ScotPHN report

Scottish Public Health Network (ScotPHN)

The Community Empowerment (Scotland) Act 2015 Parts 3 and 5: What is Public Health's role?

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Acronyms

ATR	Asset Transfer Request
COSS	Community Ownership Support Service
CPP	Community Planning Partnership
EoI	Expression of Interest
HSCP	Health and Social Care Partnership
LOIP	Local Outcome Improvement Plan
NHS	National Health Service
PR	Participation Request
SCDC	Scottish Community Development Centre
SIMD	Scottish Index of Multiple Deprivation
SURC / SURC-6	Scottish Urban Rural Classification (version 6)
The Act	The Community Empowerment (Scotland) Act 2015

Our Purpose

By way of a preface, it was felt to be important to set out very clearly why this document has been produced.

Scottish legislation sets out that Public Health within the NHS, Health and Social Care Integration Boards or Partnerships, and working through collaboration with other organisations, such as Community Planning Partnerships, have a specific role to play in promoting and supporting the implementation of Parts 3 (Participation Requests) and 5 (Asset Transfer Requests) of the Community Empowerment (Scotland) Act 2015 in order to maximise on their potential public health benefits.

To date no formal guidance around how this should be done has been produced and efforts to date have been locally developed and delivered. The formation of Public Health Scotland also provides an opportunity to consider what needs to be done at a national level. Therefore, the purpose of this document is to:

- outline the input of Public Health teams to date with regard to the implementation and operation of Parts 3 and 5 of the Act.; and
- provide direction regarding the future role of Public Health at local and national levels.

The primary intended readership for this document includes Public Health colleagues in NHS Boards, in joint Health and Social Care Integration Boards or Partnerships, and with Community Planning Partnerships.

This document may also be of interest to:

- Community organisations[1] regardless of whether they currently meet the requirements of a Community Participation Body or Community Transfer Body;[2]
- Wider third sector organisations;
- NHS Estates Departments;
- Community Planning Partnerships and

[1] *For the purposes of this document, we use the term 'community organisation' to mean any group of people within a geographic area or with a shared interest/ characteristic who work together for public benefit.

[2] Community organisations are required to meet certain eligibility criteria to make a Participation Request or Asset Transfer Request under the Community Empowerment (Scotland) Act 2015. These are outlined in sections 20 and 77 of the Act, respectively. More information can be found in the Scottish Government guidance; particularly chapter 3 of the Participation Request guidance (https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2017/05/community-empowerment-participation-request-guidance/documents/1e3c11cd-9edf-40d4-bc55-9b727c47e451/1e3c11cd-9edf-40d4-bc55-9b727c47e451/govscot%3Adocument) and chapter 5 of the Asset Transfer guidance (https://www.gov.scot/binaries/content/documents/govscot/publications/guidance/2017/01/asset-transfer-under-community-empowerment-scotland-act-2015-guidance-community-9781786527509/documents/00513211-pdf/00513211-pdf/govscot%3Adocument).

- Colleagues working in:
  - Local authorities;
  - Police Scotland / Scottish Police Authority;
  - Scottish Environmental Protection Agency (SEPA);
  - Scottish Fire and Rescue Service (SFRS);
  - Scottish Water;
  - Transport Scotland / Regional Transport Partnerships; and
  - Others including: Crofting Commission; Forest Enterprise Scotland; Further Education colleges; Historic Environment Scotland; National Parks; Scottish Canals; Scottish Courts and Tribunals Service; Scottish Enterprise / Highlands and Islands Enterprise,; and Scottish Natural Heritage.

Summary

There are community organisations across Scotland who are providing important opportunities and services for their local communities, with beneficial short and long term health impacts. It is in the interest of public health that these community activities are supported and sustained. The use of Participation Requests (PRs) and Asset Transfer Requests (ATRs) through the Community Empowerment (Scotland) Act 2015 (Parts 3 and 5 respectively) may be useful options for some organisations. There is no guidance around how Public Health Directorates or teams should be involved in supporting PRs and ATRs and so far activities have been ad-hoc.

The purpose of this report is to:

- outline the input of Public Health teams to date with regard to the implementation and operation of Parts 3 and 5 of the Act.; and
- provide direction regarding the future role of Public Health at local and national levels.

In order to do this, a proportionate evaluation of the Act has been undertaken. We conducted a literature review, interviews with community organisation members and Public Health staff, and analysed public body annual reports.

<u>The implementation of the Act</u>

Our findings reveal a mixed picture in terms of the overall support offered to community organisations and highlights barriers to successful implementation which are applicable to community members and public sector staff, e.g. lack of awareness, lack of capacity to progress requests, lack of trust that a request will lead to beneficial change and difficulty with managing the complex processes involved.

It is recommended that Public Health teams should consider how best to participate locally in:

- ongoing staff and community training (formal and informal) around the Act in the context of raising awareness about participation and asset transfer options more generally;
- tailored and targeted support to those submitting requests in the context of wider community capacity building efforts;
- strategic, clear and straightforward processes co-ordinated across partners, which cover all aspects of implementation including asset transfer ‘aftercare’, how to support community organisation members through an outcome improvement process and promote shared learning; and
- transparent and robust assessments of requests coordinated across partners and assessment decision outcomes which encourage ongoing collaboration with communities.

The role of Public Health

Public Health interviewees generally perceived Public Health knowledge around PRs and ATRs to be fairly low. They were aware of some efforts at a multiagency level to establish joined-up processes and promotional materials, but there is potential for a more coordinated and strategic approach to be adopted. Examples of Public Health activities include:

- creating a process for responding to NHS PRs and ATRs;
- identifying when and whether a request under the Act was the best option for a community organisation;
- facilitating a health impact assessment of any proposal; and
- progressing an outcome improvement process.

The project group proposes that, considering our Act implementation recommendations, the role of Public Health should cover the following three areas:

1. to support the process through the use of existing specialist Public Health resource and skills where these would be of most benefit;
2. to support community capacity building around the use of PRs and ATRs as part of wider community capacity building efforts; and
3. to support a more coordinated strategic approach by public sector partners.

In order for these to be possible, it would require Public Health to have an increased knowledge around Parts 3 and 5 of the Act, have an increased awareness of NHS and other local partnership request processes and be confident that processes will lead to beneficial public health impacts. Public Health Scotland should support the Public Health workforce to meet these requirements and should demonstrate commitment to community empowerment, recognising this as an important part of the Public Health agenda.

Part 1: Background

Community Empowerment

Community empowerment and health

Empowerment has been defined as “an enabling process through which individuals or communities take control over their lives and environments” (1). Central to community empowerment, therefore, is the concept of community power to influence and change. A community is typically thought of as a group of people within a certain geographic area, but community in its broader sense includes the coming together of individuals with any shared interest or characteristic (2). The potential benefits of community empowerment are wide-ranging and complex, but include (3,4):

- the enhancement of community capacity; e.g. the development of knowledge and skills, strengthening of relationships and connections;
- improvement in how individuals feel about themselves; e.g. self-confidence, self-esteem, sense of control, sense of meaning and purpose, social support and reduction in feelings of isolation;
- improvement in how individuals feel about their communities; e.g. perceptions of community safety and trust, sense of pride in community, sense of collective responsibility to look after the community;
- improvement in community resilience and sustainability
- more personal and tailored programmes and services; and
- improvement in educational and employment opportunities.

If these were to occur, the health and wellbeing of communities would also benefit through:

- programmes and services better meeting the health needs of the community;
- reduction in stress and depression;
- better mental wellbeing, which is linked to better physical health, recovery from illness and healthy behaviours; and
- improved quality of life.

In general, public, private and third sectors are acknowledging these benefits and the need to support community empowerment through various means.

Community empowerment mechanisms relevant to public bodies

Advice and resources for community organisations are available through Third Sector Interfaces and national organisations such as the Scottish Community Development Centre (SCDC), Community Ownership Support Service (COSS), Scottish Enterprise, Highlands and Islands Enterprise, Business Gateway and Firstport. Financial support options include grant funding and microfinance loans. The recognition by public bodies (and partners) of the need to support community empowerment is demonstrated, for instance, in many of the Community Planning Partnerships (CPP) Local Outcome Improvement Plans (LOIPs) and locality plans, as well as the setting up of CPP groups in the areas of community engagement, resilience and development.[3] Specific mechanisms by which public bodies are seeking to engage and empower communities include:

- the use of community development workers who work alongside local communities;
- community representation in CPP structures – for example, community representatives can sit on community planning subgroups, area partnerships or thematic groups, feed into LOIPs and locality plans, engage with Children's services plans, Community Justice Outcome Improvement Plans and Community Learning and Development plans;
- the promotion and undertaking of participatory budgeting[4] – involving local communities in decisions regarding how part of a public bodies' budget is to be spent. Most commonly groups bid for funding and members of the community vote on who should receive it;
- setting up and running of organisational public involvement networks, forums and groups - including Health and Social Care Locality Forums, NHS Public Involvement Networks and patient participation groups; and
- the leasing of public body assets to community organisations.

There are also alternative mechanisms by which communities can seek to collaborate with public bodies. Examples include:

- the development of community action plans – with support from other agencies to ensure that these will be utilised by public bodies as part of planning processes;
- working through/with local community councils;
- attendance at parliamentary cross-party groups;
- approaching elected members; and
- campaigns and petitions.

The extent to which these mechanisms are effective may be influenced by factors such as (3,4):

- availability and accessibility to community organisations;

[3] It should be noted that these activities flow from Part 2 of the Community Empowerment Act which places specific responsibilities on CPPs to engage with communities. However local interpretation of by the CPPs will lead to some degree of variation in local approaches.

[4] See www.pbscotland.scot for more information.

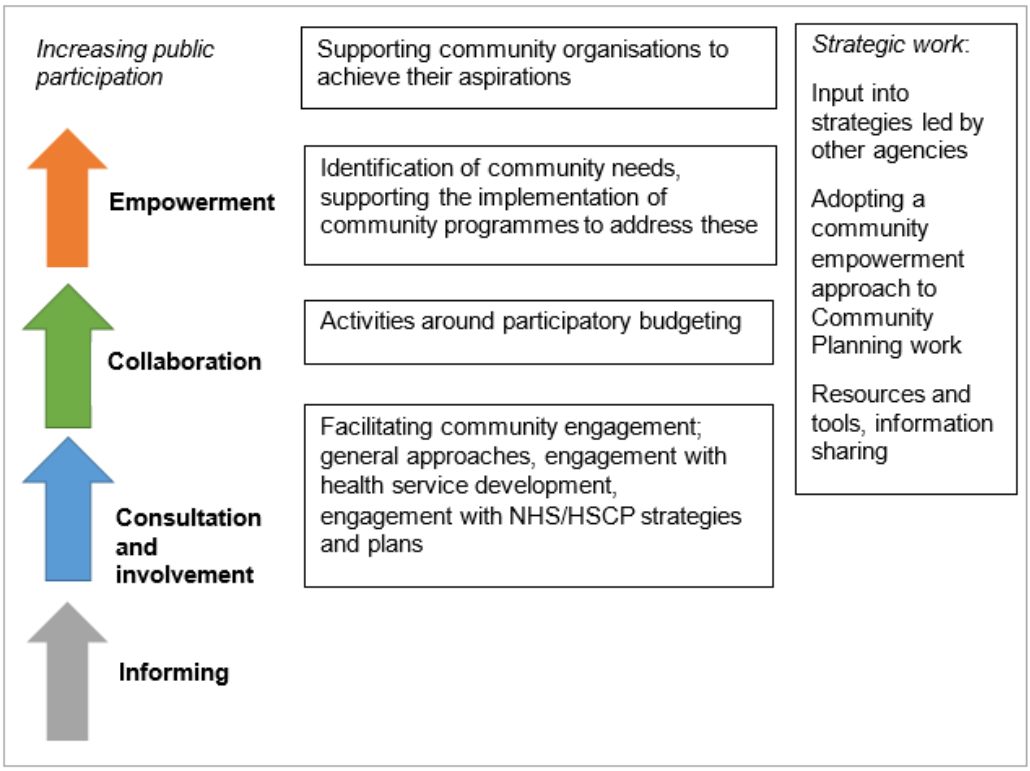
- community organisations' understanding of their options and ability to choose the most appropriate route(s);
- community organisation and public body capacity to engage with the process and make progress towards outcomes;
- level of input from and the effect on the wider community;
- community organisation and public body understanding of a community's physical (e.g. buildings, green and open spaces), human (experience, knowledge, practical skills, interest), social (networks, trust), or financial assets;
- ability to work in partnership to utilise assets; and
- level of public body commitment to sustainable nurtured communities.

Community empowerment work supported by Public Health

Public Health staff have been promoting and facilitating community participation at strategic and operational levels long before the Community Empowerment (Scotland) Act 2015 was implemented. Between 2017 and 2019 CHEX delivered six local awareness-raising workshops on the Community Empowerment Act to community organisations around Scotland and funded through NHS Health Scotland.

Recent key pieces of work are outlined in Appendix 1. These provide examples of work with communities which are going beyond informing and consulting towards a truly community empowerment approach (see Figure 1). This has, and continues to be, often in collaboration with partners such as Community Learning and Development teams in local authorities and third sector organisations.

Figure 1: Areas of Public Health work



The Community Empowerment (Scotland) Act 2015

Background to the Act

The Community Empowerment (Scotland) Act 2015 is an essential part of the Scottish Government's response to the Christie Commission recommendation that action needed to be taken to, "seek to strengthen communities' voices in shaping the services that affect them. Evidence shows that involving people more regularly and more effectively in the decisions that affect them leads to better outcomes, making the most of the knowledge and talent that lies in communities. It also increases confidence and fosters more positive relationships between communities and the public sector".[5] Ownership or control of land and buildings is seen as a powerful tool for communities to drive change, addressing local needs and create opportunities. In this regard, the Scottish Government was keen to ensure that the full range of opportunities the Act afforded communities was shared broadly.[6]

As an option for communities

The drivers for the examples of community empowerment work in Figure 1 and Appendix 1 include the motivation and commitment of operational staff and community organisations, good working relationships over many years, genuine buy in from strategic leads and the dedication of sufficient resource and time. It is very likely that these examples would have happened regardless of the introduction of the Community Empowerment (Scotland) Act 2015. However, it is recognised that the Act has further increased the opportunities available for community participation and this should be welcomed. The Act aims to 'provide a framework that will empower community bodies through the ownership of land and buildings and strengthen their voices in the decisions that matter to them'.

There are 12 parts to the Act:

1. National Outcomes;
2. Community Planning;
3. Participation Requests;
4. Community Rights to Buy Land;
5. Asset Transfer Requests;
6. Delegation of Forestry Commissioners' Functions;
7. Football Clubs;
8. Common Good Property;
9. Allotments;
10. Participation in Public Decision-making;

[5] Christie Commission on the future delivery of public services. (Available at: https://www.gov.scot/publications/commission-future-delivery-public-services/)

[6] Easy Read version of the Community Empowerment (Scotland) Bill's Policy of Memorandum. (Available at: https://www.webarchive.org.uk/wayback/archive/20170107140816/http://www.gov.scot/Publications/2014/08/5194)

11. Non-domestic Rates; and
12. General. [7]

To date, Public Health colleagues in local NHS Boards and Health and Social Care Partnerships have played a very active role in strengthening Community Planning, but appear to have been less involved in work around other areas of the Act (see Appendix 2). Parts 3 and 5 came into effect in April and January 2017, respectively. Participation Requests (PRs) give community organisations (Community Participation Bodies) the right to request to be involved in improving the services of public sector bodies (Public Sector Authorities). Asset Transfer Requests (ATRs) allow community organisations (Community Transfer Bodies) to request to buy or lease buildings or land owned by public sector bodies (Relevant Authorities). It is worth noting that local authority asset transfer predates the Act. The 2010 Disposal of Land by Local Authorities (Scotland) Regulations gave discretionary powers to local authorities to dispose of land to community organisations at a discount provided that the local authority is satisfied that it is achieving 'best value' through economic, social, environmental, health and social benefit. Similarly, PRs and ATRs through the Act are to be assessed on the grounds of their potential to improve economic development, regeneration, public health, social wellbeing, environmental wellbeing and reduction in inequalities of outcome. They should be agreed to unless good grounds for refusal. Locally agreed processes should be in place to allow this to happen, to provide timely feedback to community organisations and to facilitate follow up. More information on Parts 3, 5 and the other parts of the Act can be found on the Scottish Government and Scottish Community Development Centre websites.[8, 9]

Aside from Part 2 of the Act (which relates to Community Planning), the processes and resources around Parts 3 and 5 are arguably better developed than many of the others. This provides an opportunity to reflect, review and learn from what is already happening, consider whether further Public Health input is required and how this could be done proportionate to need and capacity.

Should Public Health be involved in Parts 3 and 5?

The first stage is to consider whether Public Health staff should even be involved in Parts 3 and 5 of the Act. We argue here that successful implementation of these parts of the Act would provide a range of public health benefits and therefore it should be a role of Public Health to support this. Evidence around joint-decision making and community control of assets suggests intermediate outcomes could include (5-11):

[7] See: Community Empowerment (Scotland) Act 2015 Explanatory Notes (Available at: http://www.legislation.gov.uk/asp/2015/6/notes/contents)
[8] https://www.gov.scot/publications/community-empowerment-scotland-act-summary/
[9] https://www.scdc.org.uk/hub/community-empowerment-act/more

- *Participation Requests* – Communities, including disadvantaged communities, have greater involvement and influence in Public Service Authority decision making and delivery, which in turn may:
  - increase the effectiveness and relevance of public services;
  - increase understanding of different perspectives, including reasons behind decisions about public services; and
  - have a positive effect on wider civic participation.

- *Asset Transfer Requests* – Increased community ownership, control and use of Relevant Authority assets, which in turn may:
  - increase funding opportunities;
  - increase tourism and footfall in nearby businesses (particularly relevant for rural communities);
  - create jobs and opportunities to engage in the life of the community; and
  - increase the sustainability of local services.

- *Both Participation and Asset Transfer Requests* – that may support:
  - increased group cooperation and cohesion;
  - improved sense of personal worth and identity;
  - the acquisition of new experiences and skills;
  - improved physical infrastructure of buildings;
  - improved relationships and increased trust between communities and Public Service Authorities;
  - shifts in the balance of power between communities and the public sector; and
  - wider community benefits through improved health, social wellbeing, local environment and/or economic development.

- *Long term outcomes* – which could include:
  - increased community empowerment and wellbeing;
  - improved public services;
  - improved access to facilities and services;
  - improved public body policies; and
  - reductions in inequalities.

We, therefore, need to understand how well Parts 3 and 5 are being implemented in order to identify whether there are potential areas which could be strengthened (see Part 2). We then need to consider in which of these areas Public Health expertise could provide the greatest benefit, taking into account challenges such as workforce capacity (see Part 3). This document outlines what we know so far, and provides guidance on the role of Public Health.

Part 2: An Evaluation of the Use of Parts 3 & 5 of the Act

To understand how well Parts 3 and 5 are currently being implemented, we first need to consider what the best possible situation would look like. We take the perspective here that the most successful outcome would be one where public health benefit is maximised.

Approach to Identifying the Ideal Situation

Use of logic models

Two logic models have been produced which link the implementation of Parts 3 and 5 of the Act to a range of short, intermediate and long term outcomes (10,12). These were used as a basis for understanding how public health benefits could be achieved.

Expert opinion

Members of the project group who work for SCDC and COSS were asked to provide expert opinion around the approach public services should be taking with regards to PRs and ATRs, respectively. Two multiagency project group meetings were used to primarily discuss and reach consensus around the steps required to maximise beneficial outcomes. In this way, a proposed ideal situation was shaped.

Participation Requests – SCDC believes that with the right support in place, participation requests enable community organisations to initiate a dialogue with public bodies around their own priorities, with the aim of improving how public services are designed and delivered. Participation requests, and the approach they set out, should therefore be seen by public service authorities as a positive opportunity to genuinely co-produce public services.

Asset Transfer Requests – COSS believes that community ownership of assets is not an end in itself, it a means by which communities can protect and enhance services, create jobs and opportunities and provide people with a meaningful stake in the future development of the places where they live and work.

While the Community Empowerment Act provides a framework for communities to take control of key local assets on the basis of management, lease or ownership, the spirt of the legislation is that the process for doing so is proportionate to the scale of the asset transfer request. This is true of both the amount of information required for a relevant authority to enable to reach a decision on an asset transfer request and actually whether there is a requirement to process the request through the Community Empowerment Act. The Guidance for the Act makes clear that it is perfectly legitimate for relevant authorities to negotiate with community groups outwith the legislation. Local authorities

in particular are most likely to run dual approaches to asset transfer requests with those cases being dealt with outwith the Act tending to be lease arrangements.

The proposed ideal situation

The project group agreed that the steps shown below (outlined in the green boxes) were likely required in order to maximise public health. For both Figure 2: Participation Requests and Figure 3: Asset Transfer Requests, short term outcomes are highlighted in red. Overall, it was recognised that a *"constructive and assistive approach…on the part of public bodies [is required] in terms of policy environment, practice and attitude"* (9).

Figure 2: Participation Requests

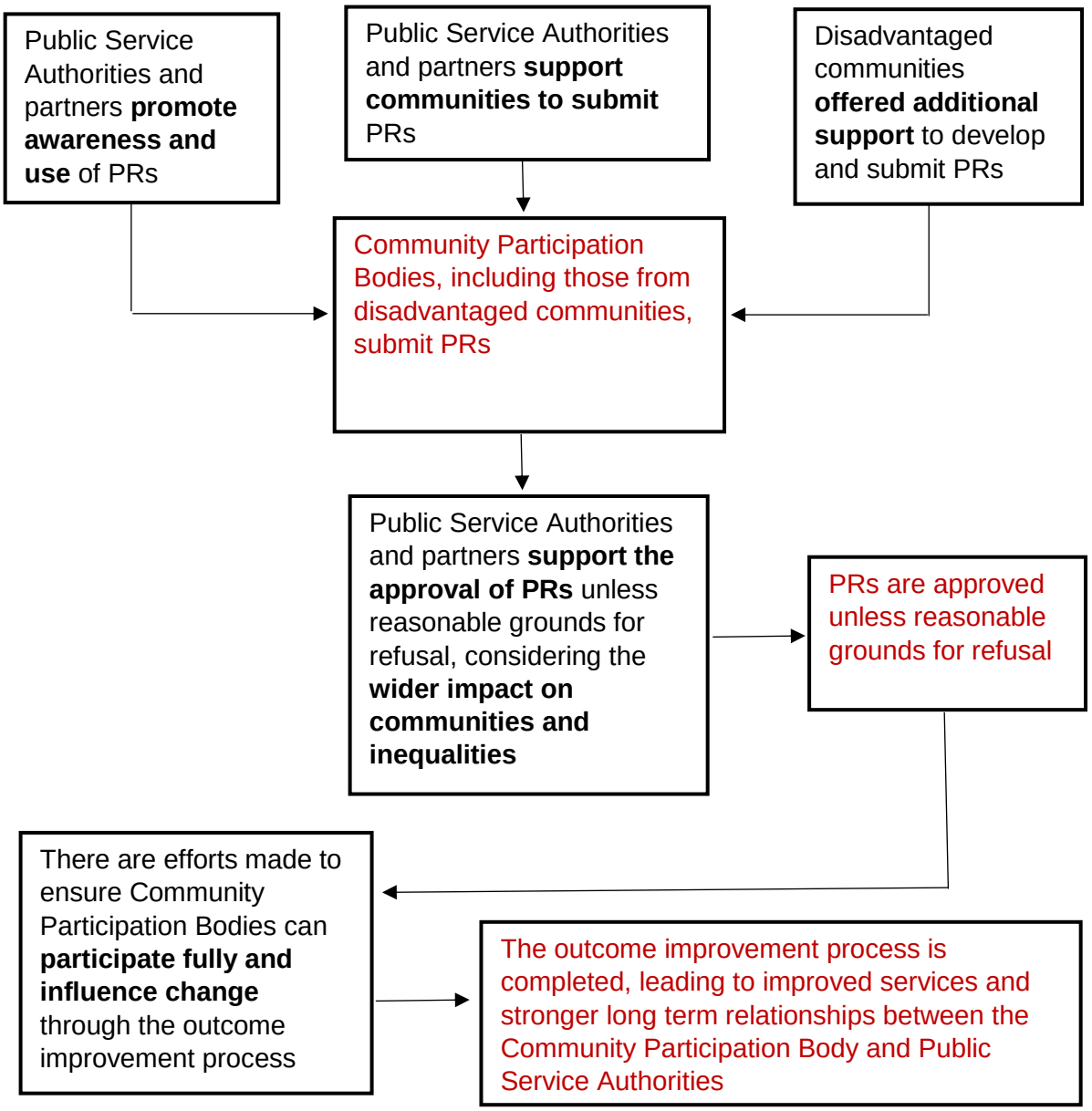
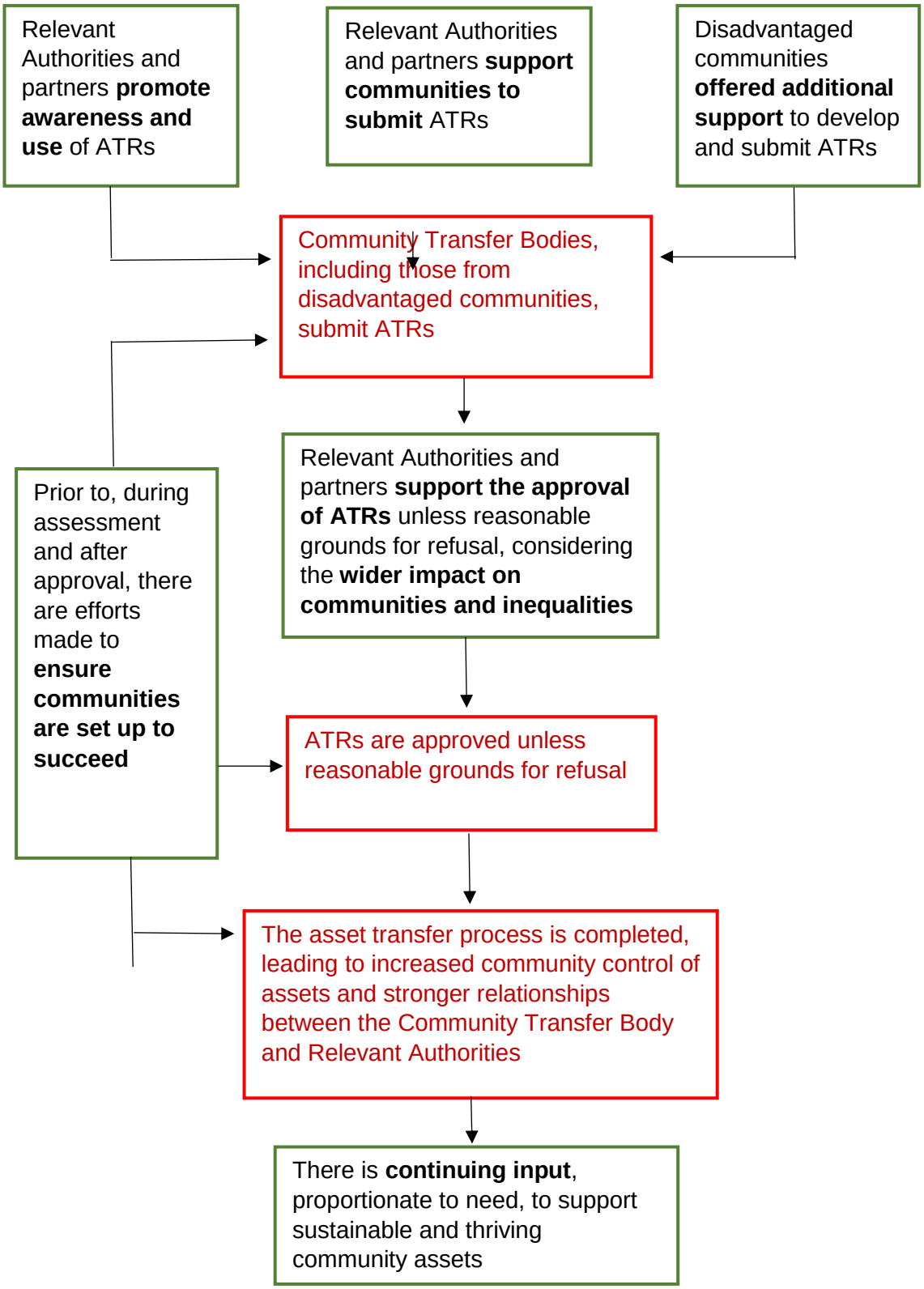


Figure 3: Asset Transfer Requests



Approach to Identifying the current situation

Outline Methods

Participation Request and Asset Transfer Request activity

Public bodies are required by the Act to publish annual reports which include how many PRs and ATRs they have received, whether they were agreed to or rejected and an outline of any promotional activities that took place. Some public bodies have also published the individual decision notices. SCDC and the Glasgow Caledonian Evaluation team helped to identify annual reports and requests that had been submitted in the 2017/18 financial year. 102 annual reports were reviewed and the following data gathered:

- promotional activities;
- if a PR or ATR had been received:
  - first public body name;
  - second public body name (where relevant);
  - decision;
  - Community organisation name;
  - Scottish Index of Multiple Deprivation (SIMD) quintile; using community meeting venue for PRs and location of asset for ATRs. SIMD is a widely used measure for ranking small area deprivation which takes into account average levels of income, employment, health, education, housing, geographic access to amenities and crime;[10]
  - Scottish Urban Rural Classification 6 (SURC-6); using community meeting venue for PRs and location of asset for ATRs. SURC-6 classifies areas into six categories, depending on population size and accessibility to larger settlements; [11] and
  - whether the community organisation was established before or for the purpose of submitting a request;
- in addition if a PR had been received, details regarding the:
  - topic of improvement; and
  - change to public service (planned and/or implemented);
- in addition if an ATR had been received, details regarding the:
  - name and type of asset; and
  - type of transfer.

Individual decision notices and community organisation websites were studied if further information was required regarding specific requests.

An analysis of the 2017/18 requests in included below

[10] For more information, see https://www2.gov.scot/Topics/Statistics/SIMD
[11] For more information, see https://www2.gov.scot/Topics/Statistics/About/Methodology/UrbanRuralClassification

Community organisation members' views

Five community organisations who have had experience in submitting a PR or ATR were contacted to provide their views on the process and outcome. This was done with the knowledge of the Glasgow Caledonian University evaluation team, to ensure that we were not approaching the same people. Three members of community organisations agreed to take part in the short timescales available; one was in the process of submitting an ATR, one had submitted a PR and was awaiting the decision and one had submitted a PR and had been part of an outcome improvement process. Interviews lasted between forty and ninety minutes. A topic guide was used to ensure all aspects of the request process and outcomes were discussed.

Public Health views

Public Health staff representing all Scottish territorial boards and NHS Health Scotland were contacted to take part in an interview. Although the primary aim of the interviews was to gather information on Public Health's input to community empowerment work, as the interviews progressed it became clear that the interviews should also be used to understand Public Health's views on the Act and so the topic guide was amended to incorporate this aspect. Fifteen interviews were conducted in total.

Available literature

Published and unpublished reports on the implementation of Parts 3 and 5 of the Act were sought. A literature scope was conducted on Medline, Embase, CINAHL and Proquest Public Health using the following search strategy: "Participation Request" OR "Asset Transfer Request" AND "Community Empowerment" from 2015 to present. This produced no results, which is unsurprising given that Parts 3 and 5 only came into effect in early 2017. We are otherwise aware of four reports which specifically look at PRs and ATRs:

- the Scottish Community Development Centre (SCDC) has conducted two online surveys around PRs and written a summary report (13);
- What Works Scotland has produced a report outlining opportunities and challenges of PRs (14);
- the Scottish Land Commission has reviewed the effectiveness of community ownership mechanisms, which includes asset transfer under the Community Empowerment (Scotland) Act 2015 (15); and
- Glasgow Caledonian University is undertaking a comprehensive evaluation of PRs and ATRs, on behalf of the Scottish Government. So far the interim reports are available but the final results will not be published until 2020.[12]

Due to the current limitations in the volume and scope of evidence around this topic, we also took into account collated previous published and unpublished reports which

[12] https://www.gov.scot/publications/independent-evaluation-of-community-empowerment-act-parts-3-and-5-interim-findings/

assessed the broader areas of community participation in public service improvement and the transfer of assets to community organisations, most notably the:

- Big Lottery Fund evaluation of community ownership, community control and sustainability – this is largely based on asset transfer prior to the Act and did not exclusively cover public sector asset acquisition (9); and the
- What Works Wellbeing systematic review on the impacts of joint decision-making on community wellbeing (8).

Pulling together the evidence

Using the proposed 'ideal situation' models, six broad areas were identified for review in order to build up a comprehensive picture of current implementation. These are:

(1) overall approach;
(2) awareness raising;
(3) support to submit requests;
(4) the decision making process;
(5) after the decision; and
(6) outcomes.

The results from the interviews and literature were divided into these categories and presented in the following sections.

Analysis of Participation Requests and Asset Transfer Request 2017/18

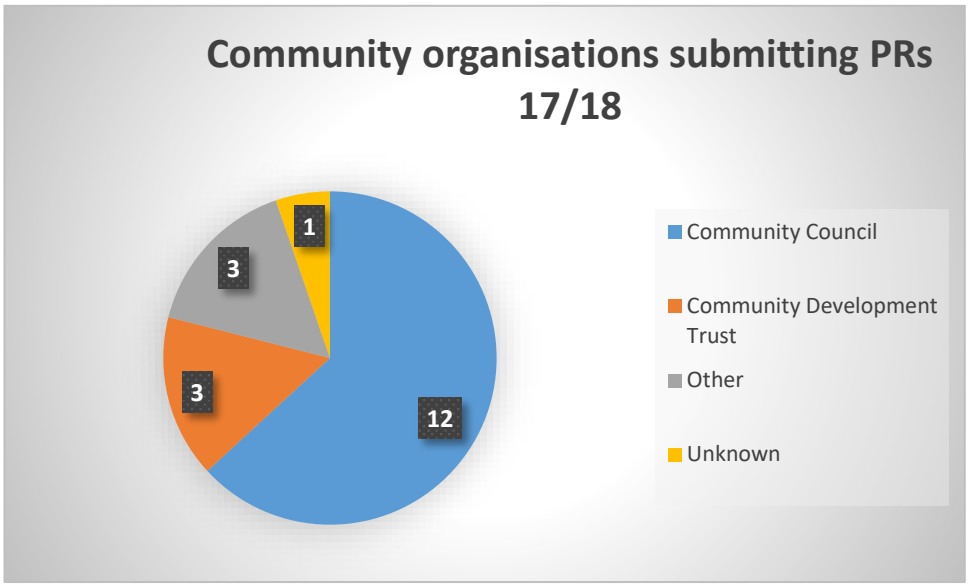
Participation Requests

21 PRs were identified which had been submitted in the 2017/18 financial year by 19 different community organisations. 20 (95%) listed a local authority as the primary Public Service Authority, although 5 of these requests also received input from another agency. 13 (62%) had been accepted, 7 (33%) rejected and 1 (5%) the outcome is unknown.

Community organisations

As Figure 3 demonstrates, the majority of requests (12/19) came from Community Councils.

Figure 3: Type of community organisations submitting PRs



All were established community organisations who had a history of working in their communities. Figures 4 and 5 show the pattern of submissions by area deprivation and rurality. Although small numbers hinder the ability to draw conclusions from these, requests do appear to be coming from community organisations who are based in areas with a range of deprivation levels. There may be a tendency for community organisations based in urban areas to be more likely to submit a request. The reason for this is unknown, but the project group discussed possibilities such as the need to submit PRs being less in rural communities and rurality acting as a confounding factor since community councils are more likely to submit requests.

Figure 4: Type of community organisation according to SIMD (Scottish Index of Multiple Deprivation) of meeting venue

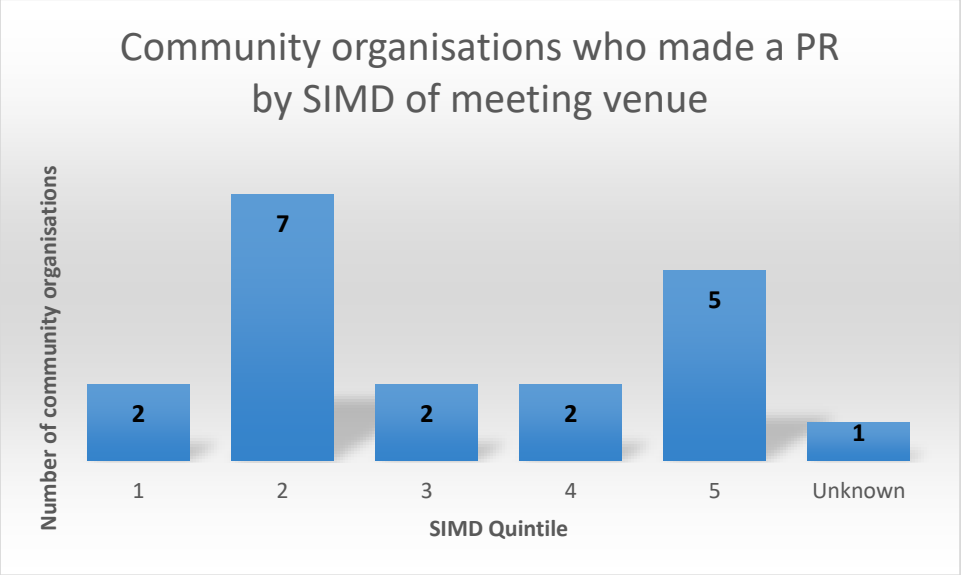
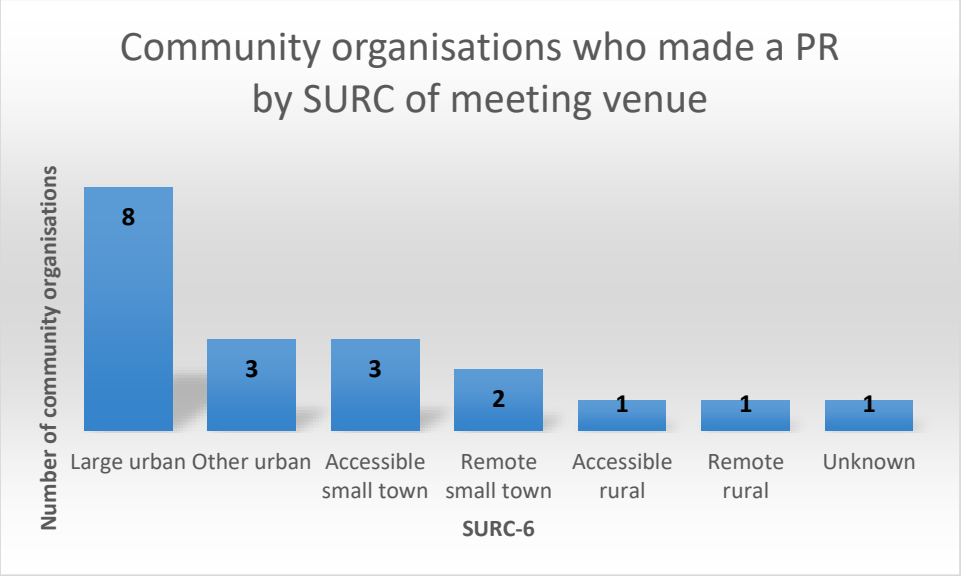


Figure 5: Type of community organisation according to SURC (Scottish Urban Rural Classification) of meeting venue



Topic of improvement

Table 1 outlines the topics which the community organisations wished to participate in. Two PRs were on exactly the same issue and so this has just been counted once. Overall, there has been a range of improvement topics considered. It would be useful to follow up the numbers accepted or rejected by topic area in the future to explore whether patterns emerge, (e.g. whether details of rejected PRs are less likely to be published).

Table 1: PR decision by topic area

	Total	Accepted	Rejected	Unknown
Traffic management, road and pavement infrastructure	5	4	1	0
Specific service provision to local community (police, school, early years child care)	4	3	0	1
Improvement of appearance	2	2	0	0
Community organisation reps on public body committees	2	0	2	0
Community infrastructure and service provision (general)	2	1	1	0
Access to current amenities	1	1	0	0
Environmental sustainability	1	0	1	0
Decision making on how land is used	1	1	0	0
Unknown	2	0	2	0
Total	20	12	7	1

Asset Transfer Requests

Prior to the Act, local authorities already had the necessary powers to transfer assets to communities at a discount without reference to Scottish Ministers. Different local authorities appear to have encouraged the transition to formal ATRs to varying extents. This means that a number of local authority transfers are still taking place as negotiated 'asset transfer agreements' outwith the Act. Since these agreements do not need to be reported in the ATR annual report, it is not possible to include them in our analysis.

Of the 63 ATRs identified as submitted in the 2017/18 financial year, 39 (62%) had been accepted, 6 (10%) rejected, 16 (25%) the outcome of the assessment was awaited and in 2 cases (3%) the community organisation had decided to withdraw their request. 53 (84%) listed a local authority as the primary Relevant Authority. Requests had also been made to Forest Enterprise Scotland, Highlands and Islands Enterprise, the NHS and Police Scotland.

Community organisations

As shown in Figure 6, community development trusts were the type of organisation most likely to make an ATR. Community councils are not an eligible organisational structure for ATRs which explains the contrast in numbers submitted compared to PRs. The majority (45/63; 71%) of those making ATRs were well established groups – see Figure 7. Only one organisation was set up for the purpose of making an ATR.

Figure 6: Type of community organisations submitting ATRs

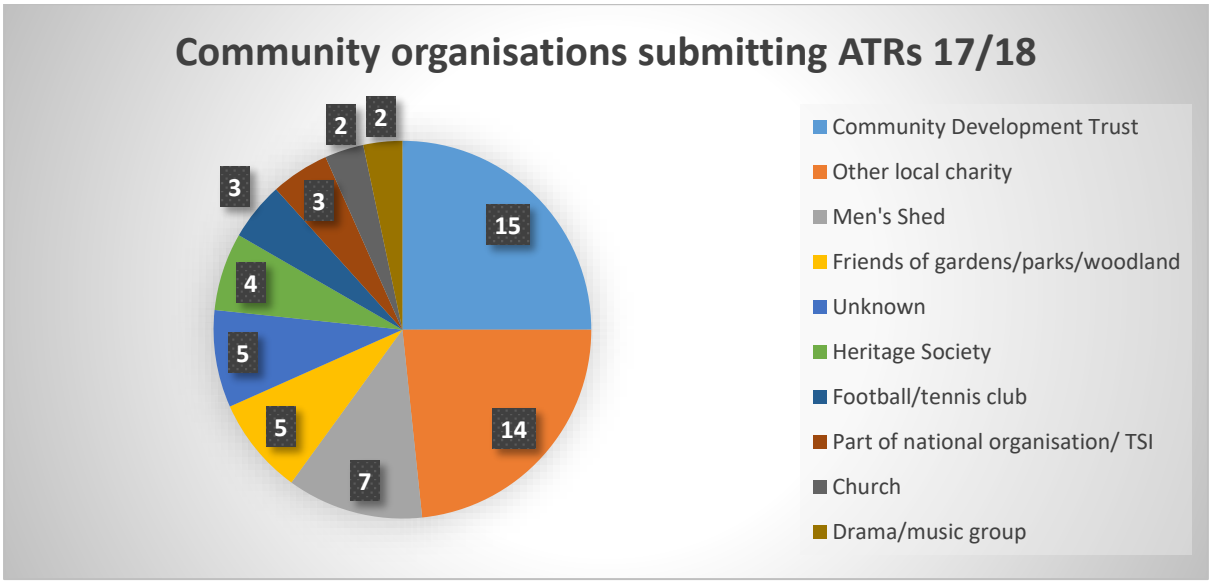
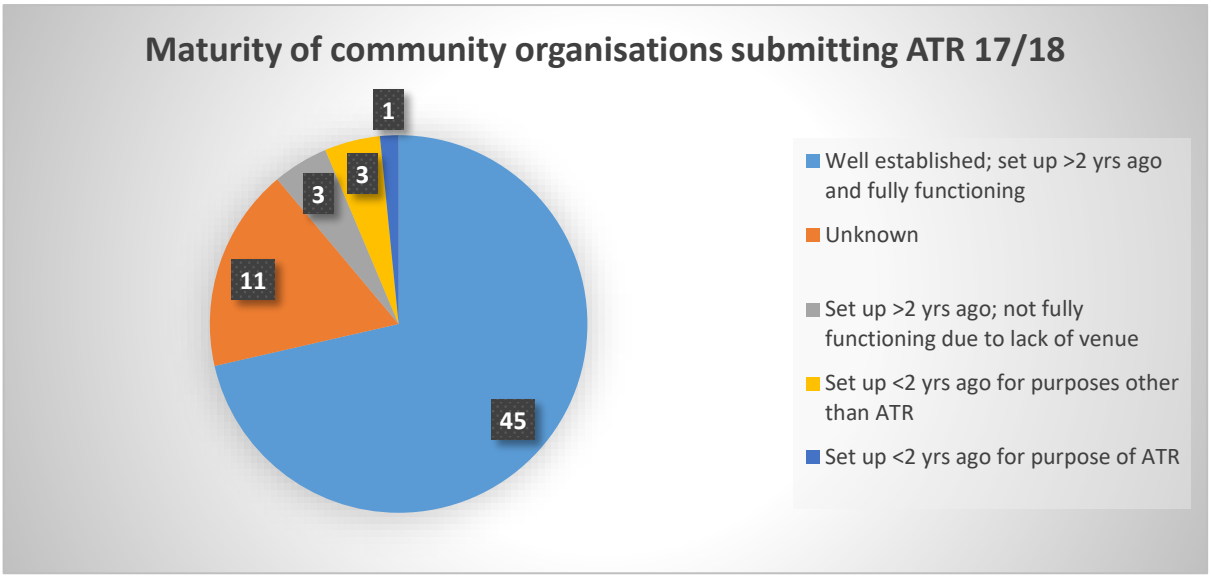


Figure 7: Maturity of community organisations submitting ATRs



Reason for and type of request

The most common primary reason for requesting ownership or lease of an asset was to use it for the community organisation's own programme delivery (see Figure 8). Other reasons were for: the general use by the community, the management/ regeneration of the requested land and the renovation of the requested building.

Figure 8: Reason for submitting an ATR

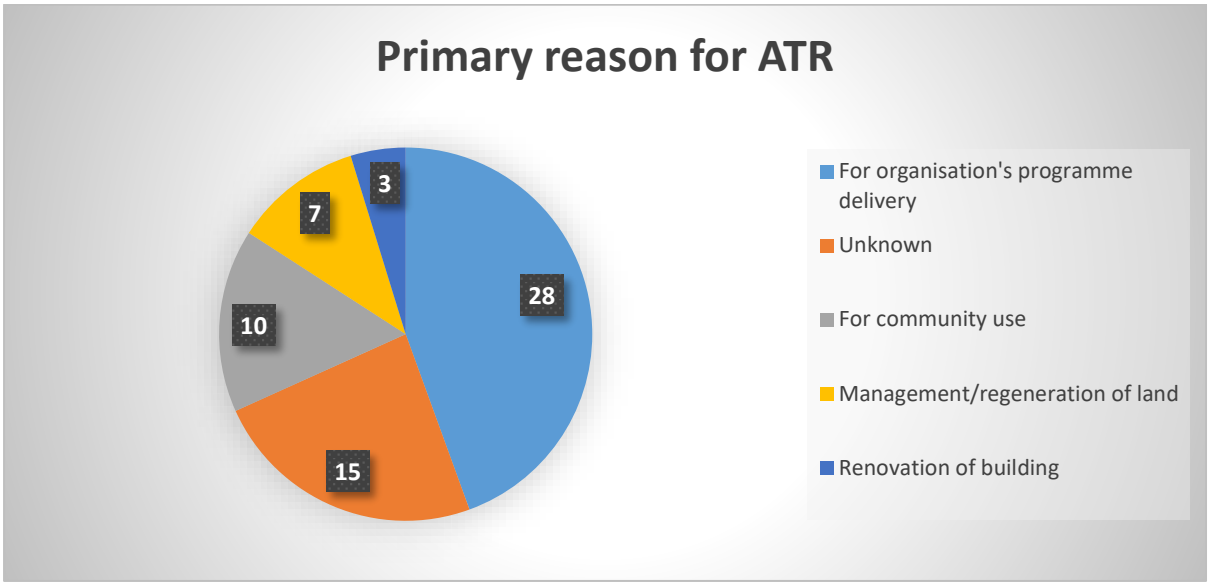


Table 2 outlines the type of asset and whether the request was for ownership or lease. For the purposes of this analysis, buildings have been categorised as either small (huts, changing rooms, public toilets) or large (anything bigger). The majority of requests were for ownership of an asset (42/63; 67%). This was consistent across the different types of assets.

Table 2: Type of assets requested

Type of asset	Total	Ownership	Lease	Unknown
Large building	26	18	5	3
Land	15	13	2	0
Small building	13	8	3	2
Building and land	5	2	2	1
Large and small buildings	1	1	0	0
Unknown	3	0	0	3
Total	63	42	12	9

Characteristics *of assets and assessment outcome*

As Figure 9 demonstrates, requests have been made for assets in all SIMD quintiles. The lowest numbers have been for assets located in the most deprived and least deprived categories and the highest numbers for assets in SIMD quintile 3. The reasons for this pattern are unknown but the project group discussed various potential influencing factors such as community capacity, community need, the total number of assets available in a community, Relevant Authority attitudes and approaches and the challenges around measuring area deprivation in remote and rural communities.

Figure 9: SIMD of asset location

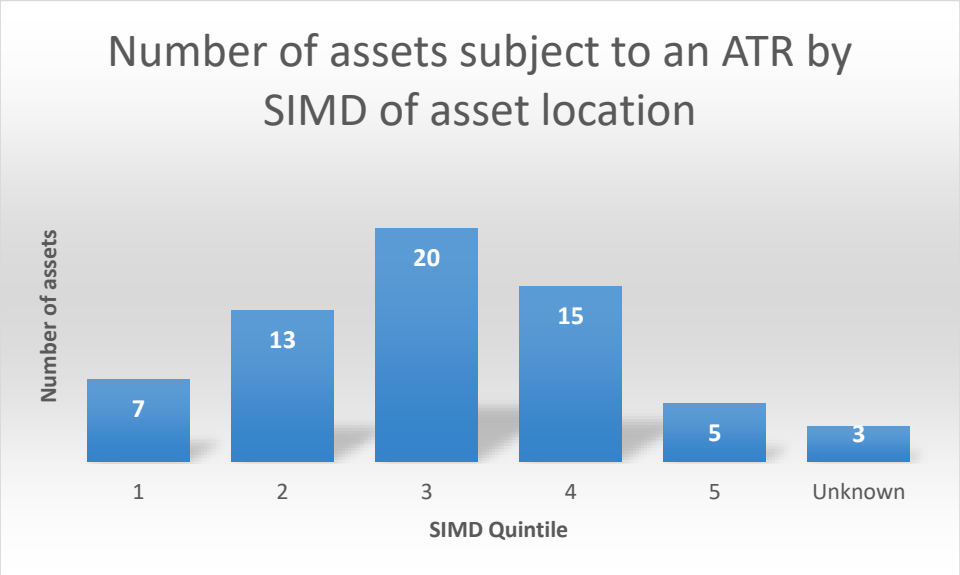
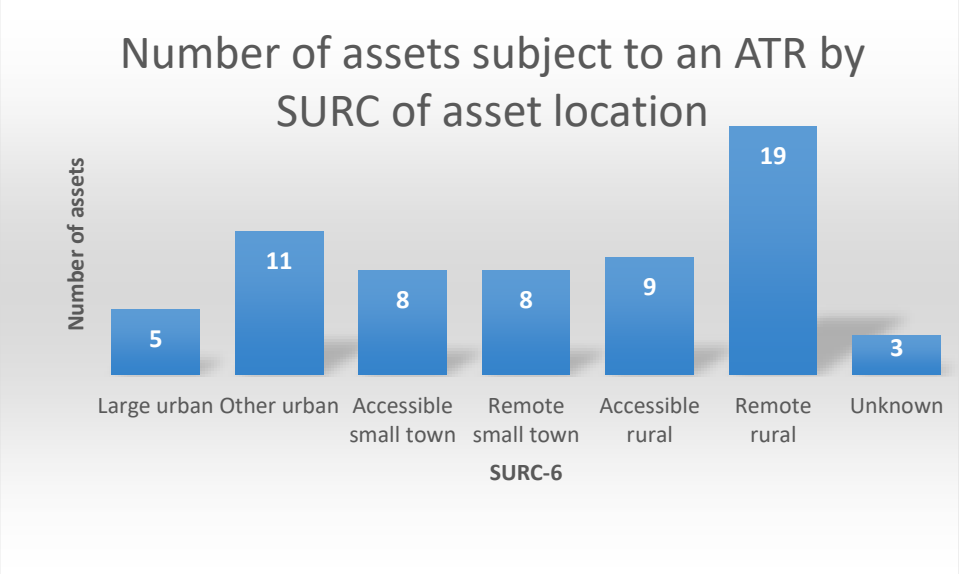


Figure 10: Rurality of asset location, according to SURC-6



There have been requests made for assets across the six Scottish urban rural categories and on a fairly equal basis – see Figure 10. The exception appears to be for remote rural assets, where numbers have been higher. Reasons for this may include:

- higher awareness levels – there is a legacy of high levels of community ownership in rural areas;[13]
- market failure – where economies of scale do not exist communities recognise that they have to respond to the closure of assets to protect service delivery;
- higher levels of volunteerism – it has been suggested that there is a "more limited interest in volunteering in urban areas" (16);
- additional funding and technical support available – for example initiatives such as LEADER, the Scottish Rural Development Programme, or Highlands and Islands Enterprise;
- more affordable assets – this may influence both the communities' ability to secure funding and the Relevant Authorities willingness to support asset; and
- transfer of assets – in preference to selling on the open market (17).

Tables 3 and 4 suggest that, by the time that a formal ATR is submitted, the majority are accepted regardless of rurality or type of asset (noting that in 16 cases the assessment was ongoing).

Table 3: Asset SURC-6 by assessment outcome

SURC-6	Total	Accepted	Rejected	Ongoing	Withdrew
Large urban	5	4	0	1	0
Other urban	11	7	0	3	1
Accessible small town	8	5	0	3	0
Remote small town	8	6	0	1	1
Accessible rural	9	7	1	1	0
Remote rural	19	10	3	6	0
Unknown	3	0	2	1	0
Total	63	39	6	16	2

[13] See: https://www.gov.scot/binaries/content/documents/govscot/publications/statistics-publication/2017/12/estimate-community-owned-land-scotland-2017/documents/00528578-pdf/00528578-pdf/govscot%3Adocument

Table 4: Type of asset by assessment outcome

Type of asset	Total	Accepted	Rejected	Ongoing	Withdrew
Large building	26	16	1	7	2
Land	15	10	3	2	0
Small building	13	8	0	5	0
Building and land	5	4	0	1	0
Large and small buildings	1	1	0	0	0
Unknown	3	0	2	1	0
Total	63	39	6	16	2

Overall approach

Ideal Situation: coordinated and assistive

Below are the findings related to the overall approaches taken by public bodies. The evidence is heavily weighted towards approaches taken by local authorities when dealing with asset transfer. This is likely due to the higher number of these taking place; asset transfer by other Relevant Authorities such as the NHS and PRs are much less well established.

Asset Transfer Requests

Although not specifically looking at ATR under the Act, findings from the evaluation of Big Lottery Funded community projects alludes to possible room for improvement in the overall approach to asset transfer; around 50% of participants stated “the organisation transferring the asset to us was helpful and supportive” (9).

Likewise, the Scottish Land Commission review found high variability in the support and attitude of Relevant Authorities (15). There were some examples of assistive and approachable Relevant Authorities, with associated opportunities for shared learning. As one participant reportedly noted:

“*It definitely felt like the Council wanted us to have the asset as much as we wanted it*”.

Others were identified as not complying with the legislation and/or the spirit of the guidance. There were examples where community organisations were left feeling undermined and that the Relevant Authority had underestimated their abilities. Some processes were seen to lack transparency, robustness and simplicity. The Scottish Land Commission review recommends that Relevant Authorities should be encouraging

the simplest route for asset transfer, as deemed appropriate for the situation (15). In many cases this would be through negotiated transfer, e.g. if seeking to extend an existing arrangement, seeking a short-term lease or the asset market value is low. However, it was thought that some Relevant Authorities are requiring community organisations to go through complicated processes unnecessarily. In addition, some have created an additional 'expression of interest' (EoI) stage. This may be useful so long as it enables the development of stronger requests and it is made clear that this stage is not part of the legislation and therefore not mandatory. It is not possible to ascertain how many EoIs are being submitted as this is not required to be published in the annual reports.

Most community organisations interviewed as part of the Scottish Land Commission review found the asset transfer process challenging and stressful, although those who already lacked trust in the Relevant Authority appeared to have worse experiences (15). Likewise, the review noted that a pre-existing good relationship between the landowner and community and clear lines of communication were perceived as helping negotiated transfers. This suggests that the status of the pre-existing relationship may affect the overall experience for community organisations seeking an asset transfer.

Finally, Community Ownership Support Service (COSS) and the Scottish Land Commission review have expressed how asset transfer is primarily being managed in a reactive way, e.g. when the asset is at threat of closure. There is a need for a more proactive strategic approach (15). This would allow more collaborative and less hasty applications to be made.

Public sector barriers to providing a supportive and coordinated approach towards PRs and ATRs

A list of barriers described in the literature are outlined in Table 5 (13-15).

Table 5: Barriers to involvement in submission of PRs and ATRs for public sector staff

Topic	Barriers to PRs	Barriers to ATRs
Process and decision making	Difficulty understanding the process	Difficulty considering transfer from multiple dimensions e.g. future site security, future strategic use of asset
		Staff can feel there are unrealistic demands from community organisations e.g. expecting staff to lead on the asset transfer process, refusing to think more broadly about whole communities needs and views
		Potential tension between supporting requests and being the decision makers
Resource and capacity	Lack capacity to support submissions; the findings of a survey of Community Planning Officials revealed that the majority of respondents involved in PRs stated that none of their time was specifically allocated to this (14).	Lack of capacity
	Lack of appropriate skill mix of staff	Lack of skills
		Costs to the Relevant Authority
Control	Difficulty handing over control to community organisations	Difficulty handing over control to community organisations; public sector is 'naturally cautious' and risk averse
		Concern around impact on Relevant Authority if asset lost
		Concern around capacity of some communities
View of requests	'One piece of the puzzle' to promoting open dialogue with communities versus 'the last resort' for communities wishing to complain about an issue	

The Public Health interviews captured some staff perceptions of public sector barriers to PRs. These were consistent with the literature:

- lack of capacity;
- lack of understanding around the processes; and
- transfer viewed as a 'the last resort'.

In this last regard, one example identified was an EoI which was not supported by the public body for development into a PR, but instead the member of the public was asked to engage with the issue through 'normal' routes.

Barriers regarding resource, capacity, skills and perceptions of control are not unique to implementation of the Act and may represent a wider issue around barriers to collaborative working in general (18,19).

Barriers to ATRs were not discussed by Public Health staff.

Awareness raising

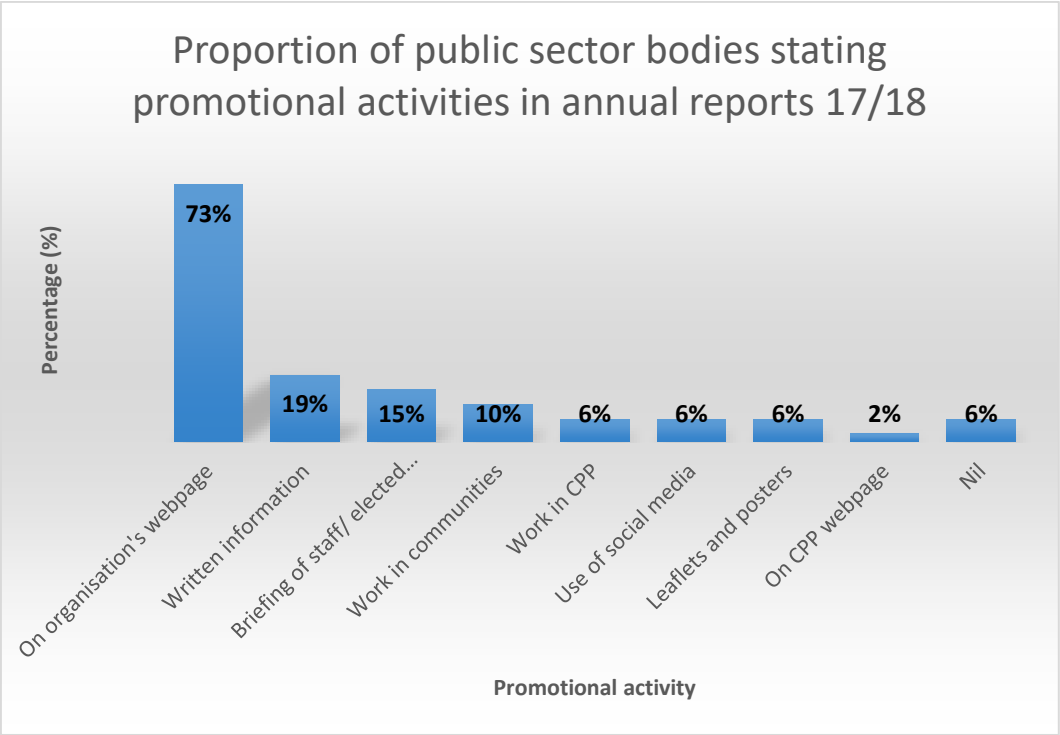
Ideal Situation: community and public body members should be aware of, and know how to make use of, PRs and ATRs. Community organisations should understand which public bodies can be approached regarding a request.

Current activity

SCDC and COSS have developed information briefings on PRs and ATRs. They have delivered a number of awareness raising sessions to community organisations, third sector and public bodies.

Out of the 48 public sector bodies whose annual reports were reviewed, 35 (73%) stated that information on PRs and ATRs was available on their webpage – see Figure 11. Other types of promotional activity were less frequently stated but included providing written information to community councils, information in community newsletters and guidance, briefing of staff and elected members and awareness raising in CPPs. Work in communities tended to focus on specific awareness raising events. However, we are aware of a number of examples where awareness raising has been carried out by public sector bodies opportunistically whilst working in collaboration with community organisations. The frequency of promotional activities in communities is, therefore, likely to be an underestimate.

Figure 11: Awareness raising by public sector bodies



Effectiveness of awareness-raising efforts

An online survey carried out by SCDC in spring 2017 revealed that 58% of respondents had not heard of PRs (13). A follow up survey in 2018 suggested awareness of PRs may have increased but there was still much room for improvement (13,14). The community organisation members we interviewed had heard about PRs through various ways including through the local authority, the Equalities and Human Rights Commission and other community organisations (see Appendix 3). All the members took a very proactive approach to finding out more, mainly by researching online.

In terms of ATR, the Scottish Land Commission review indicated that some community organisations were unaware of (15):

- the time commitments and responsibilities associated with asset transfer;
- the costs associated with asset transfer, and so not everything was included in fundraising applications;
- the pressures and constraints on Relevant Authorities;
- knowledge of other sources of support and when to approach them; and
- the optionality of EoIs;

The report also noted situations when Relevant Authorities were looking to dispose of an asset, although some had been proactively informing community organisations of their intention to dispose of an asset, others not been doing so despite knowing there was community interest. In the same way, the process of negotiating a discount and

the extension of timescales were not widely understood by community organisation members or Relevant Authorities.

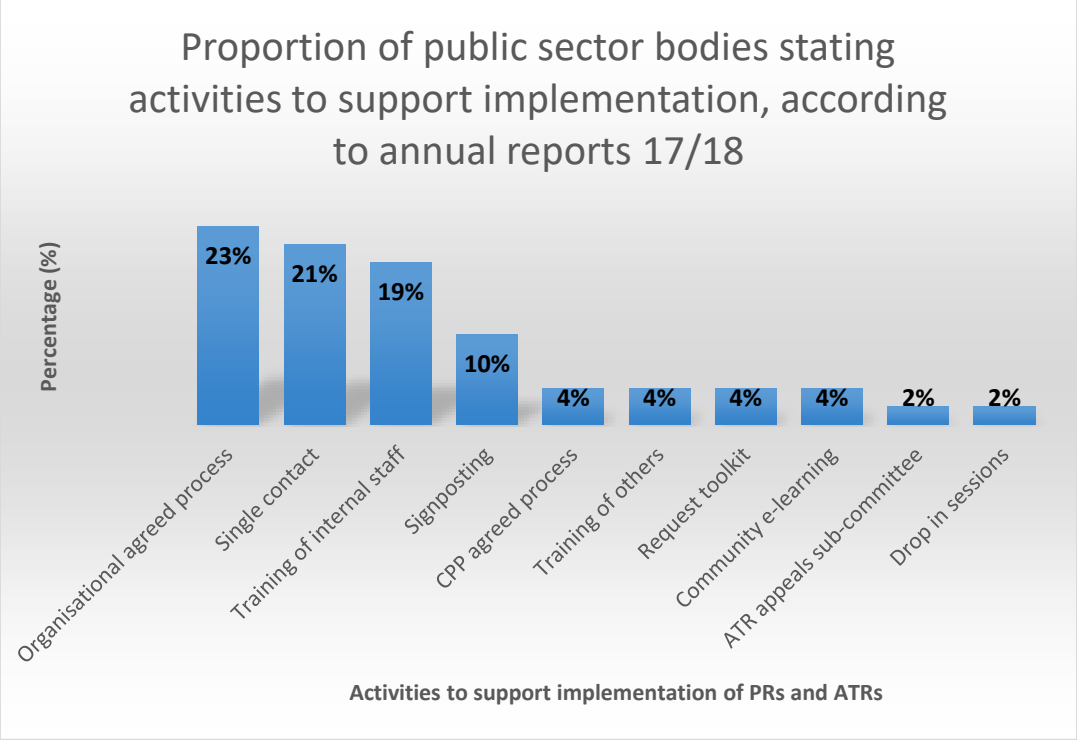
Support to submit requests

Ideal Situation: *community organisations should be supported to make requests. Support should be provided to ensure proposals are sustainable, e.g. for ATRs, consideration has been made around lease/ ownership/ use, community engagement with wider community, quality of the asset, financial and business planning, etc. Additional support should be provided to disadvantaged and marginalised communities.*

Current activity

Support should be available through the public body which the request is intended for. Wider support is available through, e.g. COSS, SCDC, Highlands and Islands Enterprise and the Community Woodland Association. Other community organisations with related experience may be a useful additional source of support.

Figure 12: Activities by public sector bodies to support requests



As shown in Figure 12, out of the 48 public sector bodies whose annual reports were reviewed, the most frequently stated activities to support implementation were: having an organisational agreed process for dealing with requests (23%), having a single point of contact for request enquiries and submissions (21%) and training of staff within their organisation (19%). Other less frequently stated activities included having an agreed process across CPP partners and training of others (nominated CPP reps and community counsellors). One public sector body stated that they had established an

ATR appeals sub-committee and one had held drop in sessions for community organisations to discuss asset transfer options.

Identification of key areas where support to submit requests is required

The findings from the literature and interviews were used to identify key barriers faced by members of the public with regards to submitting requests (13-15). From these, three key areas emerged where support to submit requests is required (see Table 7*)*. The Public Health interviews highlighted that staff saw lack of community capacity and the complexity of the process as barriers for communities. For example, an informal group of people may have a shared idea to progress into a PR but it is particularly challenging for this type of group to work together to jump over all the legislative hurdles. The literature emphasises that barriers tend to be greater for disadvantaged and marginalised people and informal community groups (13-15). Difficulty in acquiring funding for asset development work may be more so in disadvantaged communities, where the need for this funding is likely to be particularly high (15).

- *Key area 1: Community capacity building and identification of opportunities* - Clear understanding of community need and strong leadership within the community organisation have been shown to be facilitating factors in negotiated asset transfers (15). In contrast, landowners were more wary of entering into negotiations when they perceived community bodies as lacking in capacity or having undertaken insufficient business planning (15). Although only three interviews were conducted with community organisation members, they did reveal some similarities in levels of capacity. In each case, the community organisation leads:
  - had **time** to submit a request; e.g. retired or employed by the community organization;
  - had the **skills** to submit a request; leads included a community organisation university lecturer, writer, project manager and a retired councilor;
  - were **well networked** within their communities; and
  - had the **self-belief** that they could make a request.

Table 7: Barriers to submission of PRs and ATRs for members of the public

Key area	Barriers to PRs	Barriers to ATRs
Community capacity and identification of opportunities	Lack belief that acquire necessary skills	Lack belief that acquire necessary skills
	Lack of confidence that PR will bring about the desired change, lack of trust in public service providers	Need for extensive skillsets and rapid learning
	Those recovering from mental illness may lack confidence to work with others	Known costs (planning and surveys, valuation fees, development work, etc)
	Difficulty accessing information and forms (many online only)	Hidden costs (e.g. unexpected legal fees)
	Use of complicated language	Lack of capacity to work up and submit request
	Need for translated materials and translators	
	Lack of capacity to work up and submit request	
Eligibility to submit a request	Not part of a community organisation	Not part of a community organisation
	Difficulty becoming part of a community organisation (e.g. social isolation)	Community group is not constituted
Deciding on content and writing the request	Difficulty understanding if/how PRs are relevant to the issue they wish to see addressed	Process seems unnecessarily complex and time-consuming (more so than prior to the Act)
	Difficulty understanding the process	Process lacks flexibility
	Difficulty in filling out the form (e.g. identifying the outcome of the improvement process)	Difficulty in speaking to the 'right' people in the Relevant Authority to help them
		Difficulty in determining the most suitable source of advice

- *Key area 2: Eligibility to submit requests* – the interviews with community organisation members did not reveal any difficulties with the eligibility criteria to submit a request (see Appendix 3). However, in the Scottish Land Commission review, one community organisation received conflicting advice regarding how to become an eligible Community Transfer Body and it took three months to get charitable status as a Scottish Charitable Incorporated Organisation (15). There is less likely to be an issue around eligibility for well-established community organisations, which may be a contributing factor as to why the majority of submissions have come from these types of organisation (e.g. see Figure 7). As

one Public Health interview highlighted, it is likely much more challenging for an informal group of people with a shared idea to make progress.

- *Key area 3: Deciding on content and writing the request* – the Scottish Land Commission review found that assigned development officers were valued particularly when the transfer was regarding a large asset (15). Some community organisations had tried leasing the asset before buying it, which gave them and the Relevant Authority the confidence to transfer ownership. Others had decided that ownership was not desirable (15). This was the case for the community organisation which we interviewed, who decided they wished to request a long term lease (see Appendix 3*: Deciding on the content of request*). Both accounts provided by the community organisation members demonstrated support from the Relevant Authority (local authority in each case) and wider sources of support, e.g. SCDC, another community organisation and a professional fundraiser.

  The community organisation members who we interviewed relied predominantly on their own experience and skills to write the request (see Appendix 3*: Writing the request)*. Interestingly, both PR-writers found it challenging to know how to word what they were asking for. They were uncertain how specific to be and if the emphasis should rest on how they wished to participate or service outcomes.

The decision making process

Ideal situation: communities should have their PRs/ATRs approved unless reasonable grounds for refusal; consideration is taken of the wider impact on communities and inequalities. Responses are provided in a timely manner.

Timescales

There are clearly defined deadlines within the Act to avoid protracted negotiations. If these timelines are not met then they provide a basis for appeal. Anecdotal evidence from community organisations suggests that once PRs are submitted, they are being responded to fairly quickly (13). However, one community organisation member interviewed perceived the reluctance to validate their PR as a delay tactic whilst the local authority decided what to do.

In the Scottish Land Commission review, two organisations found that the decision to transfer the asset to the community had been informally agreed at an early stage; the final decision being '*just a formality*' and fairly quick. Our interview with a member of a community organisation indicated that they also felt that the transfer had already been informally agreed (see Appendix 3).

The assessment process

In the literature and our interviews, decision-making assessments have been viewed as somewhat subjective (13,15). As a result, the community organisation members who we interviewed and had submitted PRs lacked confidence in the process. Some Relevant Authorities have been perceived to reject ATRs which appeared viable (15). One organisation who thought a transfer had been informally agreed then had their formal ATR rejected, since the local authority had decided they now needed the land for their own use (15). The interview with one community organisation member in particular highlighted the potential tension between the same public sector staff member supporting a request and being the decision-maker (see Appendix 3).

The literature suggests that some public sector staff find it difficult to comprehensively assess a request, e.g. due to the multiple dimensions that need to be considered (14,15). One community organisation member perceived the local authority as struggling to manage their PR since, for example, they had not submitted an EoI and the local authority viewed the issue as one that needed to involve several stakeholders, not just the community organisation who had submitted the request (see Appendix 3). Published papers on joint-decision making more broadly have raised the possibility that public bodies find it difficult to know what to do when community members come with their own agendas (19).

In contrast, Forest Enterprise Scotland has a process which has been highlighted as good practice, since they use an independent panel to assess applications (15). One Relevant Authority stated in their 2017/18 annual report that they had set up an ATR appeals sub-committee (see Figure 12). Public Service Authorities and community organisations whom What Works Scotland spoke to suggested that, if a PR is to be rejected, other options for continued engagement should be discussed (14).

After the request has been approved

Ideal Situation: Community Participation Bodies should be supported to participate fully and influence change through the outcome improvement process. There are efforts made to ensure Community Transfer Bodies are set up to succeed. There is continuing input to support sustainable and thriving community assets.

Continuing 'aftercare' for ATRs

For the transfer of assets, it has been recognised that a "lack of aftercare" can be problematic (9). Although not specifically in the context of ATRs, the Big Lottery evaluation suggested that the overall support received by the community organisations was at its greatest in the early stages of project development and then became increasingly less as time went on (9). This is backed by findings in the Scottish Land Commission review; many community organisation members felt that community

ownership of an asset was too often portrayed by Relevant Authorities as the end point, whereas in reality it was just the beginning for the community organisation (15).

Since most assets will require work to become fit for purpose, there is a need for development funding, particularly in the most disadvantaged communities (15). An organisation in the Scottish Land Commission review were completely reliant on getting funding from one source, which was unsuccessful. They stated that:
"*the building is falling down…people are frustrated with the lack of progress. The Board are falling out with each other*" (15).

COSS suggest that the other financial challenge is generating sufficient income to cover the costs of running the asset. They recognise that there is a need for greater understanding of the experiences of community organisations and the sustainability of assets once they have been transferred. COSS are currently looking to conduct research to address this.

The outcome improvement process for PRs

Although not specifically on outcome improvement processes, Daykin et al suggest two different methods used by public bodies to manage situations where community members come with their own agendas; by refocussing the outcomes to fit into the public body's agenda or by listening to the other perspectives but not incorporating them into actions (18). Interestingly, the community organisation member whom we interviewed and had been through an outcome improvement process felt like both of these had happened (see Appendix 3). Despite this, the interviewee had an overall encouraging experience; particular positives were:

- having the opportunity to meet with all the relevant stakeholders;
- being acknowledged and listened to; and
- being treated as an equal contributor to meetings and follow up actions.

Work conducted by SCDC suggests that some community members have not had encouraging experiences, but instead have (13):

- had to take responsibility for initiating meetings and ensuring progress is made;
- felt there was a lack of communication from the Public Service Authority;
- not been given the opportunity to meet with all necessary stakeholders; and
- been disappointed at the process of involvement; seeming at times more tokenistic than meaningful.

Other problems with previous joint improvement processes have been outlined in the literature and may be relevant to outcome improvement processes (5,8,20):

- community organisation members not being given the opportunity to participate fully, including meetings being held at times and venues which are not suitable;
- lack of progress;
- lack of public sector capacity and resource;

- community organisation members coming under strain and fatigue from involvement;
- concerns regarding how well the community organisation representative(s) actually represent the wider community (e.g. overrepresentation of healthy 'middle class' views);
- concerns regarding lack of accountability to the wider community; and
- difficulties with the process may be felt most by disadvantaged communities, disabled people and people experiencing ill-health.

For recommendations on factors that may promote more effective involvement of communities in joint decision-making interventions, see Appendix 4.

Outcomes

Ideal Situation: Outcomes for PRs_should include improvements to public services, improved sense of control over public services by members of communities, good relationships with the public body and wider community benefits

Reflecting the complex nature of many of the requests, most outcome improvement processes reported so far appear to be ongoing and so it is too early to be able to identify resultant public service changes. However, beneficial outcomes from PRs have included:

- better community engagement around issues that impact them;
- better community engagement around public body strategies and policies;
- more effective relationships between community organisations and public bodies; and
- perceived improvements in physical environments.

Previous studies looking at joint-decision making more broadly in the context of health services have also suggested public participation to have influenced (18,19):

- health services to be more holistic and patient-centred;
- health services to be more accessible to 'marginalised' communities;
- the destigmatisation of some illnesses; and
- health professionals to place higher value in public participation.

This is set against the potential for problematic outcomes. Taking into account literature around joint-decision making efforts more generally, these may include (5,8,18-20):

- worsening of relationships between community organisation and public body due to negative experience during the outcome improvement process;
- disillusionment/ feelings of contribution being tokenistic when community members suggestions are not acted upon;
- perceived lack of tangible outcomes;
- difficulty quantifying how public participation improved service; and

- unknown whether there is an unequal distribution of impacts across population groups in the wider community.

Ideal Situation: Outcomes for ATRs *should include sustainable use of asset by the community organisation, improved sense of control over what goes on in the local community, good relationships with the public body and wider community benefits*

As part of an ATR, community organisations need to state the community benefits that could be expected if the request was agreed to, under the following areas: economic development, regeneration, public health, social wellbeing, environmental wellbeing and reduction in inequalities of outcome. It is not possible to provide a comprehensive account regarding the extent to which these have been delivered. Relevant Authorities are not required to report on this and many of the asset transfers are still ongoing.
Positive outcomes from the Scottish Land Commission review include (15):

- community organisation members feeling joy at a successful asset transfer;
- increased knowledge and skills through activities such as community engagement and developing business plans;
- improved networks with other community organisations; and
- improved community motivation, cohesion and pride.

Problematic outcomes from this same review include (15):

- community organisation members left feeling disappointed, exasperated and disillusioned by the process;
- worsening of relationships between community organisation and public body; and
- fatigue and burn out of a core group of volunteers within the community organisation

We are aware that in two out of the six community organisations who have had ATRs rejected have appealed to Scottish Ministers.

Overview of findings

We recognise that evidence is limited with regards to how well the Act is being implemented and its impacts. The Scottish Government commissioned evaluation, amongst other ongoing research, should help address this gap. We conducted a literature review, interviews with community organisation members and Public Health staff and analysed PR and ATR annual reports. Our findings were organised into the following categories: overall approach, awareness raising, support to submit requests, the decision making process, after the decision and outcomes. In each of these areas we found aspects of the implementation of Parts 3 and 5 that are working well and others where improvements are required.

Overall approach by public bodies

Positive Signs	• There are examples of assistive and approachable public bodies
Areas for further development	• Some public bodies have been seen to not be complying with the Act and/ or the spirit of the guidance, e.g. some are not making it clear that EoIs are optional, not taking a proportionate view of the level of information/ details required from communities. • Some public body processes appear to be lacking in transparency, robustness and simplicity. • Asset transfers are primarily being managed in a reactive rather than strategic way. • Not all Public Service Authorities/ Relevant Authorities appear to be supporting the implementation of Parts 3 and 5 to the same extent, e.g. according to the annual reports, 23% have an agreed process and 21% have a single point of contact.

Awareness raising

Positive Signs	• There appears to be growing awareness of the Act amongst community organisations. • Public bodies have promoted PRs and ATRs through a variety of organised and opportunistic means.
Areas for further development	• There is a need for more awareness raising and training amongst communities and public sector staff and for this to be done so in the context of raising awareness about participation and asset transfer options more generally.

Support to submit requests

Positive Signs	• Public bodies have supported the implementation of PRs and ATRs through a variety of methods, e.g. through the establishment of organisational agreed processes and having a single point of contact for request enquiries and submissions. • Community organisation members have reported receiving valuable support from regional and national third sector organisations and other community organisations with related experience.
Areas for further development	• Individuals and communities who are most disempowered have potentially the most to gain from PRs and ATRs but also face the most barriers to participation. • The vast majority of requests have come from well-established community organisations who were already well networked within their communities; informal groups are much less likely to make sufficient progress in order to submit a request. • Some community organisations have found it challenging to know the type of wording which is expected in requests, particularly around proposed outcomes.

The decision making process

Positive Signs	• It appears that the majority of decisions are being made in a timely manner, in accordance with the Act.
Areas for further development	• Some public sector staff have found it challenging to comprehensively assess a request, e.g. due to the multiple dimensions that need to be considered. • The decision-making assessments have been viewed as somewhat subjective.

After the decision

Positive Signs	• The community organisation member we interviewed had an overall encouraging experience with regards to the outcome improvement process.
Areas for further development	• The asset transfer process and the outcome improvement process can be time consuming and stressful; those who already have poor relationships with the public body may have worse experiences. • Some members of community organisations have felt that there is a lack of ‘aftercare’ by Relevant Authorities and partners, after an asset has been transferred.

	• There is no recognised process whereby community organisations and Public Service Authorities/ Relevant Authorities can learn from each other's experience.

Outcomes

Positive Signs	• There have been PRs and ATRs submitted from community organisations based in areas with a range of deprivation levels. • There have been a range of assets and improvement topics considered through requests. • There are examples of outcome improvement processes leading to improved community engagement and more effective long-term relationships between the Public Service Authority and Community Participation Body. • There are examples of successful asset transfers under the Act leading to improved community motivation, cohesion and pride.
Areas for further development	• Potential problematic outcomes include worsening of relationships between the community organisation and public body, and burn out of a core group of volunteers within the community organization.

Limitations

Despite being a requirement of the Community Empowerment Act, not all public sector bodies submitted annual reports in 2017/18 and those that did, did so with varying levels of detail. It is therefore possible that we have not included all PRs and ATRs submitted in this period and highly likely that not all promotional and support activities have been captured. Although SIMD is a well-recognised method of ranking area deprivation, it does not tell us about individual-level deprivation; it fails to tell us about the backgrounds of those who are leading on the request submissions or using the asset/ meeting venue. Since the annual reports only cover up till March 2018, we are unable to look at patterns of request submissions after this time. The conclusions that we can make, particularly for PRs, are limited due to the small numbers of requests and so apparent patterns may be solely due to chance. The evaluation team at Glasgow Caledonian University is planning to analyse the 2018/19 annual reports and it will be interesting to see if this evaluation supports our emerging findings. It would also have been useful to have been able to look at numbers of expressions of interest, how many go on to become formal requests and whether outcomes differ between those who make EoIs and those who go straight to submitting a formal request. However, these data are not available.

Due to time constraints, only three interviews with community organisation members were able to be conducted. Two were contacted via SCDC; contacting organisations through a support organisation such as SCDC may lead to an over-representation of

views drawn from groups requiring support. However, the need for support has also been established in the available literature (13,14). The Public Health staff and community organisation members' views are not necessarily representative of wider views but provide insight into some perspectives. Finally, it may have been helpful to conduct interviews with local authority staff to ascertain opinions but this was not possible, again, due to time constraints.

Recommendations for Public Health arising from Part 2

On the basis of this analysis there are four areas where Public Health teams could encourage, and engage with, these processes:

1. Facilitate and participate in ongoing staff and community training (formal and informal) around the Act in the context of raising awareness about participation and asset transfer options more generally.

2. Encourage tailored and targeted support to submit requests for those who need it most in the context of wider community capacity building efforts.

3. Facilitate the strategic development and operational use of clear and straightforward processes, coordinated across partners, which cover all aspects of implementation including asset transfer 'aftercare', how to support community organisation members through an outcome improvement process and promote shared learning.

4. Participate in transparent and robust assessments of requests coordinated across partners and assessment decision outcomes which encourage ongoing collaboration with communities.

Part 3: Review of Public Health's contribution

The current situation

Outline Methods

Public Health interviews

Public Health staff representing all Scottish territorial boards and NHS Health Scotland were contacted via the Scottish Health Promotion Managers Network. Those who were contacted were asked to take part in an interview or to provide details of an alternative person. The aim of the interviews was to gather information on Public Health's input to community empowerment work, particularly around PRs and ATRs. Fifteen interviews were conducted each lasting between thirty and seventy minutes. Fourteen were held over the telephone. Good examples of Public Health input were agreed by the project group and turned into case studies. These reflect what the interviewees were aware of and is not indicative of all Public Health activity.

Community organisation members' views

Three members of community organisations were interviewed; one was in the process of submitting an ATR, one had submitted a PR and was awaiting the decision and one had submitted a PR and had been part of an outcome improvement process. As part of a broader range of questions regarding their experiences, they were asked about the contributions from Public Health in supporting their request.

Pulling together the evidence

In order to be consistent with how the evaluation of the Act was structured (see Part 2), again the six broad areas of implementation were used. These are: overall approach, awareness raising, support to submit requests, the decision making process, after the decision and outcomes. The results from the interviews were divided into these categories.

Overall approach

Overall, the Public Health and community organisation member interviews suggested that Public Health staff are not currently contributing significantly to the implementation of Parts 3 and 5 (with notable exceptions as highlighted in later case studies.) The Public Health interviews highlighted some barriers to further involvement in PRs and ATRs. These are outlined in Table 8. Public Health interviewees generally perceived Public Health knowledge around PRs and ATRs to be fairly low, and 11 out of the 15 Public Health interviewees were unaware of their own NHS processes for responding to requests. Despite a lack of evidence of any impacts that could lead to an increase in health inequalities, this was raised as a concern. Barriers to ATRs were not discussed in as much depth as PRs by Public Health staff; this could possibly indicate a lower awareness and perceived relevance of ATRs for those interviewed.

Table 8: Public Health Views of Barriers to PRs and ATRs

Barrier	Examples
Lack of capacity	• Lack of Public Health capacity, funding and resource
Lack of staff awareness and knowledge around specific parts of the legislation	• Lack of Public Health staff awareness. • Who is eligible to make a PR?
Hesitancy from Public Health staff around impact of PRs	• Lack of belief that public sector request processes as they stand will lead to tangible benefits for communities. Some communities feel over-consulted already without then seeing any change from the engagement exercises; 'tokenistic' – will PRs be the same? • Hesitancy that community organisation member on the Outcome Improvement Process would be representative of community. • Perceived risk that activities may lead to increased health inequalities. Disadvantaged communities more likely not to have a community council; these are the groups who have been submitting the majority of PRs.

Awareness raising

Community organisations

Public Health staff provided examples of opportunistic awareness raising of Parts 3 and 5 when working alongside community organisations. There were no examples provided of wider awareness raising efforts. Public Health did not contribute to the knowledge and awareness of the community organisation members which were interviewed. Therefore, those with whom Public Health staff already have an established relationship appear to be more likely to learn about the Act from them.

Public sector colleagues

There were no examples through the interviews of Public Health staff contributing to general awareness raising activities for public sector colleagues. However, those who worked with partners in producing agreed processes and promotional materials stated that, as a consequence of this, knowledge and awareness amongst public sector colleagues increased. Case studies 1-4 illustrate how Public Health in some Boards are supporting public sector approaches to be more assistive and coordinated, such as creating a process for responding to requests and staff training.

CASE STUDIES 1&2: Creating a process for responding to NHS Participation and Asset Transfer Requests, producing processes in collaboration with partners

See Appendix 5 for more information.

NHS Highland

There is NHS Highland guidance for PRs and ATRs. Public Health led the working groups which developed the processes. The ATR working group included representation from NHSH Estates and COSS. Public Health has also been involved in a Community Planning working group which looked to ensure partner processes were aligned.

NHS Grampian

The Head of Health Improvement worked with Corporate Communications to create a NHSG policy for how to receive and respond to PRs.

CASE STUDY 3: Providing advice to NHS staff

NHS Highland

Public Health are seen as the NHSH experts on PRs and have been providing advice to NHS colleagues on a case by case basis. The majority of queries have come from district managers and service leads, wishing to become more familiar with the principles and process. After discussion around the use of PRs, Public Health have then been signposting to the NHS Highland guidance for further information. From a capacity perspective, the total additional workload has been small and these conversations can be used as an opportunity to discuss public participation, which may in turn reduce the need for formal PRs.

CASE STUDY 4: Producing promotional materials in collaboration with partners

NHS Grampian

Community Planning Aberdeen's (CPA) Community Engagement Group have created CPA participation request promotional material for community organisations. Public Health has led the work on this. The material consists of a poster, leaflets and online information. The names and email addresses of first points of contact for a range of Community Planning Partners have been collated and are available on the CPA website. This also allowed partners to clarify their processes. See Appendix 5 for more information.

Support to submit requests

This has been divided into three key areas, to maintain consistency with the structure of the evaluation of the Act (see Part 2). These are:

1. community capacity building and identification of opportunities
2. eligibility to submit requests
3. deciding on the content and writing the request

Key area 1: Community capacity building and identification of opportunities

Case studies 5 and 6 highlight examples of where Public Health are contributing to community capacity building which may facilitate a request being made.

CASE STUDIES 5&6: Community capacity building and the facilitation of a request submission

Glasgow City HSCP example 1

Health Improvement staff within the Glasgow City HSCP and other partners have a longstanding link with a local community trust. Specific Health Improvement work to help build the capacity of local people includes the development of a physical activity programme for vulnerable and excluded groups in the local area. This programme was a catalyst to support local vulnerable people to engage and link with other organisations and service. In addition, through the motivation and dedication of the local community trust, and multiagency community capacity building efforts, the organisation was in a strong position to have discussions and make a submission regarding the transfer of a local authority building into community ownership. Through the organisation's links with Community Planning, they could also raise their request at a strategic multiagency level.

Glasgow City HSCP example 2

Informal groups of parents have been meeting primarily for social support. These groups were set up by a member of Glasgow City HSCP Health Improvement team, in response to requests from the community. Although the primary objective for the groups is to facilitate peer support and mitigate crisis, taking part develops social capital and critical awareness of social justice. Group members have identified common issues and there is a growing collective desire for change. In the future, these groups may wish to look into their options regarding how they can influence change and this may, or may not, come in the form of the submission of a request under the Act. See *Appendix 5* for more information.

Case studies 7-9 demonstrate that some Public Health staff are involved in identifying when and whether a request under the Act is the best option for a community organisation.

CASE STUDIES 7-9: Identifying when and whether a request under the Act is the best option for a community organisation

Aberdeen City HSCP

A community organisation wished to explore the possibility of submitting an ATR after learning of a proposed move of their base into a larger community hub building. A Public Health Coordinator put them in contact with CHEX (Community Health Exchange, part of SCDC) to help the organisation find out more. It was concluded a PR may be more appropriate, and the organisation is considering this. See Appendix 5 for more information.

Glasgow City HSCP

As part of the Community Planning 'Thriving Places' agenda, communities have been supported to start their own community gardens. The local community groups running the gardens have primarily been formed for this purpose and are newly established. Health Improvement staff in Glasgow City HSCP have worked with the community garden groups and other partners to negotiate the use of land. Through close working relationships, it was evident that submitting an ATR for this purpose would not be the best option and seeking permission to use the land was more appropriate.

NHS Shetland

The Shetland Alcohol and Drug Development Officer, who is based within the Public Health Team, has identified that a community organisation may benefit from having a local authority asset transferred to them to provide a venue for their recovery work. The officer has had preliminary discussions with the local authority.

Key area 2: Eligibility to submit requests

Case studies 10 and 11 demonstrate how Public Health staff in some Boards have been facilitating the formalisation of community organisations. This has assisted the community organisations in their operational running and in applying for grants. Although neither example has led to an organisation submitting a PR or ATR, they illustrate that there is an opportunity for Public Health staff to support community organisations in this way in order to meet the eligibility criteria.

CASE STUDIES 10&11: Facilitating the formalisation of a community organisation

See Appendix 5 for more information.

NHS Borders

The Healthy Living Network helped set up a Men's Shed in the Borders. Their key contribution was supporting the production of formal processes and procedures for running the group and the clarification of responsibilities. This included working in collaboration with the Local Volunteer Centre to raise awareness of men's sheds in the community and encourage 'buy in' from partners and community members.

NHS Tayside

Public Health in Tayside assisted a group of breastfeeding peer supporters in Perth and Kinross to formulate a Group Constitution and subsequent community group status. This has enabled them to apply for funding and led to a successful grant by NHS Tayside Community Innovation Fund, Tesco Ltd and other small grants for the work they are doing supporting breastfeeding mothers.

Key area 3: Deciding on the content and writing the request

Out of the three community organisations of which members were interviewed, two explicitly considered health impacts in their request proposals. There was no Public Health input into any of these. However, case study 12 illustrates that Public Health staff in some areas are contributing to health impact assessment in order to shape request proposals. Case study 13 provides an example where Public Health staff have helped to identify how to use an underutilised physical asset in a community for public health benefit. This highlights the potential for Public Health to be more strategically involved in shaping the contents of requests in order to maximise public health. Finally, case study 14 details how Public Health in one Board supported the writing of a funding application in order for the community organisation to buy a disused privately owned building. Although the request was for lottery funding rather than an ATR or PR, this indicates that Public Health staff may have a useful role in supporting the writing of these requests too.

CASE STUDY 12: Health impact assessment

Aberdeen City HSCP

A community organisation has been considering submitting a PR in order to be involved in the decision around the future of their base. A Public Health Coordinator in Aberdeen City HSCP has been involved in supporting the community organisation to identify and articulate the health and wellbeing impacts the proposed move may have on service users. See Appendix 5 for more information.

CASE STUDY 13: Identifying how to use underutilised physical assets in communities for public health benefit

NHS Borders

The Joint Health Improvement Team, Public Health, commissioned a Third Sector Community Development Organisation to support a village hall committee to identify health improvement priorities and strengthen community work, this led to the production of a community led health improvement plan following three community engagement events.

Events included presentations from local organisations, a community lunch and discussions about what residents liked about the village; what was working well; areas for improvement and the production of a 'wish list'. Following this participatory approach 5 key themes were identified including: History Project; Community Events/Health Hub; Digital Inclusion; Outdoor Green Space; Wider Community Consultation and subsequent meeting identified 21 volunteers who wished to be involved.

The village hall committee are now leading on the development and monitoring of their plan and wider links have been established with the Central Borders Federation of Village Halls to share this learning about the role for village halls in improving health and wellbeing. See Appendix 5 for more information.

CASE STUDY 14: Supporting the writing of a request (for lottery funding)

NHS Borders

The Healthy Living Network (HLN) was linked to the local Community Futures programme. The community representatives on the Community Futures group raised the possibility of the community buying a disused privately owned building to convert it into a community hub. A Health Improvement (HI) officer took the idea to the grants officer in the local authority and sought advice regarding how to apply for funding. The HI officer then worked closely with the community, community learning and third sector partners to support writing a Stage 1 application for funding. This worked well as the community knew their own local needs and the HI officer could help articulate this in terms of health benefits and accumulate the pertinent supporting evidence. After they had successfully progressed to Stage 2, a project manager from local authority was assigned to oversee the work. Overall, it took about two years to be granted the lottery funding. See Appendix 5 for more information.

Decision making process

There were no examples provided through the interviews with Public Health and community organisation members where Public Health was involved in the decision as to whether a request should be agreed to or rejected. Therefore, it appears that Public Health do not currently have a significant active role around facilitating decision making in the context of PRs and ATRs.

After the decision

Case study 15 describes how Public Health in one Board committed (at the application stage) to renting a space in a community hub once it was transferred to community ownership and renovated. This example is not in the context of an ATR, yet it demonstrates one way that Public Health could provide continued support to a community organisation once an asset has been transferred under the Act. Case study 16 illustrates how Public Health have supported the progress of an outcome improvement process.

CASE STUDY 15: Continued support after asset transfer

NHS Borders

The Healthy Living Network agreed to support the conversion of a disused privately owned building into a community hub, including committing to renting a space in the hub. The HLN now operates from the hub and other Public Health initiatives are also based there e.g. smoking cessation and weight management interventions. There is a cafe with a good availability of healthy choices. See Appendix 5 for more information.

CASE STUDY 16: Progressing an outcome improvement process

NHS Western Isles

The local authority presented a local authority received PR to the Community Planning Partnership. The topic was a complex issue and they valued different partner perspectives. The CPP Executive Board assessed the request and identified Public Health as appropriate partner to lead on progressing the outcome improvement process. The Health Improvement Manager met with the community organisation twice and agreed actions. Public Health continue to ensure the community organisation is regularly updated on wider related work.

Where further Public Health expertise is required

Despite the limitations in our methodology, we identified four broad recommendations for improving the implementation of Parts 3 and 5 of the Act in order to maximise public health (see Part 2). These are:

1. Facilitate and participate in ongoing staff and community training (formal and informal) around the Act in the context of raising awareness about participation and asset transfer options more generally.

2. Encourage tailored and targeted support to submit requests for those who need it most in the context of wider community capacity building efforts.

3. Facilitate the strategic development and operational use of clear and straightforward processes, coordinated across partners, which cover all aspects of implementation including asset transfer 'aftercare', how to support community organisation members through an outcome improvement process and promote shared learning.

4. Participate in transparent and robust assessments of requests coordinated across partners and assessment decision outcomes which encourage ongoing collaboration with communities.

The role of local Public Health

The findings in the previous section on Public Health current activity suggest that Public Health is involved to variable extents with regards to addressing the recommendations. Below we summarise this and where Public Health expertise could be used in the future.

- Recommendation 1 – Ongoing staff and community training. There are examples of Public Health staff contributing to:
  - opportunistic awareness raising with community organisations to whom they already work alongside;
  - signposting of community organisations to external sources of support such as SCDC and COSS;
  - provision of advice to other NHS staff; and
  - creating processes for responding to PRs and ATRs and promotional materials which, in turn, increased knowledge and awareness amongst those involved in the work.

  Public Health staff can:
  - ensure awareness raising is ongoing and there is a coordinated approach;
  - support community organisations to understand their options (e.g. PR or participatory budgeting, etc.) and which may be most appropriate for their situation; and
  - share case studies, learning and ideas.

- Recommendation 2 – Tailored and targeted support to submit requests. There are examples of Public Health staff contributing to:
  - general community capacity building which may in turn facilitate the submission of a request;
  - the identification of when and whether a request under the Act is the best option for a community organization;
  - the formalisation of community organisations which may in turn allow them to become eligible to submit a request; and
  - the articulation of health impacts in a request proposal.

  Public Health staff can:
  - facilitate the shaping of requests which recognise and build on community assets and maximise public health benefit;
  - equip community organisations in order to support the writing of requests and pursuit of funding opportunities, e.g. coordinating a meeting with relevant stakeholders to discuss wording;
  - coordinate those who have been through the process to support others, e.g. community anchor organisations ;
  - identify, understand and articulate local community need and greatest need;
  - conduct health impact assessments of proposals; and

- ensure equity of access to Public Health support, as support tends to be primarily provided to community organisations who already have links with Public Health staff.

- Recommendation 3 – Strategic, clear and straightforward processes coordinated across partners. There are examples of Public Health staff contributing to the:
  - production of agreed processes and promotional materials in collaboration with partners; and
  - progression of an outcome improvement process.

  Public Health staff can:
  - work alongside partners to produce joined up processes and materials which make it easier for the public to navigate and submit a request, ensuring all relevant stakeholders are involved including external support organisations;
  - support the sustainability of community assets through local Public Health programme delivery;
  - promote good partnership working between the Public Service Authority and Community Participation Body throughout an outcome improvement process;
  - look at how PRs/ATRs can be used strategically to enhance CPP work; and
  - conduct evaluation to understand the health impacts of submitting requests and their outcomes on community organisations and the wider community, updating local processes as this information becomes available.

- Recommendation 4 – Transparent and robust assessments. There were no examples provided of Public Health staff contributing to request assessments by public bodies.

  Public Health staff can facilitate:
  - work to ensure requests are dealt with equitably and objectively; and
  - multi-department / multiagency input into assessment (e.g all requests discussed through CPPs).

<u>Identification of areas for Public Health involvement</u>

Taking into account the aspects of implementation with potential for further Public Health involvement listed above, we have identified three overarching areas for Public Health input:

1. **The use of existing specialist Public Health resource and skills where these would be of most benefit;**
2. **Supporting community capacity building around the use of PRs and ATRs as part of overall community capacity building efforts;; and**
3. **Supporting a more coordinated strategic approach by public sector partners.**

Local Public Health colleagues should consider how input into these areas can be conducted to best suit local circumstances. Generally speaking, our findings suggest that it would require Public Health to:

- have an increased knowledge around Parts 3 and 5 of the Act;
- have an increased awareness of NHS and other local partnership request processes; and
- be confident that processes will lead to beneficial public health impacts.

Possible challenges

As well as capacity and funding, the following potential challenges were discussed:

- commitment to adopting a community empowerment approach at local and strategic levels across partner agencies;
- the potential for a conflict of interest around NHS asset transfer. It was acknowledged that a situation could arise where a community organisation wished to take ownership of an NHS asset but the NHS Facilities and Estates Department wished to sell it at full value on the open market. This could put Public Health staff in a challenging situation if asked for advice. However, the intention of the legislation is to encourage asset transfer to communities and Relevant Authorities are expected to support this. As highlighted through the Public Health interviews, Public Health staff provide an independent viewpoint which is distinct from other public sector perspectives. This is core to working effectively, e.g. in health care public health. As long as staff retain the public's health as the primary motivator for what they do, we do not anticipate that this potential conflict of interest should be an obstacle to Public Health involvement;
- the potential for Public Health to be asked by community organisations to state that they 'endorse' a request in the absence of prior Public Health involvement or thorough assessment. Since one of the areas of benefit to be considered in requests is the enhancement of public health, community organisations may approach Public Health asking for backing that their proposal will do so. This could possibly influence decision-making and so increase inequalities in outcomes. If the proposed public health benefits are then not realised, Public Health staff could be challenged regarding the grounds for endorsement. This highlights the need for recognised processes to be in place for dealing with requests and that Public Health are aware of these. It may also present an opportunity for Public Health to work collaboratively with the community organisation and open up conversations around how Public Health could support them in other ways.

The (future) role of Public Health Scotland

Overall, Public Health Scotland should demonstrate commitment to community empowerment and recognise this as an important part of the Public Health agenda. There needs to be close, collaborative working with local and regional Public Health to identify what can be done once or best for Scotland.

As an initial starting point, Public Health Scotland should look at how best it can support local Public Health to be more involved in the three overarching areas identified in this report, this should encompass providing support to the public health workforce across the whole system, through facilitating:

- awareness raising amongst Public Health staff;
- training and materials, e.g. production of a toolkit to assist staff; and
- information sharing and networking across Boards/HSCPs and with external support organisations as appropriate.

Over time, as the national / local collaboration matures, the support Public Health Scotland can offer local public health inputs to the operation of the community Empowerment (Scotland) Act be elaborated more fully.

List of Appendices

Appendix 1: Key community empowerment work by Public Health, not directly related to the Act

Key areas of work	Examples
Supporting community organisations to achieve their aspirations	• Facilitating networking with relevant people in order to set up a Men's Shed • Supporting a small group of local people to start baking high quality nutritious bread to be sold to the wider community at fair prices
Identification of community needs, supporting the implementation of community programmes to address these and evaluation	• Work with public and third sector to identify which services are needed and desired in two rural communities, supporting their implementation and evaluation • Identification of community need to address loneliness and isolation in the elderly population, setting up of community groups and training according to need • Public health led on a piece of work around suicide prevention and identified training needs • Work with local authority community learning and development and residents in an area of social housing as part of one of the locality plans • Multiagency working, including the running of community engagement events, to identify local needs and assets with the aim of introducing a community led support model. Training of staff around topics such as health literacy and signposting to local assets. • Using the Charrette model, innovative multiagency community engagement work was undertaken. This included the use of food trucks, marquees and rickshaws to pick people up. • Setting up of parent support groups facilitated by Health Improvement staff, with aim to increase social connection and social capital. Through this, staff have a greater understanding of need, have been able to support crisis prevention and have identified gaps in service provision.
Participatory Budgeting	• Involvement in the delivery of Participatory Budgeting • Awareness raising around participatory budgeting cycles and timescales, so that community organisations have the opportunity to prepare
Facilitating community participation	• Opportunities for public participation advertised through third sector interface, leaflets and radio • Regular community breakfast clubs in partnership with other agencies, where communities can hear

	about what is happening locally and input into decisions
Public engagement with health service development	• The mental health and wellbeing services in one Board are very good at encouraging user involvement; for example, having people with lived experience on interview panels when recruiting new staff. Public Health supports this engagement.
Public engagement with NHS/HSCP strategies and plans	• Community engagement events and use of engagement toolkits in order to develop plans in partnership with public
Input into strategies led by other agencies	• Public Health contributes to the Community Learning and Development Strategy led by local authority
Adopting a streamlined community empowerment approach to Community Planning work	• Developing tools for CPP around inequalities and public engagement • Undertaking VOiCE (Visioning Outcomes in Community Engagement) training in collaboration with partners (http://www.voicescotland.org.uk/voice/)
Resources and tools	• NHS Health Scotland produced the Place Standard tool, which is being used across Scotland to engage with communities about where they live • NHS Health Scotland collaborates with Improvement Service to produce the 'Community Planning in Scotland' website. This has a section on community empowerment with links to external resources
Information sharing and skills development	• NHS Health Scotland runs the Community Food and Health (Scotland) programme. This supports local food organisations in deprived areas through networking, information sharing, seminars, funding and skills development. • Sharing practice amongst communities adopting a pilot approach

Appendix 2: Public Health contributions to the Act, other than Parts 3 and 5

Part 2: Community Planning

All Public Health colleagues interviewed (15/15) described input into Community Planning. This included:

- Providing NHS and HSCP representation at different levels of the CPP structure
- Chairing groups
- Influencing partners to think upstream and holistically
- Encouraging public engagement and participation
- Development of the Local Outcome Improvement Plan (LOIP)
- Identification of localities
- Development of the locality plans
- Production of easy read locality plans for use within communities
- Development of strategies such as the CPP Inequality Strategy, Active Community Strategy and Engagement, Participation and Empowerment Strategy
- Data analysis
- Needs assessment
- Community asset mapping
- Delivery of health outcomes in the LOIP

Part 9: Allotments

One Public Health colleague described input into Part 9 of the Act. Public Health in this NHS Board is contributing to the local authority Food Growing and Allotments Strategy.

Appendix 3: Community organisation members' views

Eligibility to make a request

The community organisation submitting the ATR needed to expand their constitution to be eligible to submit the request. The local authority supported this and stated what to include. Those submitting PRs did not need to change their constitutions.

Deciding on content of request

ATR to local authority

The purpose of the request is to see the asset refurbished and used again for the community. Initially the community organisation was going to request ownership but is now going for a long term lease. This was in light of another leased local authority asset requiring structural repair work which the local authority fixed. The community organisation thought this would be better as there would be less responsibility for the asset and less financial risk.

The local authority have supported the formation of the request, e.g. through discussions at meetings and via telephone, providing information and by signposting to other sources of support. They have put the community organisation in touch with another community organisation who have restored a derelict building, to learn from their experience. The local authority also funded a £10,000 feasibility study. However, the community organisation was left unclear as to what parts of the asset were being taken into account and therefore they lack some confidence in the final estimate of costs. The renovation designs had no 'health' input; they did consider the need for disabled access but nothing else explicitly around health.

The community organisation members are well networked in their local community. They know who to contact for fundraising advice and to apply for grants. However, they recognise that they need extra support around ensuring the business viability of the asset and the likely impact on local businesses. The local authority are unable to help with this and the community organisation are not sure where to access this support.

PR to local authority (agreed)

The community organisation and local authority had two meetings prior to the submission of the PR. The member found the meetings to be useful as they increased understanding of where each side was coming from. SCDC was also helpful, particularly in clarifying the necessary steps to take and when to submit the formal request.

Writing the request

ATR to local authority
The community organisation member stated that he was used to doing proposals and would be confident at writing the request.

PR to NHS and local authority (not decided)
The community organisation member was not sure how specific to make the request, particularly the desired outcomes. She asked SCDC to support the writing of the request and has kept the wording fairly vague so that there is room for discussion. She is unclear whether the NHS and local authority staff reading the request understand exactly what the community organisation is proposing.

PR to local authority (agreed)
The community organisation member stated that the writing of the request took a long time. Like the above example, she was also not sure how specific to make the request and what she should be asking for. She looked online for help, e.g. at the Scottish Government guidance, but still felt unclear. The second meeting with the local authority prior to submitting the request was used to discuss wording. They agreed that there should be room for discussion in the wording and to focus on how the community organisation wished to participate. The community organisation member felt that this was helpful and that they would have rejected her first draft if it had been formally submitted.

The assessment process

ATR to local authority
The asset has been informally agreed to be a venue for small weddings and a pop up museum, with the ground floor sublet to help cover overheads. The local authority are happy with this. It is the community organisation who are now hesitant as since their initial proposal they have received community feedback regarding the difficulty of parking and lack of hotels in the area. They are, therefore, unsure about the feasibility of the proposed use. They are planning a community stakeholder event to work out how to use the building.

PR to NHS and local authority (not decided)
One meeting was arranged by the local authority to discuss the request. The community organisation was told that the decision on how they can participate depends on the results of a funding application made by the local authority. The community organisation member felt that they were trying to fit the request into their established processes and have been reluctant to validate the request. This was perceived as a delay tactic until the local authority decides what to do. The community organisation member thinks that lack of understanding around the legislation is contributing to this. The local authority have communicated issues such as ‘jumping’ to a PR without going through local participation processes first, that it is not clear enough on the request form what the

local authority would be agreeing to and that they need to involve other stakeholder groups in the decision that the community organisation has asked to participate in.

PR to local authority (agreed)

The community organisation member felt that previous decisions related to the same issue as that raised in the PR have been based on cultural and personal views and so was hesitant about the decision making process. The first submission was returned as 'incomplete' – although the community organisation member felt this decision was subjective. The second submission was then accepted, possibly influenced by media attention and an already planned piece of work which the community organisation could input into without having to set up a new process. The community organisation member also felt like the local authority staff member who had supported the writing of the request should not have been involved in the decision making. She thought that there should have been a neutral person deciding on the basis of the Act.

Outcome improvement process

PR to local authority (agreed)

The community organisation was asked to join a strategy group. Lead members attended and contributed to meetings, were emailed drafts and provided comments. Though this, they appreciated being seen as an equal partner, to be 'given a seat at the table with the right people' and to be listened to. They were able to find common ground (the health and wellbeing of the local community) and to focus on this. However, the community organisation member highlighted that the outcome improvement process required a large time commitment, a lot of effort and was a fairly tedious process.

Outcomes

PR to NHS and local authority (not decided) – so far

- Has encouraged NHS and local authority to look into their PR processes.
- Worried that PR may make relationship with NHS and local authority worse as the community organisation will be seen as 'difficult'.
- No expectation that will lead to change in services.

PR to local authority (agreed)

- Now seen as a valid community organisation; chief executive of the local authority has agreed to meet with them.
- Better links with the local authority and other partners, e.g. NHS; feel they will now consult with the community organisation if there is a new relevant policy/ strategy and the leads of the community organisation now know the appropriate contacts with whom to speak.
- Able to support other local community organisations who may be considering a PR.
- No change to services but did not expect this; input not entirely utilised but understand why this is.

ATR to local authority - so far

- Continued good relationships with the local authority and within the community organization.
- Reduced motivation within the community organisation as no longer confident in current proposed plans and not clear what to do next.

Appendix 4: Factors facilitating public involvement

The National Standards for Community Engagement [14]

- Inclusion – we will identify and involve the people and organisations that are affected by the focus of the engagement
- Support – we will identify and overcome any barriers to participation
- Planning – there is a clear purpose for the engagement, which is based on a shared understanding of community needs and ambitions
- Working Together – we will work effectively together to achieve the aims of the engagement
- Methods – we will use methods of engagement that are fit for purpose
- Communication – we will communicate clearly and regularly with the people, organisations and communities affected by the engagement
- Impact – we will assess the impact of the engagement and use what we have learned to improve our future community engagement

What Works Wellbeing Technical Report (p.52)[15]

Factors which may promote more effective involvement of communities:

- Communication and transparency
  - Create clear and transparent arrangements for partnership working
  - Be open and realistic about what can and cannot be achieved, and about how long delivery may take
  - Ensure good communication and monitoring and provide feedback to participants on what has and has not been delivered
  - Share learning and examples of best practice

- Organisational culture and commitment to empowering communities
  - Promote full commitment to partnership working at all levels of organisations and make it a responsibility for all
  - Allow the community participants greater control over the 'rules' and processes of participation
  - Trust the process of involvement and the ability of participants and be prepared to relinquish control to communities
  - Deliver the plans that communities helped to develop

- Timing and accessibility of involvement

[14]National Standards for Community Engagement. 2016.
http://www.voicescotland.org.uk/media/resources/NSfCE%20online_October.pdf

[15] Pennington A, Watkins M, Bagnall A-M, et al. (2018) *A systematic review of evidence on the impacts of joint decision-making on community wellbeing.* What Works Wellbeing.

- Involve communities from the start, so they are involved in key decisions and to promote a sense of ownership and maintain involvement of both communities and public agencies throughout
- Identify and address barriers to communication and involvement for all participants (for example, physical and spatial barriers; financial barriers; literacy, numeracy and language barriers; cultural barriers; barriers relating to caring responsibilities and time/availability to participate) and identify any adverse impacts on participants with a view to addressing them
- Allow community participants greater flexibility to engage

- Training and support
  - Provide training and ongoing support to community participants and staff from public agencies engaged in joint decision-making.

Health Foundation Scoping Paper (p.32)[16]
Requirements for effective user involvement:

- adequate resources
- a facilitative organisational culture
- good quality information
- professional champions
- staff training (by users)
- user training (by staff)
- payment and/or employment of users (sometimes)
- representative structures
- recognition and understanding of power differentials
- acknowledgement of, and sensitivity to, likelihood of mental distress
- high-quality, meaningful and measurable involvement processes
- flexibility in how and when service users input (according to their willingness and ability) in order to achieve diversity of voices

Evaluating the impact of patient and public involvement in NHS health services

- The perception of the process may be improved by ensuring realistic expectations from the outset and ensuring a clear shared understanding about the purposes of involvement.[17,18]
- There is a need for ongoing support and education to ensure community members can participate fully.[9]

[16] Coulter A. (2009) *Engaging communities for health improvement: a scoping study for the Health Foundation.* The Health Foundation.
https://www.health.org.uk/sites/default/files/EngagingCommunitiesForHealthImprovement.pdf
[17] Daykin N, Evans D, Petsoulas C, Sayers A. (2007) Evaluating the impact of patient and public involvement initiatives on UK health services: a systematic review. *Evidence & Policy*. 3(1):47-65.
[18] Attree P, French B, Milton B, et al. (2011) The experience of community engagement for individuals: a rapid review of evidence. *Health and Social Care in the Community*. 19(3):250-60.

Appendix 5: Further information on selected case studies

Aberdeen City HSCP
For further information on the Aberdeen City HSCP case studies, contact Katie Cunningham, Public Health Coordinator, katie.cunningham@nhs.net

Glasgow City HSCP:
For further information on the Glasgow City HSCP case study regarding parent groups, contact Ruth Donnelly, Health Improvement Lead, ruth.donnelly3@ggc.scot.nhs.uk, 0141 232 0168/ 07812009695

NHS Borders
For further information on the NHS Borders case studies, contact Nichola Sewell, Health Improvement Lead – Communities and Vulnerable Groups, nichola.sewell@borders.scot.nhs.uk, 01835 825970/07748320108

NHS Grampian
The NHS Grampian participation request policy is available to view online: https://foi.nhsgrampian.org/globalassets/foidocument/foi-public-documents1---all-documents/NHSGrampianParticipationRequestPolicy.pdf

The Community Planning Aberdeen participation request information page includes the promotional leaflet:
https://communityplanningaberdeen.org.uk/our-communities/participation/

NHS Grampian Public Involvement Team are the first point of contact regarding participation requests:
nhsg.involve@nhs.net, 01224 558098

NHS Highland:
The Highland CPP website has information on PRs and ATRs:
http://www.highlandcpp.org.uk/

NHS Tayside:
For further information on the NHS Tayside case study, contact Janet Dalzell, Infant Nutrition Co-ordinator, janet.dalzell@nhs.net, 01382 424036 (external) 71036 (internal) mobile: 07766 160668

ALL INFORMATION CORRECT AS AT 09/07/2019

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ScotPHN report

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