Communities in Control

A mixed method evaluation of the Big Local community empowerment initiative in England

Keywords

disadvantaged communities, community empowerment, health inequalities, longitudinal evaluation, natural policy experiment, mixed methods, qualitative research, system theory.

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Disclosure of interest: none declared by any of the authors

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A final version (which has undergone a rigorous copy-edit and proofreading) will publish as part of a fuller account of the research in a forthcoming issue of the Public Health Research journal.

Any queries about this 'first look' version of the scientific summary should be addressed to the NIHR Journals Library Editorial Office – journals.library@nihr.ac.uk

The research reported in this 'first look' scientific summary was funded by the PHR programme as project number 16/09/13. For more information visit https://fundingawards.nihr.ac.uk/award/16/09/13

The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The PHR editors have tried to ensure the accuracy of the authors' work and would like to thank the reviewers for their constructive comments however; they do not accept liability for damages or losses arising from material published in this scientific summary.

This 'first look' scientific summary presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the PHR Programme or the Department of Health and Social Care. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the PHR Programme or the Department of Health and Social Care.

Scientific summary

Background:

This research was commissioned in response to a call in 2016 by the NIHR Public Health Research Programme (PHRP) for research 'to address urgent gaps in the evidence on which interventions, using a community engagement approach, are effective in improving health and wellbeing and reducing health inequalities'. We identified that the most glaring gaps were in relation to community empowerment initiatives. In theory these have great potential for reducing health inequalities but research has focused instead on initiatives adopting a much narrower model of engagement of communities in professional-led interventions. We were able to take advantage of the Big Local (BL) programme across England: a rare example of an nation-wide experiment in community empowerment.

BL is the largest community empowerment initiative implemented in England. Launched in 2010 with £271m from the National Lottery Community Fund, and ending in 2026, it involves giving 150 relatively disadvantaged communities in England control over £1 million each to enable residents to improve their neighbourhoods. It is overseen by a national organisation, Local Trust, and managed by a BL Partnership board in each area, with at least 51% resident

members. Our Communities in Control Study (CiC) is a long-term evaluation spanning seven years, with the latest three years funded by PHRP. It offers an unparalleled opportunity to learn from the BL experience for future community empowerment initiatives, focusing on the effects on health and wellbeing and on reducing health inequalities.

Research Objectives:

Building on two earlier phases in 2014-15 and 2015-17, the objectives of this third phase of the CiC study were to:

1. Investigate longer-term population-level health and social outcomes of BL
2. Investigate impacts of BL on health and wellbeing of engaged residents
3. Assess changes in collective control over decisions and actions amongst BL residents and pathways to changes identified
4. Illuminate residents' perspectives on health and wellbeing impacts and pathways to these
5. Conduct an economic evaluation of BL
6. Draw out implications for future design and evaluation of place-based initiatives that aim to increase collective control particularly in disadvantaged communities.

Methods

The study adopted a systems theoretical framework. It is a longitudinal mixed methods evaluation comprising four work packages.

Work Package 1 focussed on Objective 1. Secondary data were analysed to assess whether BL had any positive impacts on social and health outcomes for populations in BL neighbourhoods. It employed difference-in-difference methods comparing changes in outcomes in BL areas to those in comparator areas between 2011-2015 and 2016-2019. Comparator areas were matched to BL areas based on observed characteristics such as the Index of Multiple Deprivation, population ethnic and age profiles from the 2011 Census and the Office for National Statistics (ONS) Area Classification. The primary outcome, from the Annual Population Survey (APS), was a binary variable taking the value 1 if individuals reported a score of more than 6 in response to the question "Overall, how anxious did you feel yesterday?", where 0 is `not at all

anxious' and 10 is `completely anxious'. Secondary outcomes included a composite measure of population mental health, recorded crimes and antisocial behaviour.

Work Package 2 addressed Objective 2, assessing whether BL had any positive health impacts for actively engaged residents using the 2016, 2018 and 2020 waves of a biannual survey of BL Partnership members conducted by Local Trust. The analysis used both the repeated cross-sectional sample provided by the survey and a nested cohort of Partnership members who completed all three surveys. The primary outcome was the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) and the secondary outcome self-rated general health status. Unfortunately, we were unable to construct comparators, because the relevant questions were not in the APS in 2018 and the survey was not undertaken in 2020.

Work Package 3 addressed Objectives 3 and 4. First, qualitative in-depth interviews with national BL stakeholders and informants with expertise in place-based policies aimed to identify changes in the BL programme over time and explore the relationship with national policy. Second, continuing our longitudinal qualitative research we conducted 171 interviews in 14 areas, with people actively involved with BL from November 2018 to January 2021 (overlapping with the pandemic). Interviews covered perceptions of processes enabling or constraining residents' attempts to improve their area and the impact of BL on health and wellbeing. In the analysis we drew on the data from earlier phases of the CiC study. We also conducted observations of BL Partnership meetings.

Work Package 4 addressed Objective 5 by conducting a cost-benefit analysis using the life satisfaction approach, which compares the impact of an intervention on life satisfaction to the impact of an increase in income on life satisfaction. It used the difference-in-difference estimate of the impact of BL on life satisfaction from WP1, estimates of annual household income in BL areas from the ONS and average household sizes in the BL areas from the 2011 Census to put a monetary value on the benefits generated by BL. It then compared the benefits to the costs i.e., the funding BL areas received and the value of the unpaid hours provided by BL Partnership members (estimated from responses to the biannual survey of BL Partnership members).

Results:

Objective 1: we found limited evidence for population-level social or health impacts in BL areas compared with comparators. The estimated impact on the primary outcome – reporting high anxiety yesterday – was small and not statistically significant (-0.8 percentage points, 95% CI = -2.4 to 0.7). Similarly, the estimated impacts on the secondary outcomes were small and not statistically significant, with the exception of burglary (-0.054 change in z-score, 95% CI = -0.100 to -0.009). However, there is evidence that BL had some effect on reducing levels of anxiety after 2017. Furthermore, in BL areas that had spent more than 80% of their grant by 2019/20 and thus had made the most progress implementing their plan, we found a statistically significant reduction in the composite measure of population mental health (-0.053 change in z-score, 95% CI = -0.103 to -0.002), indicating an improvement in mental health. This improvement in mental health was greater in BL areas that had spent more than 80% of their grant *and* prioritised social activities, whilst the reduction in burglaries was also larger when the analysis was limited to these BL areas and greater still in those in this group that had focused on environmental activities.

Objective 2: Impact of BL on engaged residents varied between the cohort and cross-sectional data and by sub-groups. In the nested cohort there was a significant increase in mental wellbeing in engaged BL residents in 2018 but this was no longer significant by 2020. However, this may be explained by the fact that the 2020 survey was delivered in summer during the COVID-19 pandemic when the mental wellbeing of the whole country had declined,

The bias created by the COVID-19 pandemic potentially affects both the outcomes and all of the explanatory variables, making interpretation of the 2020 survey data problematic. However, across all waves – even in the 2020 COVID-19 data point - residents who perceived that people in the area are willing to help each other and those who agreed that collectively they can influence decisions in the area had a significantly higher mental wellbeing score. Hours volunteered also had a small positive association with increased mental wellbeing in both the nested cohort and the repeated cross-sectional analyses, for both men and women and for both high and lower educated groups.

There is some evidence of unequal benefits across sub-groups. For the cohort, there was a significant improvement in the mental health score in 2018 and 2020 among those with one or more degrees but not for those with 'no degree'. In both study designs, collective control and willing to help in the area had positive associations with mental wellbeing. In the repeat cross-section, residents in the lower education group who agreed that they had collective control had a higher mental wellbeing score in 2018 and 2020 than those that did not. In the cohort, the positive association with collective control was present for both educational groups. Together, these results suggest that the health benefits of BL participation – especially for lower educated residents - may depend on whether they felt a sense of collective control.

The results for gender were similarly mixed across the study designs. In the cohort there was no significant difference in mental wellbeing over time for women but men had a significant increase in the short term only (2018). In the repeat cross-section, higher educated women had a small significant increase in mental wellbeing in 2020. Collective control was positively associated with higher mental wellbeing scores for women and - especially - men. Feeling that people in the area were willing to help was positively associated with mental wellbeing for women but not for men.

Objective 3: We utilised qualitative data to explore changes in collective control. Qualitative, empirical markers derived in earlier phases of CiC revealed increasing capabilities for collective control – defined as different types of power - over time. Residents in all fieldwork sites reported growing confidence in their individual and collective ability to improve the area (*power within*); greater understanding of the need for alliances to deliver improvements and enhanced skills in forging and sustaining external relationships (*power with*); and in all these areas meaningful improvements were delivered (*power to act*). Using longitudinal data, we also started to identify new qualitative markers which signalled an evolution of collective control capabilities and milestones of this evolution through three programme stages: *initial implementation*, *developmental* and *bedding in*.

However, there was variation across BL areas. Local dynamics - internal and external to BL Partnerships – could undermined residents' ability to develop the forms of power needed to exercise collective control and also limit the potential for collective control capabilities to develop in the wider community. Without input from support workers, other professionals and local organisations, achievements in some BL areas would have been compromised. On the other hand, these actors sometimes also behave in ways that undermined the development and exercise of collective control capabilities by residents.

Objective 4: Qualitative data illuminated residents' perceptions of BL's impact on health and wellbeing. Frequent references were made to positive impacts on mental wellbeing at individual and collective levels. Varied pathways were identified including improvements in social connectivity and cohesion, the physical environment and material living standards. However, there were also accounts of negative impacts on individuals, most often arising from problematic relationship dynamics and/or the burden of responsibility associated with BL Partnerships, particularly with leadership roles. Residents experiencing difficulties frequently 'stepped back' from the Partnership: sometimes temporarily, sometimes permanently. This response reflects the complex relationships many had with BL. Despite sometimes significant negative impacts, residents often also stressed positive benefits from involvement. As a national participant observed, part of the reason why community initiatives may encounter challenges or at times fail is not because people involved are '*not thoughtful',* but because *'being resident led is hard'*.

Objective 5: The economic analysis suggests that the benefits of BL exceed its costs. The estimated benefits vary across the 150 BL areas due to variation in household income, household size and the number of residents in each area. There are also variations in the costs across BL areas. In total, the estimated annual benefits for all BL areas are £270 million, so over the 4-year period from 2016 to 2019 the total benefits are £1,080 million. The total costs are £121 million, so the net benefits are £959 million. Sensitivity analyses suggest that BL's impact on life satisfaction needs to be much lower than our current estimate before the net benefit becomes negative. Using the current estimate combined with the most conservative

assumptions for the other elements of the cost-benefit calculations generates a net benefit estimate of £64 million.

Conclusions:

BL has spanned a decade of unprecedented cuts in public sector finances, restrictions on welfare benefits and latterly the COVID pandemic. Despite this difficult context, our findings suggest that capabilities for collective control amongst engaged BL residents had increased considerably and they had exercised this control to deliver demonstrable improvements in their neighbourhoods. However, the story is complex. Increases in capabilities for collective control were not always linear and progress varied across BL Partnerships.

There is tentative quantitative evidence that BL improved mental health and reduced burglaries, especially in areas making most progress implementing plans. There is also evidence of improvement in mental wellbeing in resident Partnership members between 2016 and 2018, though some indication that these benefits were not equally distributed. The qualitative findings reinforce the possibility of quantifiable benefits, with residents highlighting positive social and mental health impacts through various pathways. However, there is also evidence of negative impacts on health and wellbeing. Using most conservative assumptions, BL provides a 30% rate of return on the original National Lottery grant of £196,873,499.

Our findings are particularly timely with growing calls in England for a new 'community power paradigm' drawing on the BL model and the anticipated publication of government proposals for *Levelling up* policies that may extend current policies, devolving more decision-making and resources down to local people via place-based empowerment initiatives.

Our findings have implications for future community empowerment initiatives: 1) Investment is needed to develop and sustain smaller scale community associations and organisations to emerge from and work with communities. Careful targeting of this investment is crucial if the benefits of BL type empowerment initiatives are to be distributed equally within and across communities. 2) Residents should be in the lead in defining and prioritising issues and designing solutions: partners but not necessarily leaders of action. 3) Local agencies should

prioritise working as equal partners with communities over enabling communities to act for themselves. 4) Care needs to be taken that community-based initiatives are not held accountable to externally determined governance standards that undermine the development of capabilities for collective control.

Our findings also have implications for future research evaluating community empowerment initiatives: 1) Evaluations need to be conducted over a long timeframe and include a cohort of community members and comparator areas. 2) Secondary data needs to be supplemented with primary data providing bespoke quantitative measures tailored to the programme. 3) Evaluations need to be sufficiently powered to detect small but important effects and to allow sub-group analyses that take account of variations in local programmes. 4) Evaluations must integrate an equity lens. 5) Evaluations should include longitudinal qualitative components.

Funding: The project was funded by the National Institute for Health Research Public Health Research Programme