted relationships with communities and fully engage co-researchers in the design of the objectives, approaches, and methods. Academic researchers should be accessible and be an integral part of the co-production groups to break down barriers and build trust in the research process.

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