Royal College of General Practitioners (Scotland)

Engaging Community Assets

Final Project Report

May 2014

Acknowledgements

We would like to thank the following people for their contributions to the Engaging Community Assets project:

Funders: Scottish Government, Third Sector Division

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Mr Colin Campbell, Executive Director, Assist Social Capital
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Participating Practices:
Airlie Medical Practice, Leven (formally Drs Ross and Partners)
Feddinch Medical Practice

Social Enterprises/Voluntary Organisations:
MyBus
Saje Scotland
Recycle Fife
Fife Shopping and Services
St Andrews University Student Voluntary Services

We would also like to thank all of those who attended and contributed so enthusiastically to the community engagement meetings including members of the community, representatives from local organisations and local councillors.

Glossary

Social Enterprise - Social Enterprises are values-based businesses set up for social and/or environmental purpose, driven by an entrepreneurial approach. A core principle is that economic activity should work for the common good. Social Enterprises have an asset lock on surpluses which are reinvested in their services or community. (For more information see http://www.se-code.net)

Social Assets - existing resources and strengths within communities which can be utilised to build stronger, more sustainable communities for the future. (For more information visit http://www.abcdinstitute.org)

Learning Journey - On a learning journey a group, usually comprising colleagues, go on a series of site visits together as part of a question they are pursuing or trying to understand. The site visits are immediately followed by a debriefing session design to highlight the learning which the site visits uncover in the hope of improving the understanding which the group has of the questions or issues it is interested in.

World Café style - a structured conversational process in which small groups of people (4 or 5 to give everyone a chance to speak), discuss a topic or question at several tables, with individuals switching tables periodically and getting introduced to the previous discussion at their new table by a "table host". A cafe ambience is created in order to facilitate conversation.

Social Capital – is defined by the OECD as “networks together with shared norms, values and understandings that facilitate co-operation within or among groups”

Executive Summary

- The Engaging Community Assets project, funded by the Scottish Government Third Sector Division, was built on the Royal College of General Practitioners (Scotland) (RCGP Scotland) "Essence of General Practice" initiative[1] and developed in partnership with Assist Social Capital and the International Futures Forum.

- The project team comprised the Clinical Lead, Dr Sonia Devereux, Mr Colin Campbell from Assist Social Capital, the Project Coordinator, Leanne Brown, Projects Administrator, Shelley Ell and Mr Andrew Lyon from the International Futures Forum along with input from Dr John Gillies and Dr Mairi Scott from their involvement with the Essence of General Practice Initiative.

- The project started in June 2012 with the aim of improving GP engagement with their communities by getting both the GP and community to identify local issues and improve some of these using existing Social Enterprises within the community. Research indicates that there is a connection between a person's involvement in their community and their wellbeing (detailed in the introduction). The overall aim of the project was to improve patients' wellbeing by signposting them to relevant services in their community with the potential to achieve this. **An additional aim of the project was to develop a transferrable Engaging Community Assets model for any practice in Scotland.**

- The first stage was to recruit and engage two practices and undertake a Learning Journey with each to develop their understanding of what a Social Enterprise was and to illustrate to them relevant services that were already available in their area. These Learning Journeys were found to be very insightful and inspiring to both the practices.

- Meetings were then held in each community to which members of the community were invited to attend and participate. Participants discussed what the main issues in their community were and considered potential solutions to these issues. Appropriate social enterprises and a local voluntary organisation were then selected for each practice to signpost patients to whom they felt would benefit from the types of services offered. Meetings were held between representatives from the selected organisations and staff from each practice to share information and raise awareness about ways in which they could help patients.

- Forms were created for the practice staff to track the number of patients signposted to each service and the reasons for them being signposted, during a specified implementation period

[1] Gillies J, Mercer M, Lyon A, Scott M, Watt G. 2009. Distilling the essence of general practice: a learning journey in progress. British Journal of General Practice, Volume 59, Number 562, May 2009 , pp. e167-e176(1)BJGP

which varied for each site. The Social Enterprises also kept a record of any new users using their service and noted their perceptions of any improvements to each users wellbeing.

- Following the implementation period during which patients were signposted to the selected services, interviews were held with the Social Enterprises and practice staff to gain their feedback on the project and to discuss the transferable model.

Findings

- One of the main findings from the project was that there was an **underlying issue of social isolation** with all of the issues identified by each of the communities. The project team developed a model that could be adopted by other practices in Scotland which could to assist them to engage local community assets, focusing on this universal issue initially.

- Building relationships and professional connections were found to be extremely important to facilitate signposting from the health sector to Social Enterprises.

- Another finding was that the term of this project was not long enough to enable Social Enterprises time to gain funding to expand their existing service or to create a new service to meet the demands from the community. This meant that the number of patients signposted to the Social Enterprises was relatively low and there was also insufficient time for substantial benefits to be realised and fed back to the practices involved.

Recommendation

- In response to the outcomes of this project, including the main findings highlighted above, RCGP Scotland recommends that a follow on project be developed for a greater duration (around four or five years) possibly based on the model that has been designed, focusing initially on social isolation.
- Practices are currently under a great deal of pressure from demand for clinical services. Successful development of this model will require a dedicated Engaging Community Assets Facilitator within the practice. This reinforces the similar Links Worker project model; practices and patients benefit from the additional resource of a facilitator to build links with their communities and related organisations..

Appendix 11 summarises the Engaging Community Assets project within the perspective of the International Futures Forum's 3 Horizons model; Building reciprocal networks, focussing on community-identified health issues, referral systems to Social Enterprises are all exciting and radical 'H3' perspectives identified by the project in the present which could be built on and developed by adoption of the model described in the report.

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1. Introduction

With a focus on better health and social care integration and an abundance of social concerns in communities across Scotland, this project aimed to bring a new approach to not only determine the needs within each individual community, but also to focus on the positive capability and capacity of that community by using Social Enterprises to improve the overall health and wellbeing of the community.

The Engaging Community Assets project aimed to optimise the relationships between GPs and the communities in which they work. This was achieved by building local relationship networks through engagement with local Social Enterprises and community organisations. It was hoped that the creation of such a partnership model would enable relevant suitable solutions to address the community needs to be identified.

GPs and the wider practice team have a vast amount of knowledge and understanding about their patients' communities and therefore are able to contribute to their community's wellbeing and social capital to help inform local decisions. This information is well founded as GPs have experience of their patient population, provide continuity of care and so gain a long term view of health and social needs within that community. According to statistics[2] issued by Information Services Division Scotland, approximately 24.2 million people living in Scotland had face-to-face consultations with their practice nurse or GP in 2012/13, with 82% of registered patients seeing their GP or Practice Nurse at least once during the year. Because of the high level of respect and trust patients have in GPs, they are often regarded as making contributions that are inherently for the greater good of patients/public and are regarded as the 'Jewel in the Crown' of the NHS[3].

Studies show that there is a connection between social capital and self-reported health. Research by Morgan & Swan[4] and Lisakka[5] found that residents living in neighbourhoods with greater participation and integration into wider society and higher levels of trust, attachment and tolerance/respect were less likely to have poor self-rated health. Additionally, those with higher levels of social isolation reported worse health status and the effect, for example, of living in a

[2] 22 February 2011, Practice Team Information, Information Services Division Scotland. http://www.isdscotland.org/isd/6538.html

[3] Kerr D, Scott M. British Lessons on Health Care Reform, New England Journal of Medicine. Vol 361, Number 11, September 10, 2009. e21(1-3). http://healthcarereform.nejm.org/?p=1702&query=TOC

[4] Morgan and Swan. Health Development Agency Briefing no. 21, June 2004
Working with and for communities –
http://www.nice.org.uk/niceMedia/documents/CHB21-social-capital.pdf page 2

[5] Lisakka, Laura. Social Capital in Finland –
http://www.stat.fi/tup/julkaisut/isbn_950-467-602-2_en.pdf, page 57-61, February 2006

neighbourhood with low trust is comparable with a 15 year increase in age. Braum[6] suggested that exploring the benefit of using social capital to achieve public health benefits merited further exploration.

This project aimed to increase engagement between GPs with the community in which they work. It aimed to achieve this by designing a methodology to build local networks that create reciprocity and supportive relationships and to identify and co-produce beneficial solutions and services appropriate for that community. Initially, a participation approach was used involving key informants to highlight what they perceived were the main issues in their community and facilitated discussion to enable them to identify solutions to these issues. The purpose of involving Social Enterprises in this process was to help deliver financially more viable and therefore sustainable solutions to the issues identified. Using this assets-based approach to engage the community from the outset was to empower them to take ownership of their situation and give them a sense of purpose by helping them to help themselves and to maximise sustainability.

The Christie Report[7]assert that the current public service system is "'top-down' and unresponsive to the needs of individuals and communities". In order to switch the balance of power around decision making from a "top-down" approach to a "bottom-up" approach, the project used Learning Journeys and Community Conversations. The aim was to invite the community to determine their own needs and to strengthen their capability to identify and optimise existing sustainable solutions from within their own communities, such as services being delivered by community-based Social Enterprises delivering indirect public health benefits.

[6] Braum F. Social Capital: Is it good for your health. Issues for a public health agenda. Epidemiol Community Health 1999:53:195-6

[7] Report on the Future Delivery of Public Services by the Commission chaired by Dr Campbell Christie. Published on 29 June 2011
http://www.scotland.gov.uk/Publications/2011/06/27154527/0

2. Project Development

2.1 Recruiting the Practices

The proposal required two practices in Fife to participate, with one of these expected to be connected to a community hospital. The project Clinical Lead, Dr Sonia Devereux, invited all Fife practices associated with a community hospital to participate. Other Fife practices that had previously been involved with a similar community project[8] were also offered the opportunity to join the project. The Feddinch Medical Practice in St Andrews and the Airlie Practice, Leven (formally Dr Ross and Partners), were selected to participate. These particular practices were selected to gain a variety of perspectives and enable comparisons, as the socio-economic demographics of these communities varied substantially. Feddinch Medical practice is in St Andrews, an area with a high student and elderly population; and high levels of employment, with over 67% in 2010, employed in the university and tourism sectors[9]. By contrast, Airlie practice is in Leven, an area with high levels of unemployment and deprivation, with 22% of patients registered with the practice living in the 15% most deprived datazones in Scotland. As demonstrated in table 1 below, Airlie Medical Practice, (practice list size 3331) has 53.8% aged between 25-64 years with 33.8% of the total practice population in the lowest deprivation quintile. The Feddinch Medical Practice, (practice list size 9448) has no registered patients in the lowest deprivation quintile and 58% of the practice population in the highest quintile.

Table 1: Selection of demographics comparing Airlie Practice and Feddinch Medical Practice[10]

	Practice List size	age 15-24	age 25-64	age >75	% patients in lowest deprivation quintile	% patients in highest deprivation quintile
Airlie Practice	3331	11.7%	53.8%	6.9%	33%	6%
Feddinch Practice	9448	33.6%	38%	10.2%	0%	58%

[8] LINKS project - Developing the connections between general practices and their communities
[9] http://publications.1fife.org.uk/uploadfiles/publications/c64_NEFife_EconProfile.pdf
[10] ISD Scotland - information on GP workforce and practice population

2.2 Initial Meetings with the Practices

The Practice Manager and a lead GP were the main contributors to the project on behalf of the practices. At the outset the practices were asked to consider whether they felt their community was healthy and in what way. They were also asked to identify what they perceived to be the main issues affecting the health and wellbeing of their community. Initial meetings were held in each practice with the Practice Manager, lead GP and representatives from that practice's primary healthcare team. These meetings were to discuss the project aims, explain the background of community engagement and Social Enterprise businesses and to explore the practice team view of the health and wellbeing of their local community.

2.3 Learning Journeys

Learning Journeys were then organised for each of the practices to visit Social Enterprises in Fife. The Social Enterprises chosen were considered to be relevant to the issues that were identified by the practices at the initial meetings. The purpose of the Learning Journeys was to raise awareness and understanding of what a Social Enterprise was, as well as to demonstrate some of the beneficial services already available in Fife. The Social Enterprises selected as hosts for the Learning Journeys were all members of the Fife Social Enterprise Network (FSEN), one of 22 local and thematic SENs[11] across Scotland. The project was able to connect easily with the members of Fife SEN through the project's Social Enterprise Lead, Colin Campbell's, connections. Each Learning Journey was completed with a de-brief in order to gain feedback about the process itself and the organisations visited.

2.4 Community Engagement Meetings

Open Community Conversation events (two in number) were held for each practice to introduce public participation in order to mutually identify the local issues. Members of the community, local Community Health Partnerships (CHPs) and organisations already in the community were invited. Open invitations via posters, email distribution, direct personal phone calls, local media and the third sector single interface (website) were distributed.

2.4.1 The first set of meetings were facilitated using a World Café approach. Participants were asked to:

- Consider what was good about their community.
- Identify organisations already available in the community (the existing community assets).
- Identify the issues in their community.

[11] Social Enterprise Networks

2.4.2 Subsequent Community Engagement meetings were held in each area to confirm the issues identified at the first meetings and to seek to agree potential solutions. Relevant local Social Enterprises who could potentially contribute to a discussion about some of the issues were invited to participate in these meetings.

2.5 Recruiting the Social Enterprises

Following the Community Engagement meetings, appropriate Social Enterprises with an interest in the project were contacted and invited to become involved.

The selected Social Enterprises were invited to a meeting at the GP practice, where they were asked to present relevant information about their work. This was in order to build relations and trust between the practice team and the Social Enterprises. This also gave an opportunity for the practice to gather specific information and understanding about which patients they would be able to signpost to relevant services and how to do this. The project team was in regular contact with the Social Enterprises participating in this project in order to support the process.

2.6 Data Capture and Information Gathering

Throughout the project the project team was in contact with the GP practices in order to encourage engagement and resolve any problems. A range of methods (trackers, questionnaires and interviews) were used to capture data and information pertaining to the project process.

2.6.1 Each practice was asked to complete a short questionnaire half way through the project to gain their views on how the project was progressing, recording any knowledge gained and changes made as a result of the project. A similar survey was circulated for completion at the end of the implementation period to assess the benefits and impact of the project within the practice team.

2.6.2 Following the recruitment of relevant Social Enterprises and organisations, the practices were asked to keep record of any patients signposted, during the implementation period, using a tracker that was provided to them.

2.6.3 Each of the selected Social Enterprises were asked to keep a tracker of any new users (whether signposted from the practice or other channels) using their service during the

implementation period. This included asking the Social Enterprises to give their perceptions of the user's wellbeing when they first started using the service and again at the end of the implementation period, to try and demonstrate any changes to their wellbeing.

2.6.4 A health status questionnaire was developed to identify if any changes in wellbeing (e.g. health, wellbeing or motivation) during the period of engagement with the Social Enterprise, could be identified. The questionnaire was piloted with members of local Social Enterprises and was refined before asking the selected Social Enterprises to give it to any new users using their service during the last two months of the project.

2.6.5 At the end of the implementation period, telephone interviews were held with each of the Social Enterprises to ascertain whether the project had met their expectations and to gain their feedback on the process, including working with the health sector.

2.6.6 Final meetings were hosted with the representatives from each of the practices to share with them the outcomes of the project. This gave them the opportunity to share their views and review a draft version of the Community Engagement Model that had been developed by the project team.

3. Outcomes

3.1 Recruiting the Practices

Nine Fife GP practices were sent details of the project. Of those, four expressed an interest, and two practices with differing demographics were chosen. The high level of interest and participation was due direct contact and follow up conversations from the Clinical Lead.

3.2 Initial Meetings with Practices

Work done by the Social Enterprise Lead through the Social Enterprise and Health Roundtable (an initiative funded by the Scottish Government's Third Sector Division), had identified language as a major barrier to engagement between Social Enterprises and health professionals. This was confirmed at the meetings with the GP Practices. The discussion at these meetings helped the practices understand the remit of the Social Enterprises. It was explained that a Social Enterprise is a values-based business where surpluses are reinvested for community benefit. This background information enabled the practices to feel confident to signpost to Social Enterprises.

3.3 Learning Journeys

The Airlie Practice visited three Social Enterprises on 14 November 2012. These were:

- Craigencalt Ecology Centre - which aims to improve lives through engagement with the environment.
- Saje Scotland - which works with those who have experienced domestic violence.
- Recycle Fife - a principal activity of which is to provide employment, training and volunteer opportunities through the environmentally friendly activity of recycling.

The Feddinch Practice visited three Social Enterprises on 3 October 2012. These were:

- MyBus - which provides community transport as a focus for the development of community activity.
- ForthPilgrim - which provides guided walks along the old Fife Pilgrimage routes.
- Bennarty Area Regeneration Group (BRAG) - which was established in 1988 to help with business development upon the demise of the coal industry in the area and now also provides a range of social business support and development.

Each Learning Journey was followed by a de-brief at which the key discussions included:

- Surprise at the extent and quality of such relevant Social Enterprise activity.
- Agreement that the value base, purpose and operations of the Social Enterprises visited resonated very well with those of General practice.
- Social Enterprise represented an array of hidden local resources which could be helpful in fulfilling the aim of General practice to help patients improve wellbeing.
- Social Enterprises were very positively disposed to the principle of working more closely with General practice and keen to find ways of doing this.

A full account of the extent of our learning from these learning journeys can be found at appendix 1.

3.4 Community Engagement Meetings

Two open Community Engagement meetings were held for each practice (appendix 2) at which the numbers attending varied. A range of different methods were used to publicise the events, including an article in a local newspaper, posters, leaflets attached to prescriptions and group mailings. Feedback received suggested that the timings of the meetings and the venues chosen influenced attendance. The attendance at the most successful meeting was achieved by the project team personally inviting pertinent members of the community. This highlights the importance of relationships to enable effective community engagement.

The meetings were conducted using a World Café approach, which gave the community members the opportunity to work together in small groups with members of their local healthcare team. This approach provided a forum for everyone to have an equal opportunity to contribute their thoughts in a non-threatening environment. The feedback from these meetings demonstrated that members of the community valued this opportunity.

In both areas the issues identified by the community were similar to those identified by the practices at the initial meetings, confirming that the primary healthcare team have a good knowledge of their local community.

The main issues highlighted at the meeting in Leven were:

- unemployment (sometimes even third generation unemployment)
- lack of transport
- drug and/or alcohol abuse
- social isolation
- safety in the community.

The main issues identified at the meeting in St Andrews were:

- social isolation (including a large elderly population)
- mental health issues
- pockets of poverty
- segregation between ‘town and gown' (students and residents).

3.5 Recruiting the Social Enterprises

Following the identification and agreement of the issues in each community, appropriate Social Enterprises who were willing to be involved in the project were selected.

The Social Enterprises that were selected for Airlie Practice, and the reasons for selecting them were:

- MyBus – to help with social isolation; provide community transport (including hospital visits) and provide volunteering opportunities (up-skilling unemployed people and potentially reducing isolation and mental health issues).
- Fife Shopping and Services – to help with social isolation and to support independent living.
- Saje Scotland – run the Freedom Project to support women suffering from gender-based violence.
- Recycle Fife – providing volunteering opportunities and some interview skills opportunities (to increase employability, reduce social isolation and mental health issues).

The selection of Social Enterprises for Feddinch Medical Practice was challenging. Fewer options were available in St Andrews due to the less obvious demand and the unique demography of the area. It was felt that a service in the Arts would be beneficial and a meeting was held with a Social Enterprise called Creative Stirling. While the Chief Executive Officer (CEO) of Creative Stirling felt that St Andrews would be an ideal area to work in, they did not have the capacity to expand at that time. Fife Shopping and Services was again identified as offering a relevant service for the area, as there was a high need particularly amongst the isolated elderly population. Discussions with clinicians responsible for patients in the community

hospital identified that this service could have also supported earlier discharge from the community hospital. Unfortunately, Fife Shopping and Services also did not have the staff or financial resources available to deliver a service in St Andrews.

Following connections made at the Community Engagement meetings, the practice decided to initiate a link with the St Andrews University Student Voluntary Services (SVS). Although not a Social Enterprise, it was recognised as a relevant community asset. A new relationship between the SVS and the practice was developed and the students were able to offer a befriending service for some elderly patients. The practice established a system to support patients to engage with the student befriending service, with the aim of helping to reduce social isolation and, indirectly, also reduce the gap between 'town and gown'. Building on this enthusiasm, the Practice Manager, on behalf of the practice, explored undertaking a one day course delivered by a Fife Council funded initiative called Bums-off-Seats to allow her to lead walks in the area, in order to improve community engagement. The Practice Manager even gained commitment from some students to undertake this with her, however unfortunately, by the end of the project, she and the students had been unable to gain a place on the course.

3.6 Social Enterprise meetings at the Practice

Meetings were arranged at each practice for representatives from the selected Social Enterprises to link with members of the practice team in order to explain what their service had to offer as well as other key information. The Social Enterprises were advised in advance what information the GPs would find useful to be able to signpost patients (appendix 3). This meeting was key in building relations and trust between Social Enterprises and the practice team, as well as helping them to build knowledge about what each service had to offer. The Airlie Medical Practice also offered the selected Social Enterprises the opportunity to promote their services directly to people visiting the health centre by having a stand in the communal foyer (called 'the pram shelter').

3.7 Community Planning Partnership

As a result of discussions at the Leven Community Engagement meeting, the project team were keen to find ways to embed the project in the local strategic plan. To achieve this, a meeting was arranged with a local Councillor who offered to help connect the project with the Fife Community Planning Partnership. Unfortunately, it transpired that there was little, if any, chance of achieving this aim within the remit of this project.

3.8 Data Gathering

A range of methods were used to capture data pertaining to the project process.

3.8.1 Practice Questionnaires

Practice staff, including those not directly involved in the project, were asked to complete a questionnaire to ascertain their knowledge about the project and any benefits arising from it at two stages of the project - six months into the project and again six months after that (at the end of the data collection period) (appendix 4).

Results:

Airlie Practice - Six members of the practice team completed the initial questionnaire, six months into the project (a Practice Nurse, the Practice Manager, 2 GPs and 2 admin/reception staff.) Of those six, three had been directly involved in the project. All except one respondent were able to list a number of Social Enterprise services that they had learnt of through the project (either directly from their involvement in the project or indirectly from colleagues who were involved). With the exception of one respondent, who was not directly involved in the project, all felt that this project would improve engagement between GPs and the community.

Three members of the practice team completed the end of project questionnaire: the Practice Manager, a GP and an administrative member of staff, all of whom had been closely involved with the project. All mentioned that they had a better knowledge of Social Enterprises available in the area with one respondent stating "we were able to direct patients to services that could help them, that we were unaware of previously." The GP who was involved in the project said that she "felt more confident about telling (patients) about the organisation as I have met the people who run them". This again emphasises the importance of personal relationships. All three respondents felt that the project had improved engagement between GPs and the community, however they had expected the Social Enterprises to make more advantage of an offer of promoting their services directly to the community using the pram shelter in the foyer of the health centre.

The collective feedback from both questionnaires illustrates that signposting patients to relevant services may need to be repeated, however the benefits to those using the Social Enterprises were recognised “We have been able to inform patients of different services, and although we are aware of patients who we have signposted not taking the offer up, we are also aware of two patients who have referred themselves and are finding this beneficial for their social isolation”.

Feddinch Practice - Three members of the practice team completed and returned initial questionnaire six months into the project (the Practice Manager and two GPs). Two of these respondents had been directly involved in the project. The respondents felt that through this project they had gained a better awareness of services available in their community. All of the respondents indicated that this project had improved engagement between GPs and their community, although one noted that there was still significant work to be done on this.

Five members of the practice team completed the end of project questionnaire, comprising: the Practice Manager, and four GPs. Two of these respondents were directly involved in the project. Some respondents felt they had gained awareness of services and of their community's needs through this project, however the benefits were limited. Some reported that they were not aware of benefits to patients from the project and only the two respondents who were directly involved in the project felt that engagement between GPs and their community had improved. Those who met with the SVS signposted more patients to the befriending service than those who had not been directly involved in the project. Those who were directly involved in the project stated that meeting the people from the organisations made a positive difference, with one stating "I am now in a position to signpost patients more appropriately, and through meeting some of the individuals involved, I think I will be more likely to utilise their services. The personal contact has made a difference." Some of the staff involved from the Feddinch Practice have said that they would continue to use the befriending service following completion of this project "I see this as a sustainable project which can be taken forward year on year".

3.8.2 Practice Trackers

Each of the practices were asked to keep a record of patients they signposted to any of the selected services, using a tracker provided (appendix 5).

Airlie Practice - A total of 18 patients were signposted to the relevant Social Enterprises during the 36 week data collection period. The ages of these patients ranged from 24 - 93 years.

The reasons patients were signposted were:

- 12 social isolation (of these seven were aged >75 years)
- three domestic abuse
- three unemployment.

Feddinch Practice - 13 patients were signposted to the St Andrews University Student Voluntary Service (SVS) befriending scheme. These patients were aged between 81-92 years, and were all signposted because of social isolation. By December 2013, 9 of those patients signposted had started using the befriending service.

3.8.3 Social Enterprise Tracker for New Users

Each of the Social Enterprises involved in the project were asked to record details of new users of their service, detailing their perceptions of any changes to users' wellbeing from when they first started using the service and again at the end of the project (appendix 6). Unfortunately, the timescales were very short for any significant changes to wellbeing to be identified, although this was possible in some cases with those who started using the service near the beginning of the project.

Saje Scotland recorded seven new users to their service in the duration of the project. One was signposted by the Airlie Practice, one heard about it through a friend/family member and the five remanding users were signposted by other organisations such as Woman's Aid and Social Work. The age range of the women using that service was between 19-49 years old.

Prior to attending the course, Saje Scotland noted the wellbeing of four of the users as either 'not good' or 'not good at all', and the other three were 'ok'. At the end of the project, Saje Scotland perceived that the wellbeing of six of the women had improved and the seventh one remained at 'ok'. They perceived the wellbeing of five out of the seven women to be 'good' or 'very good' at the end of the project.

MyBus recorded 11 new users to their services. One of the new users was signposted from the practice and the other ten were signposted mainly from other parts of the NHS. Due to the short timescales, MyBus was unable to rate any changes in wellbeing for nine of the new users (as they had just started at the end of the project). For the two users who had been using the service for a sufficient time, MyBus perceived positive changes to their wellbeing. Both were initially rated with 'not very good' general wellbeing, and improved to either 'good' or 'very good' wellbeing. Unfortunately, one user's wellbeing deteriorated and she was in hospital at the time of data collection.

Two new users joined Recycle Fife for volunteering opportunities. Neither of the users were signposted from the practice. Recycle Fife's perceptions of the wellbeing of these volunteers

indicated that it improved following their time at Recycle Fife. Recycle Fife noted that the confidence of both these users had improved, resulting in better communication skills for one user, and the confidence to seek employment for the other.

Unfortunately, Fife Shopping did not return their completed tracker, despite several requests. This was disappointing as it was felt that many patients could have benefitted from this service.

Unfortunately, due to a change in the student managing the befriending scheme, we were unable to obtain feedback on the patients who had started using the St Andrews University SVS befriending service. As mentioned previously, relationships are key to the continuity of a project of this nature, and changes to staffing can pose a risk to this.

3.8.4 Health Status Questionnaire

During the Learning Journeys the project team heard anecdotes and stories from the Social Enterprises, suggesting that people felt better and less lonely after engagement with their services. It had been identified early on in the project that the language used by health and Social Enterprises differed greatly. To improve the joint understanding and credibility between Social Enterprise and the health sector, a health status questionnaire was developed and piloted, including by colleagues at RCGP Scotland and employees at Recycle Fife (see template at appendix 7). The aim of the questionnaire was to record any changes in health status and feelings of wellbeing, as a possible means of translation between the two sectors. It was recognised that the results of this questionnaire could be useful for Social Enterprise organisations to demonstrate to healthcare professionals the potential benefits of social engagement. Nine questionnaires were returned, however no follow-up questionnaires were received therefore it was not possible to compare before and after the Social Enterprise engagement and thus no change in health status could be confirmed.

3.8.5 Social Enterprise End of Project Telephone Interviews

Structured telephone interviews were conducted with each of the Social Enterprises at the end of the project (appendix 8). Three of the four Social Enterprises involved in the project felt that their expectations had largely been met (to forge new links, and to raise awareness and the profile of their Social Enterprise). They felt that they had faced some barriers throughout the project, as the remit and capacity of the Social Enterprises had changed and diversified over the duration of the project. Time and staffing constraints within the Social

Enterprises were mentioned as an issue. The Social Enterprises felt that a dedicated worker to the project would be beneficial, who would be able to liaise with both the Social Enterprises and Practices involved. However, overall, all of the Social Enterprises involved responded positively that they found the project worthwhile and would choose to be involved again.

3.8.6 Final meetings with practices

The final meetings with each of the practices presented an opportunity for the project team to share the experiences and outcomes of the project of the other participating practice. It also gave the practices a chance to make any recommendations to the project team for a successful community engagement project based on their experiences (appendix 9).

The practice participants commented that they recognised that it would have been useful to gain feedback from the signposted patients, however this was not possible within the short timescales of the project. It was acknowledged that it was only appropriate to signpost a small number of patients during the project and the uptake of patients once signposted was limited. It was identified by the practices at the start of the project that it takes a few attempts at signposting a patient to a new service before they may decide to take action. The practices said that they would continue to signpost patients to the services identified after the project had ended. The practices mentioned that they would have anticipated more engagement, information-sharing and enthusiasm from the Social Enterprises and, echoing the Social Enterprise's feedback, they also suggested that perhaps a dedicated person could work on the project to liaise between participants. Both of the practices felt strongly that it had been very beneficial to meet a representative from each of the organisations they were signposting to, and suggested that all members of the practice team and extended practice team be included in this step to encourage their engagement and to build mutual respect and trust. This resonates with the feedback from the practice questionnaires that illustrated that those who were not directly involved in the project did not signpost as many patients and could not fully understand the benefits of doing so. Feedback from the final meetings with the practices highlighted that the lead GP sometimes found it difficult to engage those who were not directly involved. The practices felt that the community engagement meetings were also interesting to explore issues in the local area.

The opportunity through this project of being able to improve the health status of patients through collaboration with Social Enterprises was appreciated, however, the increasing complexity of the GP consultation means that it is difficult for GPs to have the necessary time to effectively signpost to outside services. This was reported in the final practice meetings

with the comment: “The momentum of general practice is such that I suffer from information overload. I found it impossible to mentally reference what was ‘out there’ and use it effectively.”

At these meetings, the project team presented a draft version of a proposed Community Engagement Model, illustrating how a community engagement process could be rolled out to all practices in Scotland. A local GP who had not been involved in the project was also invited to attend one of these meetings to gain a different perspective on the draft model. The overall feedback on the draft model was that if it was too complicated, practices would be unlikely to adopt it. It was realised that all of the issues identified for both communities involved in the project had an underlying issue of social isolation. It was agreed that the model should be refined to focus on this issue in the first instance, as this would, in turn, help with the consequential issues as a result of or resulting in social isolation. It was also highlighted that it was vital for any new approach to succeed first time or practices would not continue to use it. Once practices were comfortable with using the model focusing on social isolation, it could then be used to introduce a new issue relevant for that community. It was also discussed that the patients’ benefit from the process would need to be communicated back to the practice, as GPs would be unlikely to engage unless there was some evidence of patient benefit.

4. Findings and Recommendations

4.1 This project has assessed a specific proposed method to determine the benefits and constraints of a Community Engagement process, delivering suitable solutions using a Social Enterprise approach. The table below shows a summary of the project findings and the recommendation(s) relating to each finding, detailed further after the table.

Table 2: Summary of Findings and Recommendations

Findings	Recommendations
1. Differing language used by Social Enterprises from that of health professionals was seen as a barrier to engagement.	1. The facilitator (demonstrated on the model) would help to overcome this barrier. Meetings between relevant Social Enterprises and the healthcare team would also help health professionals to understand the remit of Social Enterprises and build relationships.
2. Prior to the Learning Journeys, the practice staff were unaware of many of the local Social Enterprises available in their area and were unaware of the common goal that health professionals and Social Enterprises shared. They also stated that they would be less likely to signpost patients to a service that they did not know and trust.	2. The facilitator in the model would be a natural networker and be able to take advantage of local social capital (networks of valuable relationships within the primary care and Social Enterprise sectors). They would be helped in this process by connecting directly with the Social Enterprise & Health SEN Coordinator to identify relevant local Social Enterprises and facilitate a meeting with them and the extended practice team to share information about how they could help patients.
3. It was identified that the Social Enterprises had limited resources (staff, time) to build relationships with the practices and to take advantage of promotional opportunities. They also had limited capacity with regards to the	3. The facilitator recommended in the model would be able to offer support in building the relationships between the Social Enterprises and the practices. With regards to the number of new users each Social Enterprise could accommodate, it

number of new users they would be able to accommodate.	would be vital for this to be ascertained from the outset and shared with the practice. Where these numbers are limited, it would be recommended that business support be sought to assist existing Social Enterprises to expand their capacity in response to these new opportunities. Another recommendation would be to have a dedicated ring-fenced fund for Social Enterprise and health to support Social Enterprises to meet demand.
4. The practice staff who were involved in the project valued the opportunity to meet with each of the Social Enterprises involved, to learn about how they could help patients and help them feel comfortable with signposting patients to each service. This was demonstrated by the fact that those involved in the project signposted far more patients than those who were not involved.	4. As mentioned at point 2, it is recommended that meetings be held between the extended practice team and relevant Social Enterprises. This would be to provide the practice staff with essential information about each of the Social Enterprises, but would also help the wider team to understand the benefits of working with Social Enterprises and start building the relationships and trust for signposting patients to these services, which was highlighted in the report as a key requirement.
5. The practice team highlighted that they found it easier to signpost if they were able to give the patient a leaflet about the service. Even when signposting, patients did not always take up the service and it was realised that this would take time and often multiple suggestions from the primary health care team.	5. Social Enterprises should provide the practice with a paper or electronic leaflet with all the necessary information for the health professional to print out to give to patients they are signposting. Extending this process to the wider primary healthcare team means that other health professionals such as District Nurses may have more time/opportunities to follow up with patients they have

	signposted.
6. Some of the issues identified at the Community Engagement meetings were outwith the remit of this project and would also be outwith the remit of the model. Having Community Engagement meetings inviting participants to talk about local issues may set false expectations about what can be done.	6. Changing the Community Engagement meetings to invite the community to meet and discuss a specific pre-identified issue, in this instance Social Isolation, means that participants are less likely to diversify into issues that are not relevant for this model and instead can focus on social assets that can help alleviate the issues relating to the topic.
7. The timescales of this project were too short for the potential benefits to be realised and this was echoed by the feedback from those involved. The practice staff mentioned that they would have found it beneficial to gain feedback on any health or wellbeing improvements for those patients who were signposted, however the timescales of this project did not allow sufficient time for that to happen. The journey highlighted the importance of relationship building and it was recognised that this takes longer than was originally expected.	7. It would be recommended that a much longer and larger scale project be conducted to provide space for relationships to be established and built upon. There should also be sufficient time for relevant Social Enterprises to expand their capacity to be able to accommodate an increase in demand or for new Social Enterprises to be established. It was also realised that patients did not often start using a Social Enterprise after hearing about it for the first time and that it would take time for the practice staff to encourage patients to take up the service. A step has been added to the model for any improvements to the health or wellbeing of patients signposted to the Social Enterprises to be fed back to the practice through the facilitator. It is anticipated that this would motivate the practice staff to continue to engage with the process. The facilitator providing this feedback will be able to ensure that the outcomes are expressed in a language that can be understood by

	health and Social Enterprise. This feedback can be discussed at practice meetings to encourage more signposting.
8. Feedback received on the model stressed that it should not be too complex as this would discourage practices from engaging with it.	8. To make the model simple to use and encourage uptake of the process, it should focus initially on one issue. Social isolation was identified as being a universal issue in the majority of communities. This is not the only issue but it is an issue resulting from or leading to a spectrum of issues. It was realised that **social isolation** underpinned all of the issues that were identified from both practices in the project. A small number of appropriate Social Enterprises in each community could then be identified or developed and patients signposted to. Once this was successfully implemented and the practice was comfortable with the model, they could then consider expanding to different issues and services.

4.2 Initial Meeting with the Practices

At the initial meeting with the practices, the remit of a Social Enterprise and the background of the project itself was explained. This led to increased confidence in signposting to Social Enterprises and overcoming concerns as to the nature of these businesses.

For engagement to be successful between the community and the health sector, there needs to be an increase in awareness of the benefits of working with Social Enterprises. To achieve this, direct contact between the different sectors should be facilitated to enable effective working relationships. We would recommend that a meeting/meetings is held between the relevant Social Enterprises and the extended practice team to share information about how their

services could benefit patients and also provide the opportunity to build relationships and trust between the health sector and the Social Enterprises. These meetings would be organised by an Engaging Community Assets Facilitator. They would be helped in this process by connecting directly with the Social Enterprise & Health SEN Coordinator.

4.3 Learning Journeys

Learning Journeys were arranged for each of the practices to visit Social Enterprises that were relevant to the community issues they had identified at the initial meetings. The Learning Journeys were positively received and all those involved found the experience to be very insightful and encouraging. The practices were previously unaware of any of the Social Enterprises that they learnt about through the Learning Journeys, despite one of the practices being located very close to one of the Social Enterprises. It was on the Learning Journeys that the staff from the practices were heartened to discover that health and Social Enterprises were both passionate about trying to improve the health and wellbeing of individuals. The practices could see the benefit of signposting to many of the Social Enterprises visited. It is acknowledged that it may not be possible for members of the practice team to take time out of their working day to visit Social Enterprises, therefore we would recommend that meeting be arranged within the practice for representatives from appropriate Social Enterprises to attend and discuss their service and how it could benefit patients. There is a strong belief from the Social Enterprises that the impact they can have on a person's wellbeing is significant - "We change people's lives" – Frankie Hodge, Recycle Fife.

4.4 Community Meetings

Two Community Engagement meetings were arranged in each practice area. As mentioned previously, the attendance at these meetings was mixed and personal invitation by project leads resulted in an increase in participation. At these meetings, participants identified the issues in their community, which were very similar to those that the practice had identified in the meetings at the start of the project. Participants valued the opportunity to establish links, however there was an awareness that a wide range of issues were identified that were outwith the remit of this project e.g. Leven wished for a local train station. This shows there is a risk that open Community Engagement meetings may set unrealistic expectations of what can be achieved, so the focus of the meetings would need to be clear in advance. Both GP Practices felt that their awareness and knowledge of available Social Enterprises had improved and likewise their confidence in recommending Social Enterprises to patients.

4.5 Recruiting the Social Enterprises

Following recruitment of appropriate Social Enterprises for each practice, representatives were invited to attend a meeting at the practice, with the practice staff involved in the project.

This was felt to be a key meeting by the practice and those who had met the Social Enterprises subsequently signposted more patients to the selected Social Enterprises. A recommendation would be to have representatives from appropriate Social Enterprises attend a meeting at which the extended primary healthcare team are in attendance e.g. a protected learning time (PLT) session. Additionally, engaging the wider practice team would ensure that all practice staff have sufficient knowledge and confidence to explain the services and benefits of the Social Enterprises to patients. It was also felt that other professionals within the practice team may have more time to invest in signposting patients to local services than GPs.

At the stage of the project when deciding on appropriate Social Enterprises for each practice to signpost to, the capacity of each Social Enterprise to expand their service to accommodate an increase in demand and additional time required to engage with the health sector was not factored.

Each of the Social Enterprises enlisted had a great enthusiasm and willingness to be involved in the project and with the practices, however over the course of the project it became clear that some did not have sufficient resources (time, staff resources, financial resources, etc.) to invest fully in the process. Thus some were unable to offer any service at all and others were limited in the number of new service users they could accommodate. Learning points for this project would be to have a step in the process to:

- Ascertain the number of individual signpostings each Social Enterprise could accommodate.
- Identify whether sufficient resources (human resources and financial investment) would be available to support a potential increase in increase numbers of participants.
- Refer those with limited capacity to a business support resource who could assist them to develop their business in response to these new opportunities.

4.6 Data Gathering

The information gathered from the practices reinforced that those directly involved with the project had a wider understanding of the selected Social Enterprises and felt more confident about signposting patients. Some of those involved mentioned that they found it quite difficult to engage the other members of the team in the project. Inviting the Social Enterprises to a

meeting of the extended practice team, as recommended above, would help to engage more staff and help them to review the potential health and wellbeing benefits to patients.

The feedback gathered showed that participants felt that the project was just starting to gain momentum and that the potential benefits were only beginning to be realised.

The practice staff involved stated that learning about positive outcomes from the time invested in signposting patients to Social Enterprises would motivate the practice to continue to engage with the process. It is recommended that any future project be run over a longer period of time to enable any potential changes to wellbeing to be assessed and for this to be fed back to the practice.

The data gathered from the practice illustrated that they wanted the Social Enterprises to be more forthcoming in promoting their services to patients and engage more with the practice staff. For example, Airlie Practice gave all of the selected Social Enterprises an opportunity to promote their services in the practice foyer, however, none of the Social Enterprises had the time or resources to make use of this facility. This had the potential to negatively impact the relationship between health and the Social Enterprises.

Having a step in the process to check the capacity of the Social Enterprises and their commitment (as detailed in section 4.5) would ensure that only Social Enterprises with the capacity to respond to demand would be introduced to the practices.

4.7 Final Meetings with the Practices

At the final meetings with the practices, the draft Community Engagement model was discussed, and it was agreed that it would need to be simple to encourage practices to participate.

Following discussions, the model was refined and it was recommended that a single issue be focused on in the first instance.

Upon reviewing the reports from the Community Engagement meetings and data gathered, it was acknowledged that social isolation was a common factor linking all the issues identified at the participating practices. Social isolation was either as a result of the issues identified, or the issues identified resulted in members of the community being socially isolated. For example, social isolation derived from various influencing factors such as mental health issues, unemployment, substance misuse, abuse, lack of community transport etc. It was therefore

agreed that the proposed model should focus on social isolation as the main community health issue. The discussion with the participating practices concurred with this proposal and identified that social isolation would be a relevant issue for many patients in Scotland and that practices in all areas would have patients who could benefit from this support. This may also help to address some of the challenges from the changing demographics of an ageing population.

Recent research has highlighted the negative impact of social isolation on health. 'Research[12] shows that loneliness and social isolation are harmful to our health: lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day, and is worse for us than well-known risk factors such as obesity and physical inactivity'.

The findings of a six-year study recently published in *the Guardian*[13] found that 'loneliness can be twice as unhealthy as obesity'. Regarding the same research, *the Independent* reported that 'extreme loneliness can be worse than obesity in terms of increasing the potentially lethal health risks that lead to premature death'. *The Guardian* also refers to similar studies that have 'linked loneliness to a range of health problems, from high blood pressure and a weakened immune system to a greater risk of depression, heart attacks and strokes'.

With the aging demography in Britain, social isolation and loneliness will, therefore, present an increasing amount of related health and wellbeing issues, and the shift in focus to care in the community demonstrates a need for Social Enterprises to tackle social isolation.

The value of positive feedback from patients who had been signposted to Social Enterprises by the practice was raised, and therefore it is recommended that the replicable model includes a facilitator who could follow the patient journey and feed back to the practices. This would help the health sector to realise the benefits that using Social Enterprises could have on their patients' wellbeing and thus increase their motivation and engagement with the process. Once the practice was satisfied with the process focusing on the first issue of social isolation, we would then recommend that other issues relevant to their community should be introduced.

[12] http://www.campaigntoendloneliness.org/about-loneliness
[13] http://www.theguardian.com/science/2014/feb/16/loneliness-twice-as-unhealthy-as-obesity-older-people

5. Next Steps

It is recommended that a follow up project on a larger scale is developed using the findings from this small project to further assess the health benefits of social engagement and the impact of social isolation on health. A proposed model for community engagement can be found at appendix 10, along with a diagram of the connections established prior to the commencement of this project, and the connections made through this project. As it has been identified that there is a need for Social Enterprises to develop to be able to respond to any increases in demand for their services, the term of the project would need to factor this in. It has been recommended that Social Enterprises be granted two years to establish an appropriate service. The practices also felt that the current project was finishing just as the process was beginning, therefore a longer project would allow time for patients to start using the services and feedback be given on their wellbeing to the practices. We would recommend that RCGP Scotland undertake a follow on project using the developed model for a four to five year term, involving a larger number of practices and the extended practice team. This will provide time for a Community Engagement Facilitator to be recruited, practices and their extended practice teams to be engaged, effective relationships between health and Social Enterprises to be built, meetings in each community to be held, appropriate services to be identified/expanded/created and for changes to users' wellbeing to be recognised and fed back to each practice. The recent enactment of the Public Bodies (Joint Powers) Bill brings a new focus to developing integration of health and social care, including the voluntary sector and social enterprises. Developing capacity and assets within individuals and communities to help address the social and care needs of individuals will be key to the success of the policy. Successful integration at locality level within health and social care partnerships will require the active participation of general practice and closer working between practices and communities. This will provide an excellent basis for facilitating the development and functioning of social enterprises based on identified needs within communities. A project on a larger scale using the model would, therefore, be very timely to support the integration agenda.

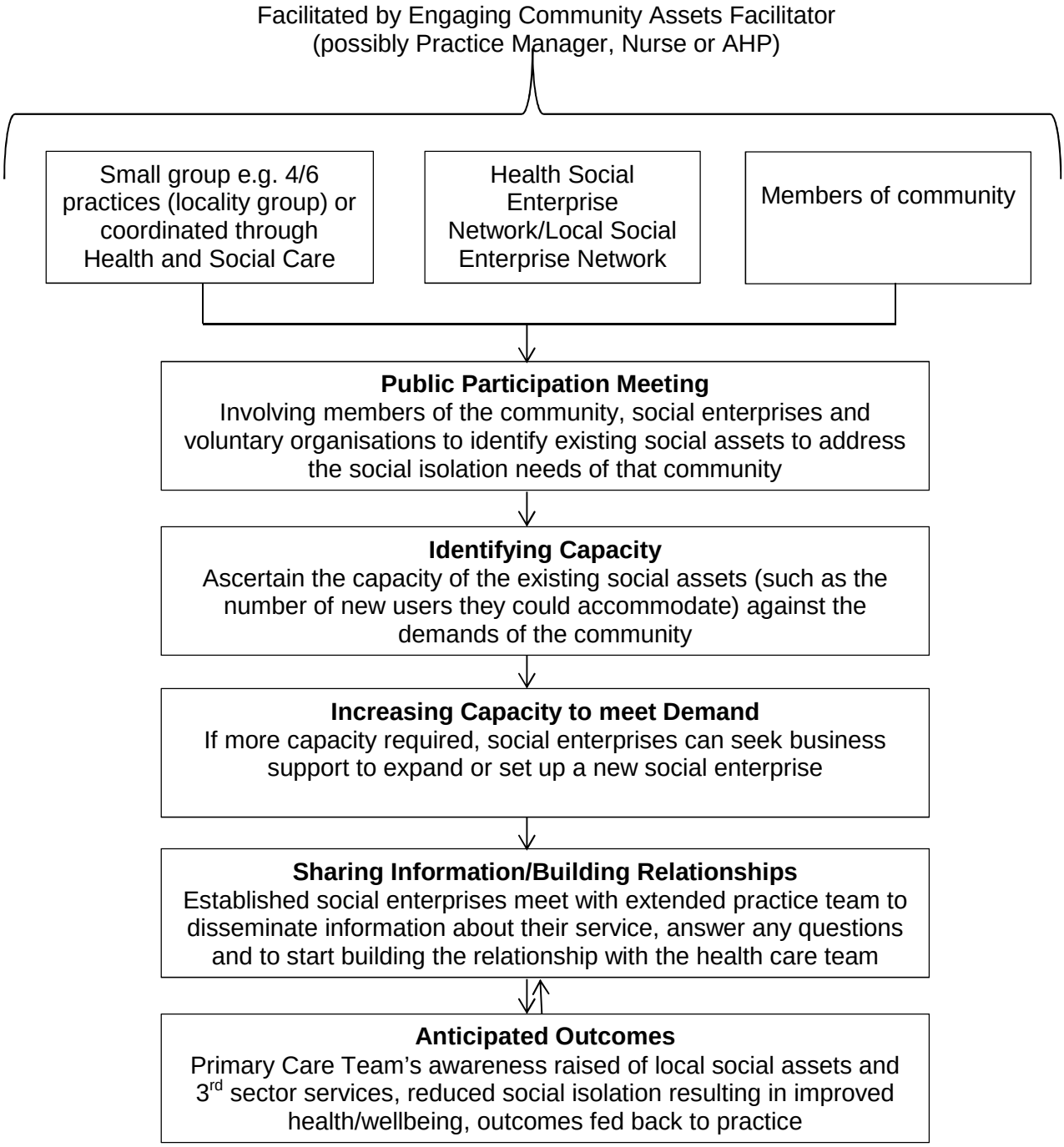
We would also recommend for the future that a dedicated ring fenced fund for Social Enterprise and health (similar to the Sports Investment Fund to develop financially sustainable sports organisations) be available to support the shift to care in the community.

6. The Model

Built upon the learning and outcomes gained through the Engaging Community Assets project, a model has been developed as a proposed method of engaging GP practices with their community and utilising social assets and Social Enterprises to improve the health and/or wellbeing of the community, below:

Engaging Community Assets Model

Aim: to improve local health and wellbeing by reducing social isolation



As mentioned in the report, this model focuses on the universal issue of social isolation, which was found to be an underpinning problem of all the issues identified during the project. This model proposes having a Engaging Community Assets Facilitator to facilitate the process and engagement between health and the social assets within the community. In this model, we recommend that community meetings take place, involving members of the community, a representative from a small group of local practices and a representative from the Health Social Enterprise Network. This meeting would be used to look at the issues around social isolation within the community and to identify social assets to address those needs. Should the existing social assets within the community be insufficient to meet demand, business support should be sought to increase capacity or an appropriate Social Enterprise to be established. Once these services were able to accommodate sufficient numbers of new users, the facilitator would arrange a meeting between the Social Enterprises and each of the appropriate practices to: allow information to be shared, relationships to be built and trust in signposting to these services to be gained. Outcomes on improvements to users' health and/or wellbeing would be fed back to the practices through the facilitator to demonstrate the benefit of the process and to motivate a continuation of signposting relevant patients.

We have also developed another couple of models to illustrate the relationships that existed between Health and Social Enterprises before this project and the relationships that were built through this project (appendix 10).

7. Unplanned Beneficial Outcomes

There has been a great deal learnt from this project, with several unanticipated positives. As a result of this, there have been a few unplanned beneficial outcomes that, although not forming part of the project report, are well worth recording. It was expected that Social Enterprises would be used to solve the issues that were identified in the Community Engagement meetings, however, due to the unique demographics of St Andrews, there were no relevant Social Enterprises available to address their issues. This meant that a shift in focus to other social assets in the community was required and a relationship between the practice and the local University was established. This not only provided a befriending service for suitable patients, but also provided a platform for improved relations between the practice and the University, including a more frequent clinic available on campus for the students and some of the students offering to take a 'bums off seats' course with the practice manager.

Following holding a community meeting at a local church hall, a connection was made between the Lead GP involved in the project from Feddinch Practice and a lead from local Alzheimer's group. This resulted in many members of the Alzheimer's group participating in the Community Engagement meeting, which they were delighted about. Additionally, following the meeting the Alzheimer group lead went to the practice to speak to other GPs to raise their awareness of the group and has resulted an increase in the number of patients with Alzheimer's attending the group. A new sports based Social Enterprise in Leven are now taking a co-production approach following this project.

7. Appendices

Appendix 1	Learning Journey Reports	Appendix 1 - Feddinch Learning Jou Appendix 1 - Leven Learning Journey.doc
Appendix 2	Community Engagement Meeting Reports	Appendix 2 - Actions from Leven Second C Appendix 2 - Feddinch 2nd commur Appendix 2 - St. Andrews World Cafe
Appendix 3	Information required from Social Enterprises	Appendix 3 - Social Enterprise Informatio
Appendix 4	Practice Questionnaire Feedback	Appendix 4 - Compiled Feddinch pr Appendix 4 - Compiled Leven pract Appendix 4 - Feddinch End of Proje Appendix 4 - Leven End of Project Questi
Appendix 5	Practice Trackers	Appendix 5 - Compiled Trackers Fe Appendix 5 - Compiled Trackers Le
Appendix 6	Social Enterprise Trackers	Appendix 6 - MyBus Tracker.doc Appendix 6 - Recycle Fife tracker.pdf Appendix 6 - Saje Tracker.doc

Appendix 7	Health Status Questionnaires	Appendix 7 - Social Enterprise User Healt
Appendix 8	Social Enterprise Telephone Interviews Feedback	Appendix 8 - Fife shopping telephone ir Appendix 8 - MyBus telephone interview.c Appendix 8 - Recycle Fife telephone intervi Appendix 8 - Saje telephone interview.c
Appendix 9	Final Practice Meeting Interview Feedback	Appendix 9 - Feddinch practice inte Appendix 9 - Leven practice interview.do
Appendix 10	Model	Appendix 10 - Model of Network Connecti Appendix 10 - connections made thr Appendix 10 - Engaging Community
Appendix 11	Three Horizons Note	Three horizons note