Updated report

Well London

Phase 2 Evaluation

Participant Outcomes

September 2015

Institute for Health and Human Development
University of East London

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Participant Outcomes

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This is an update of the final report produced in June 2015 and incorporates additional analyses on implementation fidelity.

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1. Executive summary

The *Well London* programme is one of the largest initiatives of its kind in the UK to improve health and wellbeing, reduce inequalities and build resilience in disadvantaged communities through an asset-based community development and co-production approach. The second phase of development involved eleven neighbourhoods in nine London boroughs. While all the participating boroughs were part of Phase One, nine neighbourhoods within the boroughs were new to the programme.

The Phase Two programme was modified to reflect evidence and learning from the first phase: the *Well London* framework was refined in line with new evidence, and the programme moved to a locally commissioned model, focussed on testing replicability on a 'natural neighbourhood' basis and, in some areas, scalability of the approach to larger neighbourhoods /regeneration areas. Local steering/strategy groups were formed alongside local advisory groups, and dedicated coordinators in all areas were recruited to improve coordination, link and integrate local activities and communications. The community training elements of the framework were strengthened and the Well London Delivery team and Training Communities activities started immediately. Participatory budgeting, a mechanism for involving the community in commissioning, was introduced alongside traditional direct commissioning of themed activities.

A mixed methods approach was used to evaluate the programme and was focused at four levels: participant, project, neighbourhood and the programme as a whole. Semi-structured interviews with participants and other stakeholders was combined with case studies, analysis of programme monitoring data and a longitudinal cohort questionnaire survey. The survey explored the impact of the programme and its relationship with levels of participation, participants' sex and ethnicity, and implementation fidelity.

An estimated 18,746 individuals participated in *Well London* activities, far exceeding the target of 7,000 and representing a coverage of 35% of the neighbourhood population. The programme was very well received by participants and perceptions about the benefits gained from participation were strongly positive. The more activities people participated in, the more likely they were to hold positive perceptions of the programme. Black and Minority Ethnic participants were significantly more likely to report positive perceptions compared to White participants. Men were significantly more likely to report having a healthy eating habit and show improved mental wellbeing as measured by the Adult Hope Scale. They were also less likely to reduce their total intake of fruit and vegetable.

The targeted proportion of participants showing improvement/positive change between baseline and follow up was exceeded in all five outcome areas of physical activity, healthy eating, mental wellbeing, social connectedness and volunteering. Statistically significant change was demonstrated in relation to some measures of physical activity (total MET minutes of doing physical activities per week), healthy eating (total quantity of fruit and vegetable in yesterday's diet) and mental wellbeing (Hope scale score and its two subscales of Agency and Pathway). Participants in high fidelity areas had significantly higher odds of reporting increased levels of physical activity, increased total physical activity MET minutes per week and a better understanding of mental wellbeing. They also had significantly lower odds of engaging in sedentary behaviour as measured by total hours spent sitting per day.

The overall findings of the evaluation indicate that the programme generated a high level of interest and acceptance by participants and they experienced a wide range of benefits. The learning will inform the third phase of research and development.

2. About this report

A multi-level and multi-methods evaluation framework was designed to systematically investigate the processes and impacts of the *Well London* phase 2 programme. The framework has four levels of analysis: Participant, Project, Community/Neighbourhood and Programme levels, in parallel with a health economic evaluation.

This report focuses specifically on findings at the participant level in relation to the programme outcomes agreed with the Big Lottery Fund. Some analysis from the other levels is also included where it helps to illuminate the participant findings. Findings from the other levels will be reported in further reports and papers over the coming months. These will be disseminated through the *Well London* website and scientific journals and targeted at a broad audience including funders, commissioners, academics, practitioners, policy makers and lay people.

3. Background

The Well London programme

Well London provides a robust framework for communities and local organisations to work together to improve health and wellbeing, build resilience and reduce inequalities. It is one of the most ambitious and radical attempts in the UK to develop an asset-based community development model to deliver system change that will enhance the health and wellbeing of disadvantaged communities. **The framework is designed to be embedded as a mainstream approach – a 'different way of working' rather than a fixed term intervention.**

The first phase of the (2007 to 2011) was supported by £9.46m from the Big Lottery Fund and developed and delivered in 20 of the most deprived neighbourhoods across London by the multi-sectoral Well London Alliance.[1] This partnership was led by the London Health Commission and hosted by the Greater London Authority[2]. Reports and papers from the research and evaluation of Phase 1 can be accessed via the *Well London* website[3].

There is an exciting vision and long-term development mission for *Well London*, across London and beyond as the *Well Communities* framework (Box 1). A unique feature in the development of the framework has been the parallel programme of comprehensive implementation support, to ensure the fidelity of, and learning about the model, and robust research and evaluation of its effectiveness and cost effectiveness.

The University of East London-led research has involved collaboration with a number of other research institutions including; London School of Hygiene and Tropical Medicine (LSHTM), Westminster University, London School Of Economics (LSE) and Oxford University, and has attracted significant additional research funding from the Wellcome Trust.

[1] Greater London Authority, University of East London (UEL), Arts Council England - London, South London and Maudsley NHS Foundation Trust (SLaM), London Sustainability Exchange (LSx), Central YMCA, and Groundwork London.
[2] London Health Commission. Well London: communities working together for a healthier city. London.
[3] Phase One Research and Evaluation. http://www.welllondon.org.uk/1621/phase-1.html

In November 2011, the *Well London* programme won a Health Promotion and Community Wellbeing award from the Royal Society for Public Health (RSPH). The award recognised its achievements and innovative approach to promoting community health and wellbeing and was endorsed by Professor Sir Michael Marmot:

> ***"Empowering individuals and communities, and giving people a voice is integral to addressing health inequalities. I am delighted the Partnership has achieved well-deserved recognition for its work. "***
>
> *Professor Sir Michael Marmot*

Box 1. Well London vision and mission

Our vision

Empowered local communities, who have the skills and confidence to take control of and improve their individual and collective health and wellbeing.

Our mission

To develop a robust, evidence-based framework for community action for health and wellbeing that will influence policy and practice to secure real enhancements to wellbeing and reductions in health inequalities across all communities in our capital city and beyond.

More recently, *Well London* has been recognised as a 'pioneer' by the What Works Centre for Wellbeing as a model for community engagement approaches in health and wellbeing[4].

Programme framework

Well London provides a framework for communities and local organisations to work together to improve health and wellbeing, build resilience and reduce inequalities (Figure 1). Importantly, it integrates with, strengthens and adds value to what is already going on locally to maximize resources and ensure value for money. The *Well London* framework comprises two types of activities: **community capacity building** activities and resources for all neighbourhoods; and **action on specific local needs and issues** through a portfolio of themed activities and projects determined by the needs and issues identified by each community.

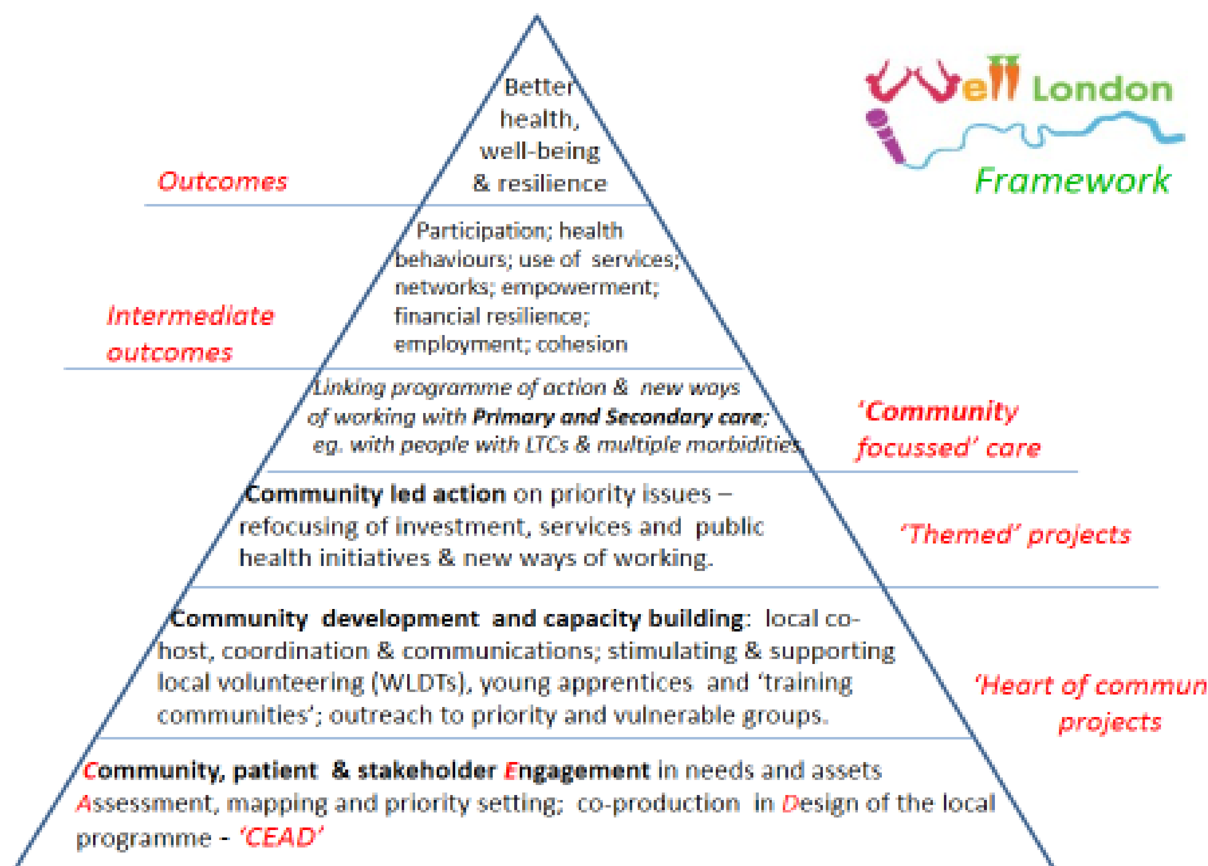
Theory of change

As an integrated community development programme based on a coproduction approach, *Well London* seeks to intervene simultaneously at multiple levels - individual, community, wider determinants of health and service delivery – to remove the barriers that constrain individual and community health, wellbeing and resilience. Thus, some programme activities and projects address specific health outcomes through traditional health behaviour change activities (e.g. exercise and cook and eat classes), while others encourage participation, volunteering, capacity building, community networks and community cohesion (e.g. community events, training and job fairs). Further, processes that stimulate ongoing community engagement and refocusing of services to make them more responsive and effective, are built into the *Well London* approach.

[4] http://whatworkswellbeing.org/well-london-communities-working-together-for-a-healthier-city/

Empowerment was the primary concept used to theorise the causal pathways by which activities impact on individuals and communities to produce change [5,6,7,8]. The theory of change model (illustrated in Figure 2) was used to guide the selection of process indicators that were measured.

Figure 1. Well London framework



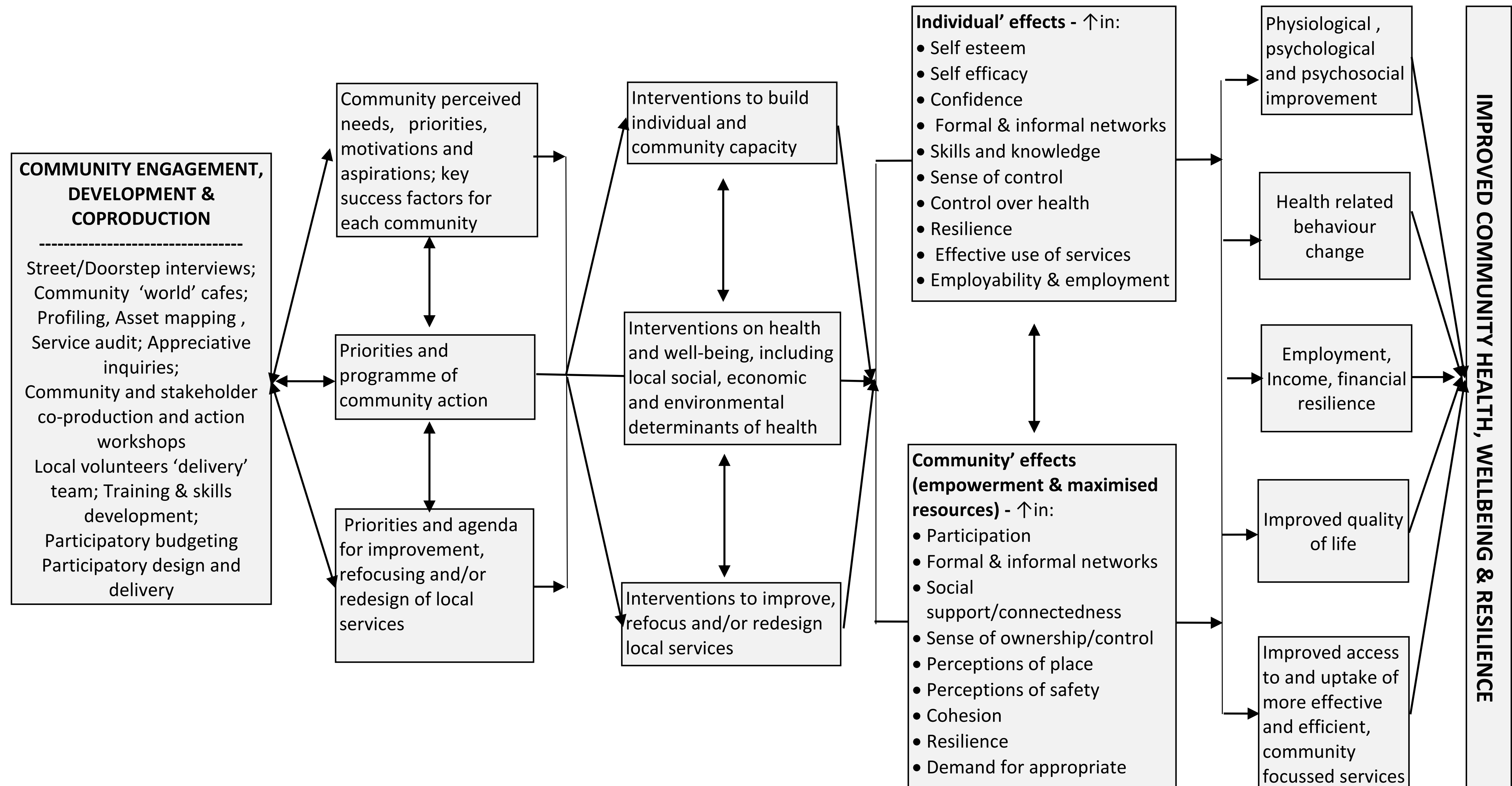
[5] Woodall J, Raine G, South J, Warwick-Booth L. Empowerment and health and well-being: evidence review. Centre for Health Promotion Research, Leeds Metropolitan University, 2010.

[6] Laverack G, Wallerstein N. Measuring community empowerment: a fresh look at organizational domains. Health Promotion International. 2001; 16(2):179-85.

[7] Rissel C. Empowerment: the holy grail of health promotion? Health Promotion International. 1994; 9(1):39-47.

[8] Wallerstein N. Powerlessness, empowerment, and health: implications for health promotion programs. American Journal of Health Promotion. 1992; 6(3):197-205.

Figure 2. Theory of change for the Well London programme



4. Well London Phase Two

Learning and changes from Phase One

With further funding of £1.8m from the Big Lottery, a second phase of *Well London* was delivered between 2012 and 2015. This phase incorporated a number of important changes reflecting learning from the delivery and evaluation of the first phase. This is in keeping with the envisaged long-term development pathway for the *Well London* programme, taking the model though a number of phases of research and development.

The *Well London* framework has been refined in line with emerging evidence, the programme has moved to a locally commissioned model[9], focussed on testing replicability on a 'natural neighbourhood' basis[10] and, in some areas, scalability of the approach to larger neighbourhoods /regeneration areas.

The *Well London* alliance was expanded to formally include the Royal Society of Public Health who have led and strengthened the community training elements of the framework. The development of the framework in other contexts, including Primary Care and work with Housing Associations, has also been explored.

Other key changes included the formation of local steering/strategy groups (new in phase 2) alongside the local advisory groups (of phase 1). Dedicated local coordinators in all areas were recruited to improve coordination, linking and integration of local activities and local communications. In addition, the Well London Delivery team and Training Communities activities started up immediately.

Participatory budgeting (a mechanism for involving the community in commissioning) was introduced alongside direct commissioning as a method for commissioning the themed activities, and changes were made to the monitoring and evaluation framework, including strengthening participant recording and using a longitudinal cohort study to investigate impacts in participants.

Figure 3. Key features of Phase Two

[9] All activities (apart from the community engagement and heart of the community projects) were commissioned and delivered locally. This model is a more cost effective and efficient way of delivering the programme and enables it to be more easily mainstreamed and scaled up further in the future, both in London and beyond, and tailored more closely to local needs and circumstances. Circa 50% of the programme funding (in cash and in kind) was identified by the local commissioning organisations to match the Lottery funding; the phase one programme was 100% Lottery funded with some additional funding and resources levered in in some areas.

[10] Phase one areas were selected on the basis of the Office for National Statistics politically defined lower super output areas (LSOAs).

Phase Two outcomes

Outcomes in six areas were agreed with the Big Lottery Fund: participation, physical activity, diet, mental wellbeing, social connectedness and volunteering. The targeted levels of change in each area are shown in Table 1.

Table 1. Well London Phase Two main outcomes

Outcome	Targeted level of change
Participation	7000 individuals participating in all programme activities.
Physical activity	15% of participants reporting increase in levels of physical activity.
	5% of participants reporting reduction in sedentary behaviour.
Diet	20% of participants reporting progress towards meeting five a day.
	15% of participants reporting decrease in unhealthy eating.
Mental wellbeing	20% of participants reporting an increase in mental wellbeing.
	15% of participants reporting a reduction in psychosocial stress.
Social connectedness	10% of participants reporting an increase in social connectedness.
Volunteering	3% of participants reporting an increase in levels of volunteering.

Intervention neighbourhoods

The second phase of *Well London* involved eleven neighbourhoods in nine London boroughs. While all the boroughs had been part of Phase One, nine neighbourhoods within the boroughs were new in Phase Two (Table 2).

Table 2. Well London Phase Two neighbourhoods

Neighbourhood	Borough	Neighbourhood part of Phase One
Chalkhill Estate	Brent	No
Regent's Park Estate	Camden	No
Woolwich Dockyard Estate	Greenwich	No
Woodberry Down	Hackney	Yes
Vauxhall Gardens Estate	Lambeth	No
Bellingham	Lewisham	Yes
Stratford Village & GP Surgery	Newham	No
East Village	Newham	No
Unwin & Friary Estate	Southwark	No
Aberfeldy Estate	Tower Hamlets	No
Old Bethnal Green	Tower Hamlets	No

Programme governance and central support

Governance for the local programmes included:

- **Local Steering Groups** - were newly established or relevant existing groups. Their role was to oversee development, management and monitoring of all of the neighbourhood programmes in the commissioning area; also facilitating partnership working at the more strategic level and leverage and refocusing of other resources to respond to the community identified needs.

- **Neighbourhood Advisory Groups** - that brought together residents from the local community and local organisations on a regular basis to facilitate on going engagement, needs assessment, partnership working and programme development at the neighbourhood level.

At the London wide level:

- Meetings of local commissioners and central delivery partners were convened, on a regular basis, by the GLA Programme Manager and UEL Well Communities Team.

- Meetings of local Coordinators were convened, on a bi monthly basis, by UEL Well Communities team.

The Well Communities Team at the Institute for Health and Human Development (IHHD) at University of East London (UEL) provided a range of commissioning and implementation advice and support services to local commissioning organisations, Coordinators and local delivery organisations. London Sustainability Exchange (LSx) provided a programme of networking, learning and celebratory events which brought together *Well London* volunteers, Young Apprentices, Coordinators and delivery organisations in various computations.

The spend on programme delivery was approximately £70,000 per year in each of the neighbourhoods, with the remaining funds used for programme development, management and evaluation.

Community engagement, assessment and design

The principles of asset-based community development and co-production[11,12] were used to ensure that newly introduced activities built on and developed existing and new assets, and that local communities were involved in decision making at each stage of development and delivery. The use of a community development approach was premised on the recognition of healthy environments and communities as a prerequisite for individual-level health and wellbeing[13].

The process for delivering *Well London* in each neighbourhood began with an intensive phase of community and local stakeholder engagement to understand the needs, concerns and priorities of the target communities. It enabled local residents and key local policy and decision makers to surface the health issues and solutions that were most important within the community. The CEAD process consisted of a sequential set of activities involving local residents and other stakeholders (Box 2). A detailed description of the process can be found on the Well London website http://www.welllondon.org.uk/33/cead.html.

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[11] New Economics Foundation. Co-production: A manifesto for growing the core economy. London, 2008.
[12] NICE, 2008: An assessment of community engagement and community development approaches including the collaborative methodology and community champions; Public health guidance, PH9 - Issued: February 2008.
[13] Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm: Institute of Futures Studies; 1991

Box 2. Community engagement, assessment and design (CEAD) activities[14]

- **Door knocking** - to gather initial information and encourage engagement from the outset of the local Well London programme.
- **Community Cafés** - informal discussions with local residents in a World Café-style to surface and explore community concerns[15,16].
- **Community profiling and asset mapping** - to generate profiles of the socio-demographic and health characteristics of the neighbourhoods, and available community assets.
- **Community Action Workshop** – with both residents and local stakeholders to identify priority health and wellbeing interventions to be implemented in each community; using appreciative inquiry approach[17].
- **Priority and Resources meeting** – brings together commissioners with other local organisations that have influence and resources relevant to the priorities identified through the CEAD process.

There were a number of themes emerging from the CEAD process that were common to all areas, possibly because of the similar characteristics of the neighbourhoods. The particularly prominent cross-cutting themes are summarised in Box 3.

Box 3. Cross-cutting themes from the CEAD process

- Designing activities that bring the community together
- Support for young people
- Providing opportunities for training, volunteering and skill-sharing
- Improving the local environment.

Implemented activities

The information generated from the CEAD process was used to shape a portfolio of interventions/activities for each area. Altogether, 263 Individual activities were designed and delivered. These were of two broad types: 'Heart of the Community' capacity building activities and 'Themed' grass-roots activities.

Heart of the Community activities

These were a core set of activities (including the CEAD process itself) common to all areas that provided dedicated coordination and activities designed to engage and build individual and community capacity e.g. through volunteering, training and employment opportunities (Box 4).

[14] Further details of the CEAD process can be found on the Well London website at http://www.welllondon.org.uk/33/cead.html.

[15] Sheridan K, Adams-Eaton F, Trimble A, Renton A, Bertotti M. Community engagement using World Café: The Well London experience; Groupwork 2010, 20(3):32-50.

[16] Bertotti M; Adams-Eaton F; Sheridan K; Renton A. Key barriers to community cohesion: Views from residents of 20 London deprived neighbourhoods. GeoJournal 2012, 77(2): 223-234.

[17] Fitzgerald SP, Murrell KL, Miller MG. Appreciative inquiry: accentuating the positive. Business Strategy Review, 2003, 14(1): 5-7.

Box 4. Heart of the community activities[18]

- **CEAD** – process of community and stakeholder engagement in needs assessment and design of the local Well London programmes.
- **Local Coordinator -** plays a key role in driving implementation of the neighbourhood programme, ensuring effective and ongoing community engagement, participation, empowerment and leadership in the programme, recruiting, developing and supporting the Well London Delivery Team volunteers and Young Apprentices, and building partnerships with, and between, local people and local organisations.
- **Well London Delivery Teams (WLDTs)** – core group of volunteers recruited from the target neighbourhood and modelled on the UK NHS Health Trainers[19], who use peer-to-peer approaches to support residents to participate in project activities, volunteer, access other local services and improve their health behaviours.
- **Training Communities** - bespoke RSPH-accredited courses; DIY Happiness training based on the South London and Maudsley Trust's Wheel of Well-being; Personal Support Packages (training grants to skill up people to lead and manage activities); Community (physical activity) Activators; and Healthy Spaces Champions.
- **Young apprentices** - development and support for young leaders recruited from the target neighbourhoods by programme partner, Youth Force, to ensure local youth engagement and action.

Themed activities

These specifically addressed mental wellbeing, physical activity and healthy eating, improve local environments and cultural and arts activities. They differed by area according to locally identified priorities.

Commissioning approach

Well London 'themed' activities were commissioned in two ways – both by traditional **direct commissioning** and through **participatory budgeting** (PB) or citizen-led commissioning[20]. PB typically involved an event organised by the *Well London* Coordinator at which local residents and organisations were invited to promote potential projects which were then voted for. Projects that received the highest number of votes were approved for funding.

[18] These projects are described in detail on the Well London website http://www.welllondon.org.uk/1603/community-capacity-building.html

[19] South J, Woodward J, Lowcock D. New beginnings: stakeholder perspectives on the role of health trainers. The Journal of the Royal Society for the Promotion of Health 2007;127:224-30.

[20] SQW, Cambridge Economic Associates, Geoff Fordham Associates. Communities in the driving seat: a study of Participatory Budgeting in England. Final report. Department for Communities and Local Government, 2011.

5. Evaluation Methods

The aims, objectives and design of the evaluation are described in this section. Not all the methods described were relevant to generating the findings reported in this document, but are presented in full here to give an understanding of the whole scope of the evaluation and where the different components sit in relation to each other.

Aim and objectives of the evaluation

Aim

To understand the impact of the *Well London* programme on health, wellbeing and the wider social determinants of health, and to make recommendations for further development of the programme in order to increase positive impacts in future phases.

Objectives

To systematically collect and analyse participant, project, community and programme level information from each intervention neighbourhood on:

1. The number and nature of activities carried out
2. The number and demographics of participants in each activity
3. The impact on participants physical activity, diet, mental wellbeing, social connectedness and volunteering
4. Participants' and stakeholders' perceptions of the individual-level benefits of each activity
5. Participants' and stakeholders' perceptions of the community-level benefits of each activity
6. Barriers and facilitators to achieving community and programme objectives
7. The extent to which the programme was delivered as planned
8. Project achievements likely to leave a sustainable legacy within communities

Evaluation framework

A multi-level and multi-methods evaluation framework was designed to systematically investigate the impacts of *Well London* at four levels of analysis:

- **Participant** – describes the characteristics and experiences of people who took part in the programme, their levels of participation and impacts on their health and wellbeing and wider social determinants of health.

- **Project** - assesses the different types of activities delivered, the number of participants, project-level barriers and enablers, and sustainable legacies.

- **Community/area** – measures community level impacts and coherence, i.e. extent to which delivered interventions align with community and commissioners priorities.

- **Programme** – considers the fidelity of delivery, programme-level barriers and enablers, scalability and replicability of the programme in new settings**.**

Information was collected on levels of participation and self-reported behaviour change among participants, as well as their experience and perceived impacts of the programme. Process learning from the coordinators and commissioners about the programme's design, coordination and delivery was also captured.

Study participants

Information was collected from a broad range of participant groups involved in the programme: a) local residents who took part in Well London activities; b) Well London Delivery Team volunteers, c) Well London Young Apprentices, d) local area coordinators, e) project deliverers, f) programme managers, and g) commissioners.

Data collection

Evaluation data were collected through a range of methods including:

- Project registration and attendance monitoring form
- Headcounts at organised events
- Before and after questionnaire survey with a cohort of participants
- Quarterly monitoring reports
- Individual End-of-project reports
- Case studies of participants, projects and intervention neighbourhoods
- Semi-structured interviews with participants and project deliverers
- Process learning sets completed by local coordinators
- End-of-programme semi-structured interviews with local coordinators and commissioners

The evaluation framework is outlined in Table 3 and shows the relationship between the level of evaluation, evaluation objectives and the methods of data collection.

Qualitative study

Participants, *Well London* volunteers and youth apprentices, and project deliverers were selected by non-probability, purposive sampling, using a maximum variation strategy to obtain as much diversity as possible with regards to their personal attributes, nature and levels of participation[21]. **Forty semi-structured interviews** lasting from 25 to 60 minutes were conducted by four researchers with the aid of topic guides. Discussion themes were informed by the theory of change model. The interviews were audiotaped with the consent of participants and fully transcribed.

Transcripts were checked for quality and, after familiarisation with the data through review, reading and listening; coding and thematic analysis was undertaken informed by Ritchie and Spencer's framework approach. Such a method is particularly suited to investigations with clearly specified questions and a pre-

[21] Ritchie J, Lewis J, Elam G. Designing and selecting samples. In: Ritchie J and Lewis J (eds.). Qualitative research practice: a guide for social science students and researchers. Sage: London, 2003.

designed sample[22] and allows themes to be clearly identified both within and across interviews so that first level analysis can be rapidly undertaken and fed into decision-making.[23]

Twenty four case studies of individuals (n=17), projects (n=3) and neighbourhoods (n=4) were undertaken to further explore the personal, organisational and structural contexts in which the programme was implemented. Candidate cases were selected to draw out participation and delivery experiences that clarified and helped refine the theorised pathways of change, programme outcomes, and enabling and constraining factors.

Table 3. Well London Phase Two evaluation framework

Level	Evaluation questions	Methods of data collection
Participant	• What are the demographic characteristics of participants? • What are the levels of participation by different groups? • What are the impacts of participation on health & wellbeing and wider social determinants of health?	• Attendance registers • Cohort questionnaire survey • Interviews with participants • Case studies
Project	• How many project sessions were delivered by area? • How many participants were engaged in each project and area? • What were the barriers and facilitators to delivery?	• Attendance registers • Quarterly and End of Project reports • Interviews with project deliverers
Community / Area	• Were the community's priorities addressed? • Were commissioners priorities addressed? • What were the barriers and facilitators to addressing local priorities? • What sustainable legacy did the programme leave in each area?	• Quarterly progress reports • Interviews with community stakeholders • End of programme interviews with commissioners • Information from coordinators learning sets • Quarterly report of local programme contribution to local legacy
Programme	• Was the programme delivered as planned? • What were the barriers and facilitators to programme delivery? • Did existing areas succeed in obtaining further funding? • Did programme succeed in expanding to new areas?	• Information from programme manager meetings • Fidelity scoring

[22] Ritchie J, Spencer L (1994). Qualitative data analysis for applied policy research. In: A.Bryman and R. G. Burgess [eds.] Analyzing qualitative data, pp.173-194. London: Routledge.
[23] Srivastava A, Thomson SB (2009). Framework analysis: a qualitative methodology for applied policy research. JOAAG, 4(2): 72-79.

Participation monitoring

Participation data

Two forms were used at activity sessions to capture participation.

- **Participation registration form**. This was completed by all participants attending an activity for the first time. It recorded contact details and basic demographic information such as age, gender and ethnicity. Registration was required for each new activity attended, so that attendance at multiple activities could be tracked.
- **Attendance monitoring form**. Information from individual registration forms was collated by the activity organisers into an attendance monitoring form which was then used to record how many sessions of a project each participant attended.

Method for estimating the number of individual participants

Estimation of the number of individual participants from the number of attendances was done by adjusting attendance records for two factors: *multiple attendances* and *under-reporting*.

- **Multiple attendance**. While some activities collected detailed information about individual participants, at other events, only head counts were done but individual participant details not recorded. A proportion of these people were assumed to have attended other projects. The proportion was estimated by extrapolating information about multiple attendances from themed activity registers with accurate records of participants. By analysing for duplicate records in the registers, ten percent of participants were observed to attend multiple activities (two different activities on average). An allowance of 7.5% was made to account for uncertainty; giving a total downward adjustment of 17.5%.

- **Under-reporting.** A second adjustment was made upward to account for under-reporting, estimated to be at least 20%[24] by the evaluation team.

The net adjustment of +2.5% was then applied to the total number of attendances. The total number of participants derived by this method represents a **conservative estimate**, and the true figure is likely to be much higher.

Longitudinal cohort survey

A longitudinal cohort survey was used to investigate the impact of *Well London* activities on participants' lifestyle, general health and mental wellbeing. Participants were surveyed over three waves - baseline, and 1st and 2nd follow ups at six and nine months.

Sample size

The sample size for the cohort study was computed with the sampsi command function of STATA v11. Baseline rates of the three primary outcomes – healthy eating (HE), physical activity (PA) and mental

[24] Based on analysis of the proportion of activities with missing or incomplete information.

wellbeing (MWB) – were derived from the control arm of the *Well London* phase 1 study[25]. The expected amount of change was based on pooled effect sizes from a commissioned evaluation of all programmes funded under the Big Lottery Well-being Programme[26]. The study was powered to detect a 20% change in HE and MW and a 15% change in PA at 80% power and alpha level .05. Considering a 32% dropout rate at first follow up, a final sample size of 219 participants was derived for all three waves.

Recruitment

Considering the practicalities of recruitment the cohort was conceived as a convenience sample of participants. From each person who agreed to participate informed consent was obtained. Consenting participants across all areas who had taken part in at least one *Well London* activity were followed up to take part in the 30 minutes survey. Recruitment was carried out in all areas until the desired sample size was reached. Participants had the option of completing the survey either as a paper or online version. To maximise responses, they were included in a prize draw at the baseline, and given £5 voucher incentives at the follow up surveys.

Questionnaire

Data was collected with the aid of a questionnaire with items derived from rating scales whose reliability and validity have been widely established from many studies. The questionnaire was organised in seven main sections:

- Section 1: Standard socio-demographic questions including age, sex, employment, education, ethnic identity, first language, etc.

- Section 2: Physical activity – self reported physical activity HPA over the last seven days assessed by the international physical activity questionnaire (IPAQ)[27].

- Section 3: Food and drink – these questions were adapted from the Health Survey for England[28]. They focused on fruit and vegetables consumed in the last day.

- Section 4: Wellbeing – the questions in this section measured both negative and positive aspects of psychological mood first using the General Health Questionnaire (GHQ12)[29] and then the Adult Hope Dispositional Scale[30]. The latter incorporates two subscales - *Agency* (goal-directed energy) and *Pathways* (planning to meet goals). Positive mental health was further measured through the Warwick Edinburgh

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Mental Well-being Scale (WEMWBS)[31]. Respondents' sense of optimism and control over their circumstances was assessed through the Sense of Coherence Scale[32].

- Section 5: Friends, family and neighbourhood – the questions here explored social capital (opinions on neighbourhood quality) and social networks.

- Section 6: Volunteering and participation in *Well London* and non- *Well London* events and activities.

- Section 7: General health –aspects of health related to quality of life[33] including diagnosed diseases, if smoking or drinking alcohol, and contact with GP and Dentist.

Implementation fidelity

Fidelity measurement has become an increasingly important part of evaluation and refers to the extent to which delivery of an intervention or programme adheres to the protocol or program model originally developed[34]; i.e. the degree to which it was delivered as intended. A set of fidelity indices for specific components of the programme was collaboratively developed with the programme management and community engagement leads. The fidelity criteria comprised a mix of quantitative and qualitative criteria against which each intervention neighbourhood was scored on a scale of 1 to 10, where 10 represented the highest level of adherence to the programme model. The programme components and related fidelity criteria are shown in Table 4.

We used two approaches to assess fidelity: a) using administrative data from project and quarterly monitoring reports (quantitative fidelity scores) and b) using expert ranking based on explicit criteria (qualitative fidelity scores). Table 4 outlines the criteria used for both type of scores. The quantitative criteria were adjusted (where necessary) to take account of differences in the size of the neighbourhood population and the scores were converted to rankings. In the case of qualitative fidelity rankings, we first summed the individual rankings done by the experts and then re-ranked this cumulative ranking. Each of these fidelity rankings were dichotomised as low fidelity area (score 1-5), and high fidelity area (score 6-10).

[31] Tennant R, Hiller L, Fishwick R, Platt S, Joseph S, Weich S, Parkinson J, Secker J, Stewart-Brown S. The Warwick-Edinburgh mental well-being scale (WEMWBS): development and UK validation. Health and Quality of Life Outcomes 2007, 5(1):63.

[32] Eriksson M, Lindström B. Validity of Antonovsky's sense of coherence scale: a systematic review. J Epidemiol Community Health 2005, 59:460-466.

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Table 4. Fidelity criteria

Component	Fidelity criteria
Coordination mechanisms	• Coordinator located locally and providing good line management • Coordinator's community development skills • Project management and monitoring[a] • Ongoing engagement with local residents • Seniority (decision-making power) of representatives on local steering group
Community engagement	• Door-knocking coverage[a] • Participation in Community Cafes[a] • Participation in Community Action Workshops[a] • Residents and stakeholders engagement with process
Capacity building	• Number of volunteers recruited and trained[a] • Uptake of training (Royal Society of Public Health, DIY Happiness, YMCA Activate, Personal Support Packages)[a] • Youth engagement[a] • Volunteers engagement with the programme
Themed activities	• Local people's involvement in design and/or delivery of activities • Projects led by local groups/individuals[a] • Joined-up delivery/integrated/complementary working
Partnerships & networking	• Engagement /partnership with local organisations and stakeholders • Extent of focusing/refocusing of other local services/investments into neighbourhood.

a. Administrative data from project and quarterly monitoring reports

6. Results

In this section, we report first on the core Big Lottery outcomes, comparing agreed targets with those achieved by the programme. More detailed analysis of each of the outcome areas then follows. Quantitative and qualitative findings are jointly presented within their relevant areas.

Summary of main outcomes

Programme attainment against the key outcome targets are presented in Table 5. The achieved levels of change were calculated from monitoring data collected by the various activities and self-reported changes in the cohort of participants who completed baseline and follow up surveys.

Table 5. Targeted versus achieved outcomes

Outcome	Indicator	Level of change	
		Targeted	Achieved
Participation	Number participating in all programme activities	7,000	**18,746**
Physical activity	% reporting increases in levels of physical activity	15%	**82%**
	% reporting reduction in sedentary behaviour	5%	**54%**
Healthy eating	% reporting progress towards meeting five a day	20%	**54%**
	% reporting decreases in unhealthy eating	15%	**51%**
Mental wellbeing	% reporting an increase in mental wellbeing	20%	**54%**
	% reporting a reduction in psychosocial stress	15%	**19%**
Social connectedness	% reporting an increase in social connectedness	10%	**31%**
Volunteering	% reporting an increase in levels of volunteering	3%	**60%**

Participation

Close to 19,000 people[35] participated in *Well London* activities across all intervention neighbourhoods, almost triple the targeted number (Table 6). In a few neighbourhoods (Chalkhill, Bellingham and Woolwich Dockyard) the estimated number of participants exceeded or was close to the total population of the neighbourhood. The likely explanation for this is a rippling out effect with residents from adjacent neighbourhoods also participating in the *Well London* activities in these areas.

Attendance at the CEAD activities (1,563) comprised people who attended the community cafés (384), community action workshops (339) and participatory budgeting events (840). The 644 participants who attended the capacity building activities consisted of those who had trained as *Well London* Delivery Team volunteers, Young Apprentices, Community Activators and Healthy Spaces Champions. It also included participants on the DIY Happiness course and beneficiaries of Personal Support Packages.

[35] The attendance figure was up-adjusted by 2.5% in order to estimate the number of individual participants. A description of how the figure was calculated is in the methods section.

Table 6. Well London participation by neighbourhood

Neighbourhood (Borough)	Popn	No. of house-holds	No. of attendances				All	Est. no. of individual participants[a]
			CEAD	Capacity building	Outreach/ Awareness	Themed activities		
Chalkhill (Brent)	3292	1100	151	145	2393	802	3491	3578
Regent's Park (Camden)	3133	1440	191	44	657	344	1236	1267
Woolwich Dockyard (Greenwich)	1748	800	46	121	947	575	1689	1731
Woodberry Down (Hackney)	3329	2050	136	44	210	492	882	904
Vauxhall Gardens (Lambeth)	3263	1480	110	43	720	416	1289	1321
Bellingham (Lewisham)	4851	2190	119	129	3963	535	4746	4865
Stratford Village (Newham)	7063	3013	130	46	184	476	836	857
East Village (Newham)	8760	3609	115	24	91	239	469	481
Unwin & Friary (Southwark)	5718	2330	91	18	291	334	734	752
Aberfeldy (Tower Hamlets)	5463	1930	142	30	1254	661	2087	2139
Old Bethnal Green (Tower Hamlets)	4818	1520	268	46	235	217	766	785
All	**51995**	**21462**	**1563**	**690**	**10945**	**5091**	**18289**	**18746**

a. Adjusted for multiple attendances and under-reporting.

Qualitative findings strongly suggested that the role of the local *Well London* Coordinator appeared to be influential in raising awareness of the programme and motivating people to participate. Local coordination is a key feature of the *Well London* approach and the coordinator also works to ensure the delivery of activities that sustain people's participation once they join.

> *"…..[the Well London coordinator] came there and talked about it, gave us a speech, that we should become involved with Well London." #9 (Male, 56, Brent)*

> *"…. she [Well London coordinator] is always electric… she comes ….and very active; always on the move like me" #28 (Female, adult, Tower Hamlets)*

Some participants had an interest in improving their health or community work prior to getting involved in *Well London* activities. This was particularly the case with many of those who went on to become volunteers, young apprentices and project organisers. One young apprentice remarked on the ambitious nature of the programme:

> *"I was surprised to see how much Well London wanted to do and I loved the idea of making an impact in my community." #7 (Female, 21, Camden)*

Levels of participation varied by neighbourhood. Areas with higher numbers of participants (Bellingham, Chalkhill, Aberfeldy, Woolwich Dockyard tended to have held more outreach and awareness events which are typically designed to target and bring together the whole community. Others with smaller numbers were partly as a result of the neighbourhood joining the programme at a later stage (Stratford Village, Old Bethnal Green) or constraints to delivery of activities for a variety of reasons (Hackney, East Village).

Characteristics of Well London participants

Table 7. Profile of Well London participants

Variable[a]	Percentage[b]	
	Programme	**Survey**
Age (years)		
<16	44	0[c]
16-25	12	10
26-40	18	24
41-65	19	32
> 65	7	19
Gender		
Female	69	80
Male	31	20
Ethnicity		
White	32	36
Black	35	34
South Asian	20	15
Mixed	9	10
Other	6	6

a. Age, sex and ethnicity were the three variables for which data on both groups was available.
b. Percentages based on complete cases only.
c. The survey was conducted among adult (>16yrs) participants only.

A profile of *Well London* participants was generated from information captured in the various activity registration forms. While it was not feasible to collect information on every individual, about 49% of participants provided their details. The most complete records were from attendances at CEAD, capacity building and themed events.

From the programme participants was drawn a small group of 487 people who took part in a three-wave cohort survey (of which analysis was carried out on the 360 who completed at least two waves). The survey data was the means by which participants' characteristics and changes related to the primary outcomes were explored. Table 7 shows the characteristics of both groups.

Non-weighting of the survey sample

The cohort study comprised a non-random sample of participants which might lead to non-representative results that could be biased. A normal practice at the time of analysis to produce population representative results is to use analytical weights. We did not do this because of the nature of the intervention which has participation as a component; and the motivation to participate in *Well London* activities and the motivation to participate in the survey may overlap.

At the beginning of the survey it was not known what these motivating factors were in order to generate appropriate weights. However, as the survey was based on a longitudinal design, **the changes detected are valid estimates of the effect sizes of the interventions studied**.

Perceptions about the benefits of participation in Well London

Table 8 reports the views of participants included in the cohort study about whether they felt any benefits had been gained from participating in *Well London* activities. In unadjusted analysis, the proportion answering 'Yes' when asked if their participation in *Well London* had led to improvements in the main outcome areas (i.e. mental well-being, physical activity, healthy eating, social connectedness and volunteering) was high, ranging from 67% (for 'got into volunteering') to 90% (for 'felt more positive about life' and 'felt that people in the community from different backgrounds and age groups got along together'). The figure for volunteering is remarkably high and probably reflects the inclusion of many Well London Delivery Team volunteers in the survey. When the analysis was adjusted to take account of the number of *Well London* activities participated in and the ethnic background of respondents was taken into account, the proportion that answered 'Yes' was even higher.

Table 8. Perceptions about the benefits derived from participating in Well London

Perceived benefits of participating in Well London	Proportion responding 'Yes'		
	N	Unadjusted *% (95%CI)*	Adjusted[a] *% (95%CI)*
Physical activity (PA)			
Increased level of physical activity	259	80 (74, 85)	88 (81, 95)
Healthy eating (HE)			
Access affordable healthy foods	233	75 (67, 82)	81 (72, 91)
Make more healthy eating choices	237	81 (76, 87)	91 (83, 99)
Mental wellbeing (MWB)			
Improved understanding of mental wellbeing	246	80 (75, 86)	84 (78, 91)
Feel more positive about life	256	90 (88,93)	94 (90, 97)
Feel more self-confident	239	84 (78, 90)	91 (87, 96)
Social connectedness (SC)			
Enjoy living in community	249	86 (83, 90)	92 (88, 95)
Feel safe walking around in community	234	76 (71, 80)	80 (76, 84)
Made friends in community	252	87 (84, 90)	94 (90, 98)
Asked people for help in community	223	70 (64, 76)	77 (69, 85)
Feel that people in community from different backgrounds and age groups get along together	248	90 (86, 93)	96 (92, 99)
Feel that people in community pull together to improve neighbourhood	228	85 (81, 89)	89 (84, 95)
Volunteering (V)			
Got into volunteering	217	67 (61, 73)	71 (63, 79)
Awareness of opportunities /Other			
More aware of local opportunities for MWB, HE and PA	264	90 (88, 92)	92 (88, 96)
More aware of opps for education, training, volunteering or work	245	81 (77, 85)	88 (82, 94)
Got into education or training	210	61 (54, 68)	69 (64, 74)
Got into work	185	42 (34, 51)	46 (39, 52)
Improved English skills	168	52 (40, 65)	65 (56, 73)

a. The model was adjusted on WL activities and ethnicity only. Sex was not included due to the small number of male participants in the sample. First language was collinear with ethnicity and so was not included in the model. No significant effects were found with other independent variables.

Qualitative data was also collected from interviews with participants to further explore their perceptions of the benefits of taking part in *Well London*. The findings from the interviews are presented in the following sections.

Qualitative insights

Perceptions about physical activity

Many participants recognised that they could benefit from taking more exercise, and in all the intervention areas, activities to encourage residents to be more physically active formed part of the portfolio of interventions delivered. The activities were observed to have quick impacts on those who took part.

> *"They actually come out of their houses! 100% you know – already I see a difference in them. It's better than sitting on your tod [own]. #33 (Male, adult, East Village).*

One such activity was Raunchy Rockers, a popular resident-led exercise group in the Chalkhill, Brent neighbourhood. It was set up to support elderly people who were sedentary to become physically active and had a particular focus on the over 50s. According to a participant:

> *"It really makes me do things, do exercise; otherwise all I would do is housework". #29 (Female, adult, Brent)*

People had different starting points prior to becoming involved with *Well London*. Some had been inactive for a long time, others had been active in the past and lapsed, while others yet felt they were active. Regardless of where they were coming from, people readily identified the benefits of attending Well London physical activity sessions and from continuing to participate, even those who felt they were doing rather well already.

> *"Now it [exercise] has increased because sometimes back I would do exercise and then relax maybe for about six months but now I just cannot give way to healthy eating and exercise; I have to continue doing it." #28 (Female, adult, Tower Hamlets).*

Perceptions about healthy eating

Unhealthy dietary habits were readily recognised by many participants both in themselves and in the wider community. Low incomes and the 'food environment' – that is, accessibility, affordability, and cultural norms – were some of the barriers they identified that made it difficult to eat healthily. Others however felt that people were too quick to accept these barriers and use them as an excuse not to make a change.

> *"It was surprising to see the barriers people put up and how quick they were to choose takeaway options since it's cheaper. I wanted to change that." #15 (Male, 59, Lewisham)*

Well London healthy eating interventions addressing aimed to raise awareness of how a healthy diet promotes good physical and mental wellbeing. They included practical activities like cook and eat courses for small groups and community feasts, which brought residents together to celebrate food. There was good engagement with these activities and their motivating influence on people was acknowledged.

> *"It's clearly a popular community fixture." #31 (Female, adult, Hackney).*

"This is a great opportunity to learn new recipes and healthy food eating and cook, and do the exercise together. It's quite good. Sometimes, we always forget these things. We know we have to eat good and do exercise more but its like this project gives us the extra push to do so". #3 (Female, 26, Camden).

Perceptions about mental wellbeing

There is well established evidence of the links between mental ill health and social disadvantage, and that living in poverty brings with it a greater risk of poorer mental health. Not surprisingly, given the deprivation experienced in the *Well London* neighbourhoods, mental health and wellbeing was identified as a priority by local residents and stakeholders in some of the areas during the community engagement process. There was an expressed desire to raise awareness about mental health and reduce the stigma attached to it. An example of the programme response to this was the commissioning of two projects in Vauxhall Gardens estate: *Mindfulness in Lambeth* and *Fighting the Stigma*.

One participant who went on to become a *Well London* volunteer in her local area described how she came up with the idea of setting up informal drop-in sessions to bring people together and tackle the problem of loneliness.

"….we wanted a place where isolated people can come, so I came up with the conversation café; ……we talk about deep and meaningful topics which relate to everyone like relationships and friendships and sharing their experiences with others. We can understand each other; it breaks down the barriers of prejudice. Everyone is different but we all have key things no matter what culture and that's a good point where you can connect with other people and start to understand [them]." #4 (Female, adult, Brent).

A number of participants had attended a DIY (Do It Yourself) Happiness course - one of *Well London's* 'Heart of the Community' activities - which uses humour, creativity and evidence-based positive psychology approaches to provide practical advice and information to increase people's ability to bounce back from adversity.

"With Well London, I've done the DIY Happiness course. I didn't have a lot of knowledge about happiness; that it wasn't kind of having things that made you happy but about things like having new skills, like how your family life benefits [from] your happiness, your physical health and mental wellbeing, etc. Since I'd done that course, I felt like there were so many things I had to change which has helped me a lot as a person. …..Unlike my job before, I was never ever happy going out in the morning. But now it's just like every day is always going to be different." #27 (Female, adult, Greenwich).

Perceptions about social connectedness

Social connectedness was both an important end outcome in its own right as well as instrumental in achieving better mental wellbeing and healthier lifestyles. The importance of social interaction in mediating improvements in specific health behaviours was evident in the way a social dimension was frequently woven into participants' comments about eating healthier and becoming more physically active. While participation in practical health-related activities was seen as beneficial, a clear added benefit was identified when these happened within a social context. A participant at a cook and eat class observed:

"I like meeting people here. You've got people coming with their babies, 80 year olds and people in their 20s all cooking in the same kitchen and eating together, for me that's a healthy thing in itself, people all eating together." #32 (Female, adult, Hackney).

Another participant stressed how getting to know people gave the area more of a true community feel.

> *"I think me being in the community centre and interacting I have got to know my community so much better before it was just faces in the street and now I know them all by name and know a bit about my life." #34 (Male, adult, Brent).*

Ensuring sessions were fun and designing them in a way that also fostered social interaction were some of the factors that encouraged people to take part and maintain participation. An organiser of a physical activity project noted the feedback she had received:

> *"When I first did it, like I said, it was just aimed at those people who either never exercised in their life or didn't like exercising……. The families have come to me and said; we are so grateful that you have brought mummy out, [we] can't believe mummy has come out and [is] dancing properly…" #30 (Female, adult, Brent).*

Perceptions about volunteering

Similar to social connectedness, volunteering was both an end outcome and instrumental factor. There was huge interest in volunteering and many participants indicated that they had done so on an informal basis. Within the *Well London* programme, there were also several opportunities to volunteer in a more formal way. Some participants opted to join the *Well London* Delivery Team who worked alongside the area coordinator to deliver the local programme while others supported project organisers to deliver activities that they had participated in.

A prominent theme among participants who took on volunteering roles was an often longstanding desire to *'do something'* or *'give something back'* to their communities, but uncertainty as to how to go about it. They saw *Well London* as providing an ideal platform to take forward their intentions. While volunteering typically seeks to benefit others, some participants highlighted the benefits to themselves such as enhanced wellbeing, a sense of achievement, self-esteem and being more confident about themselves.

> *"It has helped me in that the chair of the community centre came and offered me to be a trustee on the board and she said she saw I was committed and reliable and she felt I was a special person because I don't get paid." #34 (Male, adult, Brent).*

Although not strictly meeting the definition of a volunteering role (as an allowance was paid), many young apprentices saw their work to engage young people as voluntary.

> *"I would never have thought before this apprenticeship that I would have had the confidence to do these things, and be able to say to myself I was doing them well. The best thing about working for an organisation that aiis to encourage wellbeing is that you learn so much for your own wellbeing. I have been equipped with tools for life in this apprenticeship." #17 (Female, 20, Stratford Village.*

Further evidence on the impact of the *Well London* programme is documented in a recent video evaluation case study conducted by Ecorys for the Big Lottery (available to view at http://www.welllondon.org.uk/1622/phase-2.html). The video captures some of the key successes in Woolwich Dockyard Estate, one of the *Well London* neighbourhoods.

Changes in main outcomes

A range of scales (listed in the methods section) were used in the cohort survey to measure self-reported changes in the targeted outcome areas – mental wellbeing (MWB), healthy eating (HE), physical activity (PA), social connectedness (SC) and volunteering (V). The scales consisted of a set of items (or questions) to which participants responses were measured as continuous or categorical data. For clarity, results of the continuous and categorical outcomes are presented separately (Tables 9 and 10). For outcomes where the level of change was statistically significant (i.e. $p<0.05$), the p value is shown in bold. The tables highlight the following:

- **Physical activity**: 82% of participants did more PA at follow-up (based on total MET minutes per week) compared to their baseline. The difference was significant. Fifty four percent did less sitting (a measure of sedentary behaviour).

- **Healthy eating**: 54% were eating more healthily of whom 19% met the government '5 fruits or vegetables a day' target. Fifty one percent were eating less unhealthily.

- **Mental wellbeing**: 54% reported improved mental wellbeing on the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). The proportion was higher when based on the other MWB measures, i.e. the Adult Hope scale and General Health Questionnaire 12 item (GHQ 12) scale. With the Adult Hope scale (and its two subscales – Pathway and Agency), the level of change was statistically significant.

- **Social connectedness**: The mean positive change across all the scale items was 31%.

- **Volunteering**: 60% participants reported doing more volunteering at follow-up compared to baseline.

In summary, the proportion of participants showing desired (favourable or positive) change exceeded the programme targets. The magnitude of change in these participants translated into a net significantly positive change in the whole group on some measures of physical activity (total MET minutes of doing physical activities per week), healthy eating (total quantity of fruit and vegetable in yesterday's diet) and mental wellbeing (hope scale score).

Influence of level of participation, ethnicity and gender

The odds ratios shown in Table 11 give further insight into how participation and ethnicity influenced participants' perceptions about the benefits derived from *Well London*. With every additional *Well London* activity participated in the odds of reporting good perceptions about Well London increased by 48% (95% CI: 27%, 73%). Further, the odds of Black and Minority Ethnic participants reporting positive perceptions was significantly higher compared to White participants.

Table 9. Changes in main outcomes (continuous variables)

Theme	N	Proportion showing favourable change[a] % (95% CI)	Dispersion[b] in change Median, IQR[c] (p25, p75)		Net change[d]	*p*
			Favourable	Unfavourable		
Physical activity (PA)						
Total physical activity MET minutes/week	279	82(74, 88)	661(661, 1071)	-2961(-5193, -1926)	513	**0.03**
Total hours of sitting per day	358	54(44, 63)	3.0(3.0, 6.0)	-4.4(-9.9, -2.4)	-0.6	0.41
Healthy eating (HE)						
Score of eating less unhealthy food	360	51(46, 56)	3(1.7, 6.8)	-3(-5.9, -1.6)	0.25	0.29
Total quantity of fruit and vegetable in yesterday's diet	118	51(45, 57)	4(2.21, 6.52)	-5(-10.0, -2.1)	-0.80	**0.03**
Composite score of healthy eating	360	54(47, 61)	2(0.7, 2.7)	-2(-3.0, -0.9)	0.06	0.71
Mental wellbeing (MWB)						
Sense of Coherence	248	51(47, 56)	1(0.3, 2.1)	-1(-2.1, -0.4)	0.4	0.52
GHQ-12 Score	342	63(55, 71)	1(1.1, 2.1)	-3(-6.6,-0.6)	-0.3	0.53
Adult hope scale score	349	96(94, 98)	18(11.6, 24.0)	-5(-12.4, -3.2)	17.4	**0.00**
Pathway subscale score	289	95(94, 97)	9(5.7, 12.1)	-2(-6.6, -0.9)	8.9	**0.00**
Agency subscale score	351	94(90, 97)	9(6.0, 12.5)	-3(-7.0, -1.4)	8.6	**0.00**
Warwick Edinburgh scale score	345	54(46, 61)	7(3.4, 15.4)	-7(-12.2,-3.1)	1.4	0.17
Social connectedness (SC)						
Score of contacting families and friends	360	51(41, 61)	4(1.6, 7.6)	-5(-8.4, -2.4)	-0.21	0.75
Feeling safe in neighbourhood	360	40(33, 48)	2(0.9, 4.1)	-1(-2.4, -0.8)	0.12	0.64
Available sources for getting help in need	360	49(44, 54)	3(1.1, 4.4)	-2(-4.0, -1.2)	-0.26	0.89
Problems in neighbourhood score	360	52(48, 55)	8(2.9, 12.7)	-8(-14, -3.8)	-0.12	0.84
Quality of neighbourhood score	360	47(44, 50)	3(1.4, 5.6)	-2(-4.3, -1.6)	0.00	0.99
Volunteering (V)						
Composite score of volunteering	360	60(53, 66)	1(1.0, 2.3)	-2(-3.9, -4.6)	0.07	0.72

a. Favourable change is when proportion having good outcomes increases. The sole exception is the GHQ-12 a decrease in the score is considered favourable.
b. Dispersion denotes the magnitude of the change, both favourable and unfavourable.
c. IQR = Interquartile range (the difference between the third and the first quartiles)
d. Net change refers to the difference in the average score between baseline and follow-up.

Table 10. Changes in main outcomes (categorical variables)

Theme	N	Changes				Net change % (95%CI)	*p*
		Favourable		Unfavourable			
		%	95% CI	%	95%CI		
Physical activity (PA)							
Physical activity active levels	103	17	12, 24	11	7, 17	13 (0, 26)	0.05
Feel that they have done enough physical activity	296	12	11, 13	14	13, 15	1 (-4, 7)	0.61
Would like to do more physical activity	284	11	11, 11	10	9, 11	-2 (-7,3)	0.42
Healthy eating (HE)							
Case of meeting '5 fruits or vegetables a day'	360	19	19, 19	21	18, 24	-2 (-9, 4)	0.52
Feel that they have healthy eating habit	336	10	9, 11	6	5, 8	4 (-5, 8)	0.09
Would like to eat more healthily	195	5	4, 6	7	6, 7	-2 (-6, 3)	0.44
Mental wellbeing (MWB)							
Case of mental disorder (GHQ12)	360	19	17, 20	15	14, 16	3 (-3, 9)	0.28
Social connectedness (SC)							
Feel they can influence decisions affecting local area	232	10	8, 13	11	10, 11	0 (-5, 6)	0.88
Feel important to be able to influence local decisions	273	8	7, 9	11	10, 13	-4 (-9, 1)	0.16
Enjoy living in neighbourhood	316	16	13, 19	18	14, 24	-2(-9, 5)	0.62
Feel people help each other in neighbourhood	119	13	10, 14	7	6, 7	4 (-3, 11)	0.29
Feel people from different backgrounds get on well	247	7	5, 11	5	4, 5	3 (-1, 7)	0.19
Feel people pull together to improve neighbourhood	215	13	12, 14	11	9, 12	3 (-3, 10)	0.27
Feel people can be trusted in neighbourhood	225	14	14, 14	14	10, 17	1 (-5, 8)	0.66
Eating meal with other household members	334	22	19, 24	20	15, 26	5(-8, 18)	0.46

Table 11. Odds Ratios for positive perceptions about Well London

Covariate	Adjusted OR (95% CI)	*P*	Interpretation
WL activities attended	1.5 (1.3, 1.7)	0.00	With every additional WL activity participated in, there was an increase of 48% (95%CI: 27%, 73%) in the odds of reporting positive perceptions about the impact of *Well London*.
Ethnicity White	1.0 (ref)	-	Comparison group; results of other groups are with reference to this group.
Black	2.3 (1.3, 4.0)	0.01	Compared to White participants, the odds of reporting positive perceptions was greater by 127% (95%CI: 28%, 303%).
South Asian	2.6 (1.1, 6.1)	0.03	Compared to White participants, the odds of reporting positive perceptions was greater by 157% (95% CI: -9%, 170%).
Mixed	3.0 (1.4, 6.2)	0.00	Compared to White participants, the odds of reporting positive perceptions was greater by 199% (95% CI: 44%, 522%).
Other	-	-	Insufficient data to interpret.

In order to calculate the odds ratios, the 18 perception items were first combined into a single score whose value ranged from 0 to 18. On the basis of the median score of 9.5, participants responses were categorised into two groups: high (above median; = positive perception of Well London) and low (below median; = negative perception).

Just 20% of survey respondents (n=70) were men. The number was rather low for robust analysis, nonetheless, for completeness, we summarise the impact of gender on the perceptions and changes reported in Tables 9 and 10. Overall, a greater proportion of men reported positive perceptions about benefits obtained from participating in *Well London*, compared to women. For continuous variables (compare with Table 9), the total physical activity MET minutes per week was not significantly different. However, there was significant reduction in the total quantity of fruit and vegetable intake for women, but not for men. Also, both the subscales and the overall score of the Adult Hope Scale were greater for men. On the categorical variables (compare with Table 10), men were significantly more likely to report having a healthy eating habit.

Influence of implementation fidelity

There was moderate correlation between the qualitative and quantitative rankings (r = 0.51). We present results separately for the two types of fidelity scores. Table 12 compares the perceptions of respondents about the benefits of participation. On most of the question items, a higher proportion of respondents in qualitatively ranked high fidelity areas reported positive perceptions. The difference was significant for physical activity where the odds of reporting increased level of physical activity as a result of taking part in *Well London* were 2.3 times greater in the high fidelity group than in the low fidelity group (OR 2.3, CI 1.1-4.7, p=0.02). The pattern was similar when the areas were compared based on quantitative ranking. The proportion of positive responses was higher in the high fidelity areas on most items, and the difference was significant in relation to improved understanding of mental wellbeing (OR 2.1, CI 1.1-4.0, p=0.02).

Table 13 explores the association between fidelity and favourable changes in the targeted outcomes. The odds of participants in high fidelity areas reporting an increase in their total physical activity MET minutes per week was 3.6 times higher than the odds for participants in low fidelity areas (OR 3.6, CI 1.3-10.4, p=0.02). The high fidelity group also had significantly lower odds of sedentary behaviour as measured by total hours spent sitting per day (OR 0.6, CI 0.4-0.9, p=0.02). However, on measures of mental wellbeing, the high fidelity group had lower odds of reporting a good score on the Agency subscale of the Adult Hope scale (OR 0.3, CI 0.1-1.0, p=0.04).

Table 12. Association between fidelity and perceptions about the benefits derived from participating in Well London

Perceived benefits of participating in Well London	N	Qualitative fidelity ranking					Quantitative fidelity ranking			
		Proportion responding 'Yes' (%)					Proportion responding 'Yes' (%)			
		Low fidelity	High fidelity	Odds ratio (95%CI)	*p*		Low fidelity	High fidelity	Odds ratio (95%CI)	*p*
Physical activity (PA)										
Increased level of physical activity	259	67	82	2.3 (1.1; 4.7)	**0.02**		70	79	0.9(0.5; 1.7)	0.79
Healthy eating (HE)										
Access affordable healthy foods	233	69	76	1.4 (0.7; 2.9)	0.36		69	78	1.6 (0.9; 3.0)	0.11
Make more healthy eating choices	237	76	82	1.5 (0.6; 3.3)	0.38		77	84	1.6 (0.8; 3.1)	0.16
Mental wellbeing (MWB)										
Improved understanding of mental wellbeing	246	80	81	1.0 (0.4; 2.3)	0.98		73	85	2.1 (1.1; 4.0)	**0.02**
Feel more positive about life	256	88	91	1.3 (0.4; 3.6)	0.65		92	90	0.8(0.3; 1.8)	0.52
Feel more self-confident	239	86	83	0.8 (0.3; 2.2)	0.67		79	86	1.7(0.8; 3.4)	0.13
Social connectedness (SC)										
Enjoy living in community	249	82	87	1.5 (0.6; 3.7)	0.34		82	89	1.8 (0.9; 3.7)	0.13
Feel safe walking around in community	234	68	77	1.5 (0.7; 3.3)	0.26		70	79	1.6 (0.8; 3.0)	0.13
Made friends in community	252	88	87	0.9 (0.3; 2.4)	0.80		86	87	1.1 (0.5; 2.3)	0.79
Asked people for help in community	223	62	72	1.6 (0.8; 3.3)	0.21		71	69	0.9 (0.5; 1.6)	0.73
Feel people of different backgrounds and ages get along together	248	96	88	0.3 (0.1; 1.5)	0.16		88	90	1.2 (0.5; 2.8)	0.64
Feel people pull together to improve neighbourhood	228	84	85	1.1 (0.4; 2.9)	0.81		83	86	1.3 (0.6; 2.7)	0.51
Volunteering (V)										
Got into volunteering	217	54	69	1.9 (0.9; 4.0)	0.07		63	69	1.3 (0.7; 2.4)	0.35
Awareness of opportunities /Other										
More aware of local opportunities for MWB, HE and PA	264	90	90	1.0 (0.4; 2.8)	0.99		90	90	1.0(0.4; 2.3)	0.99
More aware of opportunities for education, training, volunteering and work	245	76	82	1.4 (0.6; 3.1)	0.40		75	84	1.7 (0.9; 3.2)	0.11
Got into education or training	210	47	64	2.0 (1.0; 4.0)	0.06		56	64	1.4 (0.8; 2.4)	0.30
Got into work	185	30	45	1.9 (0.8; 4.2)	0.13		36	45	1.5(0.8; 2.7)	0.24
Improved English skills	168	61	51	0.7 (0.3; 1.6)	0.38		48	55	1.4(0.7; 2.5)	0.33

Table 13. Association between fidelity and favourable changes in main outcomes

Theme	N	Qualitative fidelity ranking						Quantitative fidelity ranking					
		Mean change		Proportion with positive change (%)		Odds ratio (95%CI)	*p*	Mean change		Proportion with positive change (%)		Odds ratio (95%CI)	*p*
		Low fidelity	High fidelity	Low fidelity	High fidelity			Low fidelity	High fidelity	Low fidelity	High fidelity		
Physical activity													
Total physical activity MET minutes per week	118	409.82	536.10	64	86	3.6 (1.3; 10.4)	**0.02**	129.50	757.29	76	86	1.9(0.8; 5.0)	0.17
Total hours of sitting per day	341	-0.42	-0.60	49	45	0.9 (0.5; 1.5)	0.59	-1.09	-0.25	54	41	0.6 (0.4; 0.9)	**0.02**
Healthy eating													
Score of eating less unhealthy food	360	0.96	0.09	56	50	0.8(0.5; 1.4)	0.41	0.42	0.14	50	52	1.1(0.7; 1.7)	0.72
Total fruit/vegetable in yesterday's diet	360	-0.50	-0.86	54	51	0.9 (0.5; 1.5)	0.65	-0.68	-0.87	56	48	0.7(0.5; 1.1)	0.15
Composite score of healthy eating	360	0.09	0.06	52	54	1.1 (0.6; 1.9)	0.79	0.22	-0.03	58	52	0.8(0.5; 1.2)	0.25
Mental wellbeing													
Sense of Coherence	342	-0.16	0.09	43	53	1.5 (0.8; 2.6)	0.17	0.15	-0.02	51	52	1.0(0.7; 1.6)	0.93
GHQ-12 Score	289	-0.47	-0.18	55	65	1.5 (0.8; 2.8)	0.17	0.05	-0.40	67	61	0.8 (0.5; 1.2)	0.28
Pathway subscale score	351	9.23	8.89	98	95	0.3 (0.03; 2.3)	0.24	8.95	8.96	96	95	0.8(0.3; 2.3)	0.66
Agency subscale score	349	9.11	8.52	98	93	0.2 (0.03; 1.8)	0.16	9.15	8.32	98	92	0.3(0.1; 1.0)	**0.04**
Adult hope scale score	345	18.18	17.19	98	96	0.4 (0.04; 2.9)	0.34	17.75	17.15	98	95	0.5(0.1; 1.9)	0.31
Warwick Edinburgh scale score	279	1.13	1.49	56	53	0.9 (0.5; 1.7)	0.79	3.48	0.23	57	53	0.6(0.4; 1.0)	0.06
Social connectedness													
Score of contacting families and friends	360	0.65	-0.39	56	50	0.8 (0.5; 1.4)	0.41	0.19	-0.45	56	48	0.7(0.5; 1.1)	0.11
Feeling safe in neighbourhood	360	-0.46	-0.24	37	41	1.2 (0.7; 2.1)	0.53	0.06	0.15	45	37	0.7 (0.5; 1.1)	0.12
Available sources for getting help in need	360	0.18	-0.07	49	49	1.0 (0.6; 1.7)	0.96	0.06	-0.08	47	50	1.2(0.8; 1.8)	0.51
Problems in neighbourhood score	360	-0.54	-0.02	52	52	1.0 (0.6; 1.7)	0.90	-1.16	0.51	53	51	0.9(0.6; 1.4)	0.79
Quality of neighbourhood score	360	-0.21	0.04	49	47	0.9 (0.5; 1.6)	0.73	-0.29	0.17	44	49	1.3(0.8; 1.9)	0.30
Volunteering													
Composite score of volunteering	358	0.12	0.06	60	60	1.0 (0.6; 1.7)	0.92	0.17	0.02	59	60	1.0 (0.7; 1.6)	0.88

7. Discussion

Summary of main findings

The overall findings of the evaluation indicates that the programme generated a high level of interest and was very well received by participants, and that they reported a wide range of benefits. Programme monitoring data showed impressive results on participation. The overall estimated participation numbers of 18,746 was close to three times the targeted number of 7,000. The true figure is likely to be higher given that a conservative method was used to derive the estimate. The number of participants in the *Well London* programme constituted 36% of the entire population of 51995 in the 11 participating neighbourhoods (although some of the participants are likely to have come from ripple out into adjoining neighbourhoods). The high level of participation highlights the effectiveness of the *Well London* approach in engaging disadvantaged populations. The acceptability of the programme to local residents is evidenced by the findings from the qualitative strand of the evaluation. Further, a recent video case study conducted by Ecorys for the Big Lottery has captured some of the key successes in Woolwich Dockyard Estate, one of the *Well London* Neighbourhoods. http://www.welllondon.org.uk/1622/phase-2.html

The evaluation findings were also broadly positive in other outcome areas, showing that programme targets were exceeded in all five targeted outcomes: physical activity, healthy eating, mental wellbeing, social connectedness and volunteering. The more activities people participated in, the more likely they were to hold positive perceptions of the programme. The findings showed that Black and Minority Ethnic participants were significantly more likely to report positive perceptions compared to White participants. This is particularly important for programmes that operate in neighbourhoods characterised by high ethnic diversity. The high levels of volunteering (60% participants reported doing more volunteering at follow-up compared to baseline) probably owes to the fact that many survey respondents were members of their local *Well London* delivery teams.

Different instruments were used to assess change and with the first three outcomes, (physical activity, healthy eating, mental wellbeing), statistically significant levels of change were achieved on some of the measures. With the other measures and outcome areas (social connectedness and volunteering), the net level of change was relatively modest (i.e. positive but not statistically significant) and in some cases, worse than at baseline. This was because while some participants showed improvement, others reported no change or had worsened.

A number of factors influenced the perceptions people had about the benefits derived from participating in *Well London* activities and the changes measured in the survey. The level of participation in was important: the more people participated, the more likely they were to have positive perceptions about the benefits of the programme. Black and Minority Ethnic participants were significantly more likely to report positive perceptions compared to White participants. Although the proportion of men sampled was small, analysis by sex indicated that, on the whole, a greater proportion of men reported positive perceptions about *Well London* compared to women. Compared to women, they were significantly more likely to report having a healthy eating habit and show improved mental wellbeing as measured by the Adult Hope Scale. They were also less likely to reduce their total intake of fruit and vegetable.

Implementation fidelity was analysed by both qualitative and quantitative indices. Across both criteria, compared to those in low fidelity areas, participants in high fidelity areas had significantly higher odds of reporting increased levels of physical activity, increased total physical activity MET minutes per week and a

better understanding of mental wellbeing. They also had significantly lower odds of engaging in sedentary behaviour as measured by total hours spent sitting per day. However, on measures of mental wellbeing, the high fidelity group had lower significantly odds of reporting a good score on the Agency subscale of the Adult Hope scale.

Implications of the findings for programme development

Variations in participant outcomes in programmes like *Well London* that target whole communities are not unusual. Indeed, given the considerable diversity in the neighbourhoods, they are expected. Nevertheless, there are important lessons to be learned about whom *Well London* works well for, and whom it works less well for; and further insights will emerge from the additional analyses that will be undertaken over the following months.

Another area for further investigation is the rippling out effect of the programme to adjoining neighbourhoods as suggested by the participation numbers in some areas that exceeded the size of the resident population. The reach of the programme beyond the target area offers promising opportunities for scaling up the approach over a wider locality – a key objective of the next phase of development of the programme. The information on participants' postcodes collected during registration at activities will be mapped in further analysis to determine the pattern of geographical coverage.

The detection of positive changes in a large number of the outcomes measured is particularly encouraging when the circumstances in which the Phase Two programme was designed and delivered are taken into consideration. The programme was implemented in a time of austerity and significant organisational change in the NHS and local government, marked by severe cost-cutting and cut-back of services that have been shown to have disproportionately affected disadvantaged communities. Analysis using the government's 2010 Index of Multiple Deprivation (IMD) has shown a clear tendency for the percentage cuts to be greatest in the most deprived category and least in the most affluent. On one key measure, the most deprived English authorities have had a level of cut nearly six times higher than the cut experienced in the least deprived areas[36]. London-specific evidence about the vulnerability of disadvantaged populations to service reductions has come from a series of case studies that included two of the *Well London* boroughs – Brent and Camden[37]. Given this context, the trajectory of change in the *Well London* neighbourhoods, in the absence of intervention, would have in all likelihood got worse rather than better.

The proportion of men who participated in *Well London* activities (30%, see Table 7), even though far less than the women, was still encouraging given the acknowledged difficulties of engaging with this demographic. The literature indicates that men, especially in the older ages, use fewer community based health services than women, and are less likely to participate in preventive health activities. They also find it harder than women to make friends late in life, and are less likely to join community-based social groups that tend to be dominated by women[38]. Learning from interventions to increase physical activity levels highlights

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that using participants as advocates to promote and advertise activities, and locating activities in a familiar and established setting with a good track record of providing services for older people were was found to be important factors in successfully engaging older men[39]. Interventions like *Well London* therefore need to ensure that they incorporate into their design both the activities and evidenced-based strategies that encourage and engage participation by men.

Implementation fidelity has assumed growing importance in evaluation research and was a key area of focus in this study. The issue is relevant to all programmes but particularly to complex social interventions such as *Well London* where the multiple intervention sites, different contexts of delivery and local adjustments to the programme to overcome barriers can make it more challenging to ensure the programme is delivered as intended. Implementation fidelity is a potential moderator of the relationship between intervention adherence and intended outcomes. In other words, it is a factor that may impact on the relationship between these two variables[40]. Measuring fidelity therefore enables a more informed understanding of how and why an intervention works, and the extent to which outcomes can be improved[41]. It has further been suggested that measures of intervention fidelity can be used to identify specific active ingredients of the programme[42]. More intensive exploration of implementation elements and further testing and refinement of the fidelity criteria will form a core aspect of future phases of research and development of the *Well London* framework.

Finally, the Phase Two programme (as in Phase One) was delivered as a fixed term, localised intervention, whereas the *Well London* framework approach is designed to be introduced as an embedded, mainstream approach – a **'different way of working'** over the long term, with a view to being scaled up across the whole system. So, given some of the promising short term results demonstrated in this evaluation, we would expect to see more significant results over time (which may be tested in the Phase 3 scaling up phase of development).

Limitations of the evaluation

A great deal of effort was made to ensure that the evaluation was conducted as robustly as possible, but it is important to recognise that there were some limitations, and that these impact on the conclusions that can be drawn.

The population size and characteristics of the intervention areas were not precisely known as the areas were based on natural neighbourhoods rather than ONS lower super output areas (LSOAs). However, the approximations made by averaging the data from the LSOAs that geographically overlapped each neighbourhood area, were believed to be reasonably accurate.

Monitoring data was collected from over 260 implemented activities across the 11 intervention neighbourhoods. Many of the activities were organised by local residents with limited experience or capacity

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in data capture. As such, the quality of data collected was variable, and about 20% of data was estimated to be missing (based on the proportion of activities with nil returns or incomplete information).

There were particular challenges in determining the numbers of different individual participants from the headcounts and the activity registration data due to the likelihood that individuals could be counted several times. Adjustment was made in the analysis to mitigate the effect of multiple counting, but there still remains some uncertainty.

A key limitation was the single group design of the survey which meant that counterfactual analysis could not be performed to fully understand how participant outcomes such as participants' well-being would have changed if the intervention had not been undertaken. Also, even though optimal numbers were recruited to ensure that the studied was adequately powered to detect change in the targeted outcomes, for practical reasons, a non-probability, convenience sampling strategy was used to recruit respondents. It is likely that participants who had experienced positive impacts were over-represented in the sample.

Most participants completed the survey as a paper version, but some did so online. It is not clear the extent to which these different routes of administration affected their responses. Measurement of change in the targeted outcomes was based on widely used rating scales whose reliability and validity have been well established. However, they are self-reported questions that are influenced by the subjective perceptions, introspective ability, response bias and honesty of participants. However, while there are many problems with using self-report questionnaires, because of their utility they continue to be a popular methodology in behavioural science research.

8. Conclusion

The *Well London* programme aimed to improve health and wellbeing using a community development approach, empowering local people to actively participate in taking action on the local priorities they had identified in their communities. The programme sought to build individual and community confidence and sense of control, by improving individual and community support networks, as well as providing opportunities for individuals to take part in activities to boost levels of mental well-being, healthy eating and physical activity. Community engagement was used to identify each community's assets and needs, and a co-production process was used, drawing on local knowledge, in order to identify and design solutions.

The evaluation identified a wide range of positive impacts on participants, including: high levels of participation in both the community engagement process and the subsequent activities; high proportions of participants reporting improved mental well-being, physical activity and healthy eating behaviours after participating in Well *London* activities; participants reporting additional benefits such as improved confidence, educational, job and volunteering opportunities, expanded social networks and improved community cohesion.

Improving the health and wellbeing of disadvantaged populations in the UK remains a major public health challenge[43]. It is also acknowledged to be a long term or generational process[44]. While there has been considerable progress made in understanding the issues affecting these groups, more is known about the causes and consequences of the health inequalities they experience than about what interventions are effective in reducing them. The evidence for public health interventions aimed at healthy eating, healthy physical activity and mental health and wellbeing is weak[45]. Particularly deficient is the evidence around interventions which seek to reduce health inequalities through assets-based, community-strengthening approaches[40]. The *Well London* programme is such an approach and the findings from this evaluation, and the further reports that will follow, which build on and take forward the learning from the Phase One programme, make a vital contribution to the evidence base.

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