Evaluation of ‘Reducing the burden of Coronary Heart Disease, Stroke and Cancer’ Programme in Wales, Scotland and Northern Ireland

Year 2 Report

Big Lottery Fund

Confidential - Commercial 12 April 2007
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Executive Summary

Background

1. The Big Lottery Fund (BIG) has financed a range of programmes aimed at reducing the burden of coronary heart disease, stroke and cancer in Scotland, Wales and Northern Ireland.

2. The programmes in Scotland and Northern Ireland aim to:
   - Reduce the risk of coronary heart disease, stroke and cancer through the provision of effective evidence-based prevention programmes.
   - Improve access to high quality services and facilities for the diagnosis and treatment of coronary heart disease, stroke and cancer by specifically tackling inequalities in provision.

3. The programmes in Wales aim to:
   - Provide evidence-based prevention activities and services in order to reduce the risk of people from disadvantaged groups developing CHD, stroke and cancer.
   - Reduce the impact that CHD, stroke and cancer have on people's lives by improving the availability and quality of related support and rehabilitation services.
   - Improve access to specialised services for the detection and diagnosis of coronary heart disease.

Evaluation

4. Tribal Consulting in association with CRG Research Ltd have been commissioned to undertake a three year evaluation of BIG's 'Reducing the burden of coronary heart disease, stroke and cancer' Initiatives in Northern Ireland, Scotland and Wales.

5. The evaluation is designed to be both an evaluation of the whole programme via a three year tracking study and a more focused evaluation of projects based on a case study approach.

6. This document presents the evaluation of BIG's 'Reducing the burden of coronary heart disease, stroke and cancer' Initiatives in Northern Ireland, Scotland and Wales. This takes the form of results and analysis of a questionnaire completed by 134 BIG projects and sixteen case studies of BIG projects. Most projects were coming into their final year of funding in the Reducing the Burden of Coronary Heart Disease, Stroke and Cancer Programme.

Questionnaires

6. Taking an overview of the 134 completed questionnaires, it can be concluded that most projects consider that they have successfully fulfilled their aims and objectives. Over a third of all projects, 45 (34%), believed they had totally met their aims and objectives. A further 68 (51%) felt they had mostly met these.

7. The majority of projects believed that they have addressed inequalities in provision, with 28 projects (21%) stating they had totally addressed inequalities in provision. A further 83 (62%) stated that they have addressed inequalities in provision to a large extent. This was often achieved by measurements and by more informal methods; for example analysis and comparison of group for regional statistics and knowledge of deprivation scores; information assimilated by targeted individuals who then pass it on to the extended family.
8. Most projects felt they had linked in with local and national strategies, with 65 (48.5%) believing that they had totally linked to such strategies. A further 46 (34%) felt they had mostly achieved this. This was achieved by measurement against such strategies, but also in more direct ways at national and local levels, for example: forming links between acute trusts and national health commissions; reducing prices and changing the times of gym sessions to encourage more participants.

9. The only perceived downside for some projects is a belief that they would have been able to achieve an even greater impact with initial longer term funding of their projects.

10. Another measurement of success could be seen in that 63 projects (47%) said that they seen a reduction in the impact that CHD/Stroke/Cancer has on people’s lives as a result of their project. For a number of projects this was considered too early to be able to say.

11. There were 32 (24%) projects who believed they had seen an impact of reduced risk or incidence of CHD/Stroke/Cancer. Many projects attached this partly to their methods of education and increasing awareness, such as via publicity events and campaigns (including literature, telephone helplines and websites); increasing target group knowledge of the relationship between physical activity, diet and health and well being; increased access to specialist services.

12. Over half of all projects, 70 (52%), believed they had developed innovative or new approaches to meeting the needs of the target population. Successful methods of achieving this included the development of nurse led clinics; establishment of drop-in centres, visiting schools and leisure centres; Involving local communities through volunteer services, using lay people to identify health issues in communities and to distribute information. Methods included face to face, such as developing disabled-friendly publicity and premises, as well as publicity through the Internet and health promotions campaigns.

13. Typical benefits for users resulting from the projects were an improved quality of life and an increased awareness of the condition. For instance, many patients and carers felt more empowered, knowledgeable, confident and had higher self esteem.

14. Partnership working with the statutory, voluntary and private sectors was effective for many projects. For instance, specialist nurses appointed to hospices and rural communities; education and training through projects, schools and Higher Education colleges; forming local working groups to develop services with voluntary and private sectors, with statutory involvement; sponsorship and hands-on involvement from local traders.

15. With regard to sustainability, most projects, 85 (63%) were investigating or had plans in place for service continuation. This included 44 projects (33%) that had already secured service continuation funding at the time of the survey. Funding was from sources such as NHS Boards and Trusts, local councils and BIG.

Case Studies

16. In the course of the study evaluators spoke to a total of 16 project managers along with a number of project delivery staff. Although all projects have a similar end outcome, i.e. reducing the incidence of coronary heart disease, stroke and cancer in their target populations, the activities and services they provide are very different. There are also a number of country specific issues providing a differing contextual backdrop to each of the projects. It has therefore been considered most useful within this executive summary to provide a country by country snapshot examining the issues relating to each country and illustrating with examples.
Scotland

17. In summary, the Scottish based initiatives supported by BIG were originally set within health improvement policy developments focusing on reducing risks associated with heart disease, stroke and cancer. The sustainability of such initiatives must now be set within wider NHS policy developments concerned themselves with sustainability, modernisation and aspects of efficiency and effectiveness.

18. The six Scotland based initiatives can be most usefully separated into four that are based in hospital settings and two in community settings. All the hospital based projects were planned in consultation with the Managed Clinical Networks which supported the bids for funding and were in a position to continue financial support. Continuation being conditional to projects achieving objectives, and sustainability being part of subsequent planning to mainstream the programmes as part of improved efficiency and cost effectiveness. In essence, as part of current ‘modernisation’ within the NHS, this would mean that each project demonstrated ‘fit for purpose’. In that respect there is gathering evidence that projects have modified and invested in training which has resulted in improved quality measures such as involving patients and communities in the planning of improvements, improving data bases and improving the interface between primary and secondary care.

19. Each hospital had focused on different aspects of quality improvement, including improving the experiences of those from ethnic minority groups who had suffered a heart attack; improving assessment processes following evidence of increased risk of stroke; reducing hospital bed-stay rates following admission with stroke, by having a consultant led outreach follow-up rehabilitation service for up to 16 weeks. Given the current focus on patient involvement and patient choice, it was important that both patient and main carer would be satisfied with this kind of provision in potentially stressful circumstances.

20. The community-based projects were very different in both their organisation and philosophy. One was relatively very business oriented with strong leadership and an enthusiastic and flexible workforce able to move and modify available resources according to demand. There were clearly based partnership arrangements with a local council and local authority. Several sources of funding and innovative approaches were achieved to attain the engagement of those most hard to reach, such as obese youngsters and adolescents not used to taking regular exercise. Of special interest were reports from parents that their obese children had not only lost weight but had improved self esteem.

21. Both community-based projects needed to work in partnership with those in primary care services since they both depended to a greater or lesser extent on referrals. The project involving several voluntary agencies was probably the most difficult to organise and sustain in the medium to long-term. This was due to the nature of their target groups and the traditional difficulties associated with engaging those in deprived areas. It was also the project most likely to have difficulty in obtaining measures of effectiveness within the specified timescale, the one with least flexibility and most difficulty in achieving sustainability. It was particularly surprising that an exit strategy did not form part of the planning process, given the predictable problems associated with those who are most difficult to reach and engage.

Wales

22. Within Wales the evaluators were not able to identify any wider specific contextual issues which would have impacted upon projects. What has remained a key concern to most project managers is the issue of sustainability. Only one project has succeeded in securing future funding for the next three years. All other projects are faced with the same issue of obtaining forthcoming financial support.

23. Key to their future sustainability will be the supporting evidence built up over the past two years in terms of beneficiary data. As was outlined in the last report, some projects are successfully collecting and interrogating a very wide range of beneficiary data, not only in terms of changes
to behaviours and attitudes but also in terms of more measurable data, such as changes in blood pressure and weight. Project managers have also ensured that beneficiaries contribute to the ongoing development and evolution of the projects. This was by either continuing the user forums developed in Year 1 of the projects, or by ensuring that individuals are engaged on the individual steering groups. Here they are given the opportunity to express concerns or satisfaction with the services and activities provided.

24. It is also clear that some projects are delivering activities and services into very local, accessible areas and this is to the satisfaction of beneficiaries. The evaluators have had very limited opportunities to speak to some beneficiaries within a certain project. They can confirm the project has been a very welcome lifeline for some of the beneficiaries, their families and carers. With a continuing trend towards locally accessible activities and services this should provide some reassurance as to the continued operation of all of the projects that evaluators assessed.

25. Partnership working remains particularly strong within all the projects, particularly within two projects which are led by hospital trusts but which have their delivery firmly situated in the community. It should be noted that one project which is local authority led has been awarded a recognition of good practice by the Institute of Leisure Amenities Management in respect of its partnership working.

Northern Ireland

26. Within Northern Ireland a great deal of change is occurring as a result of the Review of Public Administration. The review, now completed, is considered to be the most extensive re-organisation of public services for 30 years and has resulted in a number of significant changes. These include:

- One new authority to replace the four health and social service boards.
- Five health trusts to replace 18 health trusts.
- The setting up of seven local commissioning groups.
- A Patient and Client Council to replace four health and social service councils.

27. Given the changing situation of both the management and delivery of health and social services it is unsurprising that many of the project managers and staff that evaluators spoke to are concerned about the future sustainability of their respective projects. Many of the agencies project managers would have approached in order to secure funding are no longer in existence and project managers are faced with the dilemma of deciding where best to place their projects in the context of securing future funding. Despite this situation many project managers are proceeding with gathering evidence and developing business plans which will form a necessary part of future funding applications. They are also examining recently developed strategies to ensure their projects have a good fit with the priorities and measures contained within those strategies. This again will be used to demonstrate the necessity of continuing activities and services in order to meet those priorities. In relation to this point it is interesting to note that some project staff, due to increasing workloads and commitments, have found it a significant challenge to keep abreast of new strategies and policies which perhaps could have fed into the continuing improvement of certain projects.

28. Most projects have been developed in tandem with user consultation groups and, whether they are delivered within hospital settings or within the community, they have continued to engage users in their evolution and developments. Given the continuing emphasis and trend towards locally delivered accessible services which have the engagement of not only frontline staff but also of the service users themselves this should provide some reassurance as to their continued future operation.
29. Each project without exception has focused upon not only meeting obvious gaps in provision but has also concentrated upon providing services which have the same standards in quality and content across all communities. Given the past political situation this has been one of the most important facets of those projects. Many project managers in the past have stressed that, although their projects have encompassed both Catholic and Protestant communities, what has been important, and remains so, is their commitment to delivering activities and services of equal quality and content no matter where they may be delivered.

30. Within some projects it is evident that some very new and innovative approaches have had to be utilised when attempting to engage excluded groups. This has required a great deal of flexibility not only in terms of content but also in terms of how projects are delivered. It is to the credit of some project staff that they have risen to this challenge and modified their activities and services accordingly. Within certain projects it has also been vital to build up relationships of trust when engaging certain groups, this has been particularly true when attempting to engage Eastern European migrants, Traveller communities and substance addiction groups.

31. Some of the hospital based projects have continued over the past year to develop their processes in terms of screening and referrals and this has enabled more beneficiaries to be engaged onto certain projects than would otherwise have been the case.

32. In more general terms all project managers and staff considered that their services and activities had positively impacted upon the intended beneficiaries, and that services and activities were being provided in areas of greatest need. For instance, all projects cover Health Action Zone areas. Limited opportunities to speak to beneficiaries have confirmed the positive impact activities and services were having on them in a wide variety of ways.

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1 Heath Action Zones are working to tackle health inequalities by focusing programmes on the wider determinants to health such as poverty and employment and also lifestyle factors such as diet.
1 Introduction

1.1 Reducing the Burden of Coronary Heart Disease, Stroke and Cancer Programme

1.1.1 The Big Lottery Fund (BIG) has financed a range of programmes aimed at reducing the burden of coronary heart disease, stroke and cancer in Scotland, Wales and Northern Ireland.

Scotland and Northern Ireland

1.1.2 The programmes in Scotland and Northern Ireland aim to:

- Reduce the risk of coronary heart disease, stroke and cancer through the provision of effective evidence-based prevention programmes.
- Improve access to high quality services and facilities for the diagnosis and treatment of coronary heart disease, stroke and cancer by specifically tackling inequalities in provision.

1.1.3 The priorities for both programmes have been developed in the context of relevant policy initiatives and through public consultation in each country. In Scotland, consultation has identified coronary heart disease, stroke and cancer as the agreed clinical priorities and encouraging a healthy lifestyle and tackling smoking, poor diet and inactivity will be key parts of the strategies to address these problems. In Northern Ireland BIG’s programme has responded to consultation by agreeing that a minimum of 60% of funding should support evidence-based prevention programmes.

1.1.4 Of the £26.6 million available in Scotland, BIG anticipate that approximately £16.6 million will be committed to projects that reduce the burden of coronary heart disease and stroke, and £10.0 million will be committed to projects that reduce the burden of cancer.

1.1.5 In Northern Ireland, the programme is valued at £9.4 million for coronary heart disease, stroke and cancer projects.

Wales

1.1.6 BIG has provided £15 million to fund projects in Wales which aim to:

- Provide evidence-based prevention activities and services in order to reduce the risk of people from disadvantaged groups developing CHD, stroke and cancer.
- Reduce the impact that CHD, stroke and cancer have on people’s lives by improving the availability and quality of related support and rehabilitation services.
- Improve access to specialised services for the detection and diagnosis of coronary heart disease.

1.1.7 In order to achieve this, BIG has developed three strands to the program, focused as follows:

- Community-based prevention and rehabilitation (about £4 million for cancer and £5.5 million for CHD),
- Stroke support via the Stroke Association (£500,000).
The provision of angiography equipment for detecting and diagnosing CHD (up to £5 million).

1.1.8 In Scotland and Northern Ireland, awards were announced from August 2003, and projects ran for up to three years. In Wales, awards were made in October 2003 for projects that ran for up to three years.

1.2 Evaluation of the Programme

1.2.1 Tribal Consulting in association with CRG Research Ltd have been commissioned to undertake a three year evaluation of BIG’s ‘Reducing the burden of coronary heart disease, stroke and cancer’ initiatives in Northern Ireland, Scotland and Wales.

1.2.2 This evaluation is designed to be both an evaluation of the whole programme via a three year tracking study and a more focused evaluation of projects based on a case study approach.

1.3 About this Document

1.3.1 This document presents the evaluation of BIG’s ‘Reducing the burden of coronary heart disease, stroke and cancer’ initiatives in Northern Ireland, Scotland and Wales. This takes the form of results and analysis of a questionnaire completed by 134 BIG projects and sixteen case studies of BIG projects. Most projects were coming into their final year of funding.
2 Survey Methods

2.1 Introduction

2.1.1 There were a total of 218 questionnaires distributed during September 2006 to BIG projects across Northern Ireland, Scotland and Wales. These were mostly distributed as paper copies sent with a stamped addressed envelope. A small number were distributed by email via the Scottish and Northern Irish Health Board contacts (see 2.1.5).

2.1.2 A deadline of 6th October 2006 was given on the questionnaires, but it was later agreed with BIG that it was important to allow any late responses to be included in the analysis. There were 90 questionnaires returned by the original deadline, and a further 44 were returned for up to a further six weeks afterwards. This resulted in a total of 134 questionnaires being completed and returned during the September to November time period.

2.1.3 Upon their return, completed questionnaires were entered into a database for analysis. Three further questionnaires were submitted in December 2006. This was after the analysis had commenced and therefore these three responses have not been included in the report. They have however been read to ensure that they contained no significantly different findings to the analysed questionnaires.

2.1.4 Due to the differences in the ways in which the programmes were set up, the questionnaires were distributed using different methods. In Wales BIG’s direct relationship is with the organisation that delivers the services. Therefore the questionnaires for Wales were sent directly to named individual project leads.

2.1.5 A different method was used to send project questionnaires to those projects based in Northern Ireland and Scotland. This was due to BIG’s direct contact being with the Health Boards in these two countries, who are at the top of an umbrella grant, with third party projects sitting beneath. The health boards are responsible for monitoring and distribution of grant monies. These questionnaires were distributed by post to the Health Board contacts for them to send onto the regional umbrella holders. Some of the questionnaires were also distributed electronically to Scottish and Northern Irish projects via these Health Board contacts.

2.2 Aims and Objectives

2.2.1 The questionnaire was divided into nine sections which covered the following areas:

- Organisational details.
- Project details.
- Partnership Arrangements.
- Delivery and Management.
- Beneficiaries.
- Evaluation, Impact and Shared Learning.
- Sustainability.
- Conclusion.
Any additional comments.

2.2.2 The Organisational Details section captured the name and location of the Organisation and project and the name of the project representative completing the questionnaire.

2.2.3 The Project Details section asked for the title and five main aims and objectives of each project. It also asked for any modifications to the original project, the areas the project targeted, the type of activities it included, and whether these had changed over the course of the project.

2.2.4 The Partnership Arrangements section aimed to capture levels of engagement each project felt it had with the statutory, public and private sectors. It also captured levels of local partnerships and local and community involvement. These were all captured by a numerical ratings scale and by free text comments on project experiences.

2.2.5 The Delivery and Management section captured the project management arrangements that were in place, levels of representation within management structures, and staffing skills and provision.

2.2.6 The Beneficiaries section captured each project's main target beneficiaries, and which particular groups were also targeted e.g. low income groups, older people etc. It also asked if projects had been successful in addressing their target groups, the systems in place for vulnerable groups, local access, and for examples where these had been met.

2.2.7 The section on Evaluation, Impact and Shared Learning addressed internal and external evaluations undertaken by projects and dissemination thereof. It also asked for examples of the impact of projects in reducing the risk or incidence of CHD/Stroke/Cancer, the impact on people's lives, and any developments of innovative approaches to meeting the needs of the target population. Projects were also asked to list three benefits, three challenges / lessons learnt and if and how such learning had been disseminated.

2.2.8 The Sustainability section aimed to secure information about projects' secured funding and future funding expectations.

2.2.9 The Conclusions section aimed to capture each project's opinions on how well they had met their original aims and objectives, how well they addressed inequalities in provision, and how their project had linked in with local and national strategies. This information was captured by both a numerical rating and free text explanation.

2.2.10 A final free text box enabled projects to express any additional comments.
3 Findings by Themes

3.1 Introduction

3.1.1 In total there were questionnaires distributed to 218 projects across Northern Ireland, Scotland and Wales (See Table 1 below).

3.1.2 For Northern Ireland 61 questionnaires were sent out and 41 were completed and returned.

3.1.3 For Scotland, 115 were sent out, with 75 completed and returned.

3.1.4 For Wales the questionnaires were sent to 42 projects, of which eighteen were completed and returned.

3.1.5 There were 134 completed questionnaires, which was an overall response rate of 61.5%.

Table 1: Response Rates of Projects by Country

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<tr>
<td>Northern Ireland</td>
<td>61</td>
<td>41</td>
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<td>Scotland</td>
<td>115</td>
<td>75</td>
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<td>Wales</td>
<td>42</td>
<td>18</td>
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<td>Total</td>
<td>218</td>
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3.1.6 The majority of questionnaires were fully completed, with only a small number omitting information or not fully answering all of the questions. For example, two questionnaires were completed by project members who were unable to give complete answers to all questions, and two projects did not know what ‘BME’ stood for.

3.2 Organisational Detail

3.2.1 The section on Organisational Detail asked for the basic details of project: the name of organisation, the country it was located in, and the name and job title of the respondent. Most questionnaires were completed by project directors, officers, managers or clinical leads. In some cases they were completed by project coordinators or administrators.

3.3 Project

3.3.1 The Project section commenced by asking for the project title and its aims and objectives, in five bullet points. These inevitably differed for each of the 134 projects but could be summarised in that most covered the areas of:

- Developing awareness of the condition (e.g. Cancer, CHD, Stroke etc.).
- Improving access to information and services regarding the condition.
- Improving the quality of life for service users.
3.3.2 The questionnaire asked if the aims and objectives had been modified since the project began. Although in most cases these had not changed at all, 31 out of the 134 projects (23%) did report some changes. These were generally as a result of natural project evolution and/or where a project had amended or increased its aims. For instance, additions were made in order to:

- “…include looking at training employment, new challenges and learning links.”
- “Programmes expanded to cater for other special populations; Mental Health, child obesity, post-stroke.”
- “Not all home visits commenced as patient caseload rapidly rose.”

Areas Targeted By Projects

3.3.3 Each project was asked to state which areas it targeted from a list of Cancer, CHD, Stroke and Other. The following figures include the many projects which targeted more than one condition: Cancer was targeted by 56 projects (42% of all projects); CHD was targeted by 74 projects (55%); Stroke was targeted by 50 projects (37%). There were 37 projects (28%) that stated their target groups also came under ‘Other’, which included:

- Diabetes.
- Huntingdon’s.
- Neurological illness.
- Oral health.
- Substance abuse.
- “Healthy eating promotion.”
- “Hypertension, controlled diabetes, stress, depression, BMI 225, asthma, bronchitis.”
- “Multiple sclerosis, motor neurone disease, HIV/AIDS.”
- “Mental Health problems especially depression.”
- “Parkinson’s, Dementia.”
- “Respiratory disorders, muscular & skeletal disorders, metabolic disorders, obesity and inactivity.”
- “Sedentary population, disabled groups, older people.”

3.3.4 Projects were asked if they included activities, such as Screening and Diagnostics, Community development etc. The following Table 2 shows how many projects each activity was included in:
Table 2: Activities Included Within Projects

<table>
<thead>
<tr>
<th>Activity type</th>
<th>No. of projects which included the activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Diagnostics</td>
<td>35</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>51</td>
</tr>
<tr>
<td>Education and Information</td>
<td>117</td>
</tr>
<tr>
<td>Improved access to services</td>
<td>71</td>
</tr>
<tr>
<td>Continuing Care and Development</td>
<td>60</td>
</tr>
<tr>
<td>Community Development</td>
<td>63</td>
</tr>
<tr>
<td>Other</td>
<td>37</td>
</tr>
<tr>
<td>Use of non-medical equipment</td>
<td>34</td>
</tr>
<tr>
<td>Use of medical equipment</td>
<td>27</td>
</tr>
</tbody>
</table>

3.3.5 There were 37 projects (28%) which stated that they also included activities that were categorised under the heading of ‘Other’. Some examples of these are as follows:

- “We tried to provide a variety of information requested by people based on survey and questionnaires done in the preparation stage of the project. Information includes transport, mobility equipment, image (wigs and hairdressers), support and counselling.”
- “The advisor works to provide advice, education and facilitate access to all of the above areas for clients and families affected by Huntington’s disease.”
- “Food safety, hygiene, labelling.”
- “Promotes positive mental health, self esteem, daily living skills through budgeting.”

3.3.6 Projects were also asked if they included activities that targeted lifestyle risk factors. Table 3 below shows how many projects did so.

Table 3: Targeting Of Lifestyle Risk Factors Within Projects

<table>
<thead>
<tr>
<th>Activity type</th>
<th>Number of projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking and Cessation</td>
<td>17</td>
</tr>
<tr>
<td>Nutrition and diet advice</td>
<td>37</td>
</tr>
<tr>
<td>Exercise</td>
<td>34</td>
</tr>
<tr>
<td>All of the above three</td>
<td>42</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
</tr>
</tbody>
</table>
3.3.7 When asked if any of these activities had changed over time, 38 out of 134 projects (28%) stated that they had. The main reasons for such changes were service development or increases in demand, for instance:

- “Increase on referrals in palliative and terminal.”
- “Service usage has been monitored closely and the service has been geared to respond to articulated need. For example, new workshops were developed; e.g. fatigue, what is cancer, body image and then the presentation of others was changed from programme to programme.”
- “Screening is a major part now, and lifestyle advice.”
- “Developed from hospital, clinics and home visits to the development of rural communities.”

3.4 Partnership Arrangements

Effectiveness of Engagement with Statutory, Voluntary and Private Sectors

3.4.1 The opening question in this section asked projects to rate themselves between zero (not at all) to six (totally) based on the effectiveness of their engagement with the statutory sector, voluntary sector and private sector. See Figures 1 to 3 below. They were also asked to comment on their experiences. Most projects reported successful engagement and collaborations, examples including:

- “Throughout the project all partners have been fully committed and their individual contribution and expertise has helped the project meet and surpass its goals.”
- “The project has successfully involved all three sectors with more work required with NHS staff to allow the project to reach all of its objectives.”
- “Partnership working has been key to the success of the pilot and there have been some excellent examples of partnership working around the key activities. However, some partnerships have worked better than others due to a number of factors e.g. timescales.”
- “Excellent partnerships established with the voluntary sector which will continue after the project ends.”

3.4.2 There were some exceptions and minor issues, as illustrated by the following comments:

- “As an external (to the statutory sector) agency we developed and enjoyed good working relationships... However, there were some occasions when our pilot project got caught up in localised operational strains between these statutory bodies.”
- “Very worthwhile experience, unfortunately private sector agenda is often very different from public sector.”
Figure 1: Effectiveness of Engagement with Statutory Sector

Figure 2: Effectiveness of Engagement with Voluntary Sector
3.4.3 Out of the 134 projects, 104 (78%) stated that local partnerships had been developed. Only seventeen stated that they hadn’t. There was one ‘don’t know’ reply and twelve projects that did not answer or for whom the question was not applicable. Examples of the many successful local partnerships included:

- “A professional relationship which has proved very successful in liaising with the medical profession and the G.P. Referral Consultant.”
- “The project is based on effective partnership working, particularly with the statutory and voluntary and community sector. Key element of work undertaken.”
- “[Local statutory body] looking at underage sales, trading standards, point of sale tobacco.”
- “[The project] involves partnerships with school, teachers, pupils, parents, caterers, and other statutory bodies. It crosses both education and health.”
- “Liaising with community representatives, local council Environmental Health departments and Trust Health Promotion departments.”

3.4.4 An example of a project which had enjoyed partnership working with some success, but not across all sectors, included the statement that the project had been “working with County Council and NHS trust, and jointly delivered. Voluntary sector had a poor take-up due to the community transport element. Limited private sector involvement.”

3.4.5 An example of partnership working which had come to fruition after a less positive beginning was illustrated by: “difficulty linking with colleagues in the community as a new service but now excellent rapport.”

**Changes to Partnership Arrangements**

3.4.6 There were 35 (26%) projects which indicated that there had been some changes to partnership arrangements. These were mostly due to development of the projects,
organisational changes, strengthening existing partnerships and creating new partnerships. Such changes can be illustrated by the following quotes:

- “Membership of groups evolved and were restructured to reflect the new Health Service organisations following a Northern Ireland Public Administration review.”
- "Arrangements have developed and matured with the project."
- “Links made stronger between...Cancer Information and Counselling Centre and GPs and nurses in primary care. They will more readily contact centre for information now.”
- “… the partnerships are developing and growing slowly over time in that people and groups are taking on more responsibility.”

**Increased Local Involvement within Projects**

3.4.7 Respondents were asked if their project had resulted in more local people being involved, for example in the running of the project, volunteering or other ways. Overall most projects reported more local involvement in a voluntary capacity, where it was possible. This manifested itself in a variety of ways, such as with local individuals, organisations, schools, community groups and local shops:

- “Volunteers provide invaluable social input and contribute massively to the overall ethos of the Drop-In Day, providing welcomes, hand care and refreshments. The …Volunteer Programme is continually recruiting.”
- “We have been able to involve three volunteers affected by disabilities with the project, distributions of promotional material in all areas are done by the volunteers, some phone calls to update information gathered in the early stage of the project is done by another. Another three volunteers have been trained to answer the 24 hour help-line and download information from the website and answer enquiries.”
- “Parents, teachers and children were all involved in a poster competition and subsequent prize giving...Fire and Rescue hosted the event and gave a fire prevention/safety session to all those attending.”
- “Among other events that we have run locally, there have been three at local ASDA and Somerfield supermarkets. Apart from the involvement from the public at these events we have had help and interest shown by the management and staff of ASDA and Somerfield.”
- “Working with various groups brings more people onto the scheme and maintains a better level of fitness in the community.”
- “Volunteer numbers are now 40 and have increased to a level where we have been able to introduce an evening service as a way of increasing access to services. Members of local communities are active in arranging fundraising events for the centre.”
- “The project has used already established networks to develop themes and activities. People who attend locations within the network have signed up as members of the Steering Group, and are actively involved in how the project is progressed.”
- “Local people equipped to deliver the information in their own settings where they found it useful.”
3.5 Delivery and Management

Arrangements in Place to Ensure Effective Management and Delivery

3.5.1 When asked what management arrangements were in place to ensure their project was effectively managed and delivered, all projects (bar one, who did not complete the entire questionnaire) confirmed that they have such arrangements. These typically took the form of steering groups, advisory groups and project boards, with project managers or coordinators. Standard responses included:

- "A Steering Group and Project Board was set up at the beginning of the project and an evaluation sub-group has been set up to ensure evaluation measures are developed and collected. There is also an identified project manager who has day-to-day management responsibility."
- "The Project Team consists of Project Lead and an Educational Facilitator to roll out the programme. There are also regular team meetings with the BIG representatives and progress meetings with local representatives from BIG and the NHS along with quarterly reporting systems."
- "…regular meetings of clinical team to discuss progress, and of heart failure MCN team to discuss progress and help."
- "A monitoring group: council leisure managers, health and social care reps, GPs, physios, dieticians and users ensure effective management and delivery"
- "Line management support provided by nurse consultant and education facilitator. Local steering group oversees project."

3.5.2 Mention is made by many projects of regular management meetings that ensure delivery along with updates and progress reports. Typical examples include:

- "Two full-time staff co-ordinate the project and report to the management committee weekly, monthly and quarterly."
- "All service providers submit quarterly reports to project lead. Quarterly meetings held with all partners."
- "Weekly team meetings with staff. Good monitoring and evaluation structure."
- "Lead project manager, daily meetings, communication channels, audits, patient questionnaires, patient satisfaction surveys…"
- "Regular team updates. Team meetings, steering group and Northern Board BIG Project meetings. Regional meetings."
- "Project steering group established, operational plans agreed. Quality control group, QA and expert advice. Financial department support."

Management Representation

3.5.3 Projects were asked if their management arrangements included representation from staff, patient/users, carers or others. The vast majority of projects (114 or 85%) included representation from staff. Representation from patient/users occurred on 66 (49%)
projects. There was representation from carers on 42 (31%) projects. The ‘Others’ category was selected by 53 (40%) projects. These usually included members from the community / voluntary sectors, local authorities and health professionals (such as community pharmacists, GPs and ‘retired practitioners’). For instance:

- “The Monitoring Group has representation from Local Authorities, patient/carer groups and the voluntary sector as well as the NHS.”
- “Consultation with relevant health service personnel for particular programmes e.g. breathlessness.”
- “University, local Public Health team, Health Authority partnership, local Health Board.”

**Full Complement Of Appropriate Skilled and Qualified Project Staff**

3.5.4 There were 110 (82%) projects that stated they had the full complement of appropriately skilled and qualified staff necessary to deliver successfully. Twenty felt that they did not, and the question was not applicable to four projects. Of those twenty without a full complement of staff, the reasons tended to relate to staffing retention and recruitment issues.

3.5.5 Some projects reported delays due to recruiting specialist staff taking longer than expected. An example of is the replacement of specialist clinical staff that had moved to other posts. When projects could not offer permanent positions this sometimes had an effect on staff retention. A staffing issue raised by one project was that there were no other members of staff trained to cover holidays or sickness, whilst another project regretted that they had insufficient administrative support built into their funding. Comments in this area included:

- “One post vacant as post holder has moved to a more permanent job.”
- “… Software Developer recently (September 2006) left post. We hope to appoint a replacement as soon as possible to complete the post-discharge component of the project, including providing access to the existing and populated stroke resources.”
- “Recruitment problem with speciality.”
- “Difficulty for some hospitals to secure and maintain staff caused by the short duration of project.”

**Changes in Skills Required by Project Staff**

3.5.6 Some 56 out of the 134 (42%) of projects reported that they had seen the skills required by staff to deliver the programme change over time. These were generally new skills that derived from staff development and training initiatives introduced during a project’s lifetime. Some quotes from projects that accurately summarise some of these additional skills include:

- “Access to training and seminars has been possible therefore the development worker's skills have increased e.g. Completion of the PATH approved distance-learning module Brief Advice in Smoking Cessation.”
- “As the project developed it became apparent that more emphasis than originally expected should be placed on the marketing and publicity. As a result, the project coordinator’s time is more dedicated to those areas of work rather than the administrative and technical side.”
“…Community Health Educators are lay-people who have been trained to deliver this project. This training is ongoing and develops as the project develops. This project has been a valuable learning experience for the project manager and many others involved.”

“Project staff have expanded their skills in website development, facilitation and project management and library searching techniques. Non-IT staff developed IT skills to ensure content editor sustainability.”

“More training in mental health issues was required as 60% of [target group] have some form of clinical depression.”

“The staff have had to attend a range of physical activity training for trainers training courses to enable them to roll out a training programme.”

“A staff development programme was created at the start of the project with a series of secondments followed up with personal areas for development being identified and explored within each individual’s Personal Development Plan. These are reviewed annually.”

“Community Health Educators are lay people who have been trained to deliver this project. This training is ongoing & develops as the project develops. This project has been a valuable learning experience for the project manager and many others involved with it. This is expected with a project which has been allowed to adapt to the needs of local women.”

“As the project developed it became apparent that more emphasis than originally expected should be placed on the marketing and publicity. As a result, the project coordinator’s time is more dedicated to those areas of work rather than the admin and technical side, which was the original plan.”

“More staff have had to attend a range of physical activity training for trainers training courses to enable them to roll out a training programme.”

“Development of leadership skills. Also keeping abreast of ever changing political arena of care homes standards.”

“Through our training needs assessment with staff a number of training needs were identified e.g. young people and smoking, group work and peer education. Staff indicated they needed this training before they could undertake this type of work with young people. To address this we have developed training programmes and resources for staff and it is envisaged that other staff will be more involved in other training programmes in the future as this will help with sustainability. The training programmes and packs developed will also be accredited.”

### 3.6 Beneficiaries

**Target Beneficiaries of Projects**

3.6.1 Respondents were invited to select who the target beneficiaries for their project were. Options were from a list consisting of: People with CHD, People at risk of developing CHD, People recovering from stroke, People at risk of a stroke, People with cancer, People at risk of developing cancer. See Table 4.
### Table 4: Target Beneficiaries

<table>
<thead>
<tr>
<th>Target beneficiaries</th>
<th>Number of projects with these target beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with CHD</td>
<td>57 (42.5%)</td>
</tr>
<tr>
<td>People at risk of developing CHD</td>
<td>47 (35%)</td>
</tr>
<tr>
<td>People recovering from Stroke</td>
<td>39 (29%)</td>
</tr>
<tr>
<td>People at risk of a Stroke</td>
<td>45 (33.5%)</td>
</tr>
<tr>
<td>People with Cancer</td>
<td>34 (25%)</td>
</tr>
<tr>
<td>People at risk of developing Cancer</td>
<td>45 (33.5%)</td>
</tr>
</tbody>
</table>

3.6.2 Respondents were also asked if they targeted particular groups, and to name those that they did, from the following list in Table 5.

### Table 5: Target Beneficiaries by Particular Groups

<table>
<thead>
<tr>
<th>Particular Groups Targeted</th>
<th>Number of projects with these target beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME groups</td>
<td>18 (13%)</td>
</tr>
<tr>
<td>Low income groups</td>
<td>54 (40%)</td>
</tr>
<tr>
<td>Homeless</td>
<td>18 (13%)</td>
</tr>
<tr>
<td>People with poor access to services</td>
<td>55 (41%)</td>
</tr>
<tr>
<td>Carers</td>
<td>47 (35%)</td>
</tr>
<tr>
<td>Children &amp; young people (0-18)</td>
<td>37 (28%)</td>
</tr>
<tr>
<td>Adults (18-64)</td>
<td>84 (63%)</td>
</tr>
<tr>
<td>Older People (65+)</td>
<td>70 (52%)</td>
</tr>
<tr>
<td>Special Needs groups</td>
<td>31 (23%)</td>
</tr>
<tr>
<td>Other</td>
<td>35 (26%)</td>
</tr>
</tbody>
</table>

3.6.3 Examples of categories and groups given by 35 (26%) projects in the ‘Other’ category included:

- “The most important target group is young people between 12 and 30 (since they will get the most benefit from positive lifestyle changes). We also provide an Urdu version of the information in both text and audio forms.”
“Mental Health organisations, prisoners, Youth Justice Agency etc.”

“25% most disadvantaged people in [local area].”

NHS staff, GPs.

Patients and Carers.

Unemployed.

Success In Reaching Target Groups

3.6.4 Most groups (91.7%) stated that their project had been successful in reaching their target group with just four stating ‘no’, three stating ‘not applicable’, two stating ‘don’t know’, and two giving their own ‘yes and no’ answer. Exceptions, i.e. those that answered ‘no’, were:

- “Difficult to recruit on an ongoing basis.”
- “The predicted numbers of referrals has been less than estimated.”
- “The inpatient target group has been reached via the inpatient monitoring, but the project has not yet met its goals reaching carers etc. via the internet. The emphasis to date has been in completing the inpatient module.”

3.6.5 The two projects that answered “yes and no” explained why, thus:

- “Yes – people using the website. No – target groups (older people) not high internet users.”
- “Yes and No: Project was slow to start before recruitment of lead. Since this, the project has been very successful in reaching the target groups but not as successful as predicted in the original funding bid.”

3.6.6 However, the majority can be illustrated by these examples of how projects considered they had successfully reached their target groups:

- “Predicted beneficiaries 3500: current beneficiaries 3991.”
- “The annual figures demonstrate this. We set out to cater to 100 patients and 100 carers a year. At the end of 2005 we had seen 434 people (235 patients and 199 carers). And development has been restricted by service finance.”
- “The project still has a year to run but has been successful in reaching target groups as a result of the skills of the CHEs (community education background and Urdu & Punjabi speakers). Also the support from other agencies who helped introduce & identify local groups in the area.”
- “Evaluation shows we are reaching target audience and beyond.”
- “Predicted 200 clients over three years. 500+ at present.”

Procedures And Systems for Targeting Vulnerable Groups in Local Area

3.6.7 When asked “Do you have a procedure or system in place to help identify and target the most vulnerable groups in the local area?”, 80 (60%) out of 134 projects did have such a
system. There were 28 (21%) who did not, for 24 (18%) projects the question was not applicable, and two did not know. There were a wide range of examples of how those projects that did have such a procedure or system in place addressed this area. For instance:

- “Through our joint working with partners we are able to try and reach some of the more vulnerable young people in both a school and community setting.”
- “…coordinator has specifically liaised with City Council and local charities re: wheelchair access. Successfully attained help for individual clients with ramps, public toilet access, links to other projects, other agencies, benefits help etc.”
- “Volunteers are trained to educate their own families. Local population are aware of services.”
- “Transport is available for all participants; childcare costs met; leisure centres which deliver are in main six towns in the area covered.”
- “We need to keep marketing the service to GPs. Would like to improve patient self-referral. The BME link worker is crucial.”
- “Service access improved by publicity (media releases, word of mouth, banners, radio interviews) and prominent sighting of clinic van.”

3.6.8 Procedures and Systems to Improve Local Access to Services and Facilities

There were 78 projects (58%) that reported having procedures or systems in place that helped improve access to services for the local population. This typically included local telephone help lines, leaflets, websites, presentations to local groups, focus groups, questionnaires, one-to-one interviews, publicising in rural areas. Some quotes illustrative of such include:

- “Community talks are given to raise awareness of the existence of the centre. Information sessions are held with healthcare professionals, social work and associated agencies to increase their awareness and to encourage referrals of appropriate clients.”
- “Services are sourced close to the catchment area of the client.”
- “Local smoking cessation help line number where people can be directed to most appropriate cessation classes. Regular contact with [NHS regional Communications Manager].”
- “Helpline and internet access, leaflets and posters. Information days – targeting specific groups. Presentations to local Community Group.”
- “Information, Exit strategy folders with evaluation forms, names to contact etc; phone numbers of specialist nurses and other services available to older persons and guidelines.”

3.7 Evaluation, Impact and Shared Learning

3.7.1 Internal and External Evaluation Undertaken

Internal evaluation and occasionally external evaluations had been carried out by most projects. Table 6 shows the type of evaluations undertaken by each project, and percentage of projects that undertook them.
Table 6: Internal and External Evaluations of Projects

<table>
<thead>
<tr>
<th></th>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit</td>
<td>65 of 134 (48.5%)</td>
<td>26 (19%)</td>
</tr>
<tr>
<td>Service evaluation</td>
<td>78 (58%)</td>
<td>42 (31%)</td>
</tr>
<tr>
<td>Patient / user satisfaction surveys</td>
<td>85 (63%)</td>
<td>33 (25%)</td>
</tr>
<tr>
<td>Staff satisfaction surveys</td>
<td>41 (31%)</td>
<td>17 (13%)</td>
</tr>
<tr>
<td>Other</td>
<td>12 (9%)</td>
<td>7 (5%)</td>
</tr>
</tbody>
</table>

Dissemination of Evaluation Findings And Results

3.7.2 Many projects (89 in total, 66%) disseminated their learning to other projects through internal and external reports, presentations and at conferences. Typical examples included:

- “All stakeholders, partner agencies, referral agencies, other projects and any other interested party.”
- “Results and progress have been shared in order to influence policy development in this area; particularly influencing the Prevention 2010 planned initiative for young people.”
- “The results are disseminated to the G.P Referral Consultants, the medical professionals and the Health Promotions Manager (NHS).”

Project Impact in Reducing Risk or Incidence of CHD/Stroke/Cancer

3.7.3 There were 32 (24%) cases where a project believed it had seen an impact of reduced risk or incidence of CHD/Stroke/Cancer. For instance:

- “There has been a general increase in understanding of the issues around CHD amongst participants. The project, along with other initiatives, has raised the priority of healthy food and more exercise.”
- “Audit, increased awareness of harmful UV sunrays and proactive use of sunscreen.”
- “Significant decrease in resting heart rate, decrease in waist size and blood pressure.”
- “Reduction in admissions due to heart failure by 33% and 44% in two major hospitals.”
- “Changes in shopping, cooking and eating habits.”
- “Associated blood pressure testing has resulted in a number of people being identified who had dangerously high blood pressure – therefore, these were possibly life-saving interventions.”
Evaluation of ‘Reducing the burden of CHD, Stroke and Cancer’ Programme

Reduction in Impact Of CHD/Stroke/Cancer On People’s Lives As Result of Project

3.7.4 When asked if they had seen any reduction in the impact that CHD/Stroke/Cancer has on people’s lives as a result of the project, 63 projects (47%) said that they had. For a number of projects it was deemed too early to be able to say. Some illustrative examples of reductions in impact follow:

- “Better care from staff who have greater awareness and understanding of the issues.”
- “Improved quality of life for people affected by stroke, and their carers, by facilitating a smooth transition from hospital back into the community.”
- “Information giving, signposting to appropriate services, Support and advice, understanding of the information.”
- “Clients report that they are better able to cope with the emotional effects of illness both as patients and as carers.”
- “People feel more empowered in their own care. People express that they are happy to be helping other people affected by CHD/Stroke. People using computer who previously had no experience i.e. using a mouse, especially with stroke community.”
- “Attendance at rehab from 55% previous to BIG to 90% now. Better risk factor management and exercise ability.”
- “Speedier access to angiography allows more rapid decision making in care of cardiac patients.”

Development of Innovative Approaches by Projects

3.7.5 When asked if their project had resulted in the development of any innovative approaches to meeting the needs of the target population, just over half, 70 projects (52%), said this was so. Some examples of such innovations include:

- “The project provides free access to all services recommended. Health checks are taken out of the clinical environment and carried out in informal community venues allowing a better client engagement as stated in the qualitative interviews from a previous report.”
- “Young Stroke Support Worker helping meet the particular needs of younger patients in areas such as employment, education and training, family and sexual relationships.”
- “Used subsidised mobile child care facilities to encourage mums to bring children to exercise classes.”.
- “Going Back to Basics cooking skills.”
- “Men’s groups i.e. clubs, race nights, golf clubs.”
- “Care Homes are now promoting nurse facilitators to roll out palliative care education within their environment.”
“People in rural areas will have easy access to what is available to them in their locality rather than what is available nation/worldwide that they can not benefit from.”

“This project is the first of its kind in Scotland (has been successful in Leeds). It uses lay people to talk with women, individually or in groups in their community (not in a medical setting).” This project is the Community Health Educators Project that aims to improve access to breast and cervical cancer screening programmes in Lanarkshire. Its target groups are ethnic minority women and women living in deprived communities.

“Walking groups have been established in the two mental health units… to allow access to the service for those people experiencing mental health problems.”

“Water exercise classes; one to one exercise; community weight loss; individual patient assessment in the community.”

“Different physical activities such as gardening. Moving away from traditional walking, cycling etc approach.”

**User Benefits Resulting from Projects**

3.7.6 Typical benefits for users resulting from the projects concerned an improved quality of life and an increased awareness of the condition. Examples given included:

- “Improved social interaction, energy levels, improved knowledge of exercise = improved quality of life.”
- “…to be aware of the main indicators leading to the adoption of a healthy lifestyle.”
- “Local residents trained in skills which give them more self-confidence and make them more employable.”
- “Access to information that is not passed on by the hospital or the health care team, for example local support groups or complementary therapists.”

3.7.7 There were 87 projects (65% of all projects) that stated this learning (benefits for users) had been shared with other projects and/or organisations. Ways in which such information had been disseminated typically included sharing with partner agencies and local authorities, presentations in other companies, local and national conferences, stakeholder events, internal meetings, via steering groups and project boards, published works, (such as conference papers, newsletters and websites), through other lottery funded projects etc.

**Challenges and Lessons Learnt From Projects**

3.7.8 Typical challenges and lessons learnt resulting from the projects concerned issues with staff recruitment, funding constraints, communication channels and the need for regular reviews. Amongst many positives included were partnership working and the raising of awareness. Examples given included:

- “Obtaining accurate monitoring information from service providers requires careful advance planning and constant contact thereafter as it may not be viewed by them as high priority.”
- “Publicity events are very important to raise awareness of the project and encourage users to access the key messages.”
“Everyday is a challenge and there are always lessons to be learned from the project.”

“Dispel myths and fears of a diagnosis of cancer.”

3.7.9 There were 81 (60%) projects that stated this learning (challenges and lessons learned) had been shared with other projects and/or organisations. This was typically done through meetings with other agencies, regular quarterly and annual reports, external evaluation reports to stakeholders, steering group and project board meetings, at events, conferences and seminars etc.

3.8 Sustainability

3.8.1 The majority of projects (85 projects, 63%) were in the process of exploring possibilities, or have plans for, service continuation. There were 44 projects (33%) that had secured funding for service continuation at the time of the survey. This funding was from sources such as NHS Boards and Trusts, local councils and BIG.

3.9 Conclusions

3.9.1 The Conclusions section ascertained to what extent projects considered that they had been successful. Projects were asked to rate themselves from zero (not at all) to six (totally) in three questions.

3.9.2 When asked to what extent projects felt they had met their overall aims and objectives, the majority believed that had achieved a high success rate. A third of all projects stated they had totally met their aims and objectives and just over half (51%) that they had mostly met their aims and objectives. See Figure 4 below.

![Figure 4: Overall Aims and Objectives Met](image)

3.9.3 The majority of projects (83, 62%) believed that they have addressed inequalities in provision, to a large extent, rating themselves with a four or a five. There were 28 projects (21%) who stated they had totally addressed inequalities in provision. See Figure 5 below.
3.9.4 Examples of how projects feel they have addressed inequalities in provision include:

- Project targeted a "vulnerable group of people [and the project has] decreased isolation and encouraged friendships."
- "The project is by definition designed to provide the cancer prevention messages to the [local] communities... Marketing and publicity has ensured reach throughout this local population."
- "The project has addressed health inequalities in a holistic manner in an area of high deprivation and associated poor health."
- "Young people are a vulnerable group within society and prior to the pilot there was inequity of services between those available for adult smokers and young people who smoke. The pilot ensured, in four locality areas, that there were services designed specifically."
- "Targeted hard to reach ethnic minorities and groups and incorporate inclusion issues in training."

3.9.5 Several projects stated they had met varying degrees of success in addressing inequalities. These were usually due to cultural, political or geographic factors. Examples of these being:

- "We have started, but due to demographic make-up a large amount of work still to be done."
- "Certain areas not accessed service fully; geographical isolation or local political issue."
- "A difficult one to answer. Reaching out further with education is very important in palliative care. I believe we have gone some way towards this but more can be achieved. The project is beginning to attract General Practitioners."
- "T in the Park is a white man's music festival, limited ethnic population. Have reached low paid and hard to reach population."
“Continually re-examining [project] training. Some areas and ethnic groups remain inaccessible.”

3.9.6 Most respondents stated that their project had linked in with local and national strategies. Of these 65 (48.5%) believed that they had totally linked to such strategies. See Figure 6 below. Typical examples of local and national strategies that were mentioned were: National CHD Strategy, National Nutrition Strategies, Fit Futures, local authority policies etc. Guidelines from the World Health Organisation were also cited.

![Figure 6: Linked In With Local and National Strategies](image)

3.9.7 Projects listed those initiatives that they had linked with. These included:

- “Increased access to health services; demonstrated the benefits of partnership working between sectors; provided sustainable job opportunities for long-term unemployed individuals, some with registered disabilities.”

- “Both projects have linked their work with regional strategies, such as Physical Activity Strategy, Fit Futures (Childhood Obesity Strategy), Investing for Health, the Eastern Health and Social Services Board’s Older People’s Strategy and the new regional strategy; A Healthier Future.”


- “Recent review of obesity in children, Fit Futures, local and national agendas, Investing for health etc.”

- “Targeting CHD prevention; Obesity reduction; physical activity; Empowerment/Expert Patient; Social Capital.”

3.9.8 A small number of projects stated that they had not necessarily linked in with local and national strategies. This was generally due to project constraints and staffing issues.
“A great deal of time is required to develop relationships and make links with appropriate partners. There isn’t a lot of evidence about what works with this particular age group therefore work has been very developmental.”

“Due to resignation of newly trained nurse endoscopist the target number of wider beneficiaries was reduced slightly.”

“More time needed, support from strategic level, secured funding would all have improved [this].”

3.9.9 One project stated it was too early to judge necessarily linked in with local and national strategies:

“Statistics indicate that the system/service has been well-used, but the main test of overall success is whether users who have accessed the service have made any lifestyle changes. We will only know about lifestyle changes when we get the final evaluation.”

3.10 Other Issues

3.10.1 There were few issues raised by respondents. However the one area that was commented on by several projects concerned the funding and length of projects. Some emphasised how more could be achieved with further funding and the importance of ensuring that long-term funding was secured. Examples of this can be illustrated by the following:

“Due to the increase in a cancer diagnosis and people living longer, the need for accessing information and advice is paramount to allow them to proceed on their cancer journey. Supportive services need to be developed to help individuals and their families.”

“Thanks to BIG for allowing us the chance to make this happen. Very important to secure long-term funding as this would otherwise leave a huge gap in service”.

“We completely underestimated the amount of money asked for – the project could have taken a dedicated G Grade Nurse. The initiative has changed the provision of Day Care Services [locally] entirely.”
4 Case Studies Scotland

4.1 Overview of Projects in Scotland

4.1.1 Five projects were selected for case study in Scotland. One project, primarily concerned with making cardiac health advice available in six ethnic minority languages was completed in year one. A new hospital based case study was included in year two, so now six case studies will be completed in Scotland. All projects are closely linked to the specified health goals of the Scottish Executive supported by BIG.

4.1.2 In terms of organisational and contextual differences likely to affect the delivery and impact of projects, the three District General Hospitals (DGHs) will be considered together and separately from a non-profit making Leisure Organisation and one Health Board involving a Voluntary Sector partnership. Each organisation serves a specified geographical area, two of the three hospitals and the voluntary sector being set within a major city conurbation.

4.1.3 From observations and information gathered to date, organisational structure and purpose, and the usual source/s of finance seem likely to have made most difference to the extent of flexibility and development during the second year of the evaluation, and to the approaches taken to secure sustainability. Hospital based projects for instance, are largely concerned with a captured population, a relatively controlled entry gate and predictable resources, while those concerned with reaching and involving target groups within the general population are less able to predict demand or resource needs, particularly when objectives include involving the ‘hard to engage’, or developing community capacity.

4.2 Partnership Arrangements

4.2.1 During the second year of the case studies, an emerging theme from all projects, both hospital and community based, has been the need to involve the local community and/or primary health care professionals, as well as schools and other organisations, if optimum efficiency and effectiveness is to be achieved, particularly with reference to prevention. The nature of the organisation’s focus and priorities tends to predict how and why such additional partnership arrangements have been developed. Within hospital settings for example, where the focus can shift from primary through to tertiary prevention, the hospital concerned with the prevention of a major stroke has utilised resources for:

- The education of hospital staff including Accident and Emergency (A & E) staff and community nurses.
- Reaching agreement with General Practitioners (GP’s) and A & E staff regarding the criteria for clinic referral.
- The education of the wider community through Age Concern and Information Stands in supermarkets.

4.2.2 Where a hospital has been concerned to ensure equality of access to treatment for heart disease and heart attack among specified ethnic minority groups, it was deemed essential first of all to create a bi-lingual team able to identify priority needs within the target group and to provide training for hospital staff, but subsequent priorities included:

- Involving community leaders in the dissemination of information.
- Involving local primary health care professionals in achieving key objectives.
4.2.3 The hospital based team concerned with improving early discharge of stroke patients, while improving both patient and carer satisfaction with the service provision, also found it necessary to ensure close links with GP practices to: (i) assist in assessment of progress, (ii) provide support for carers and (iii) arrange any follow-up care once the hospital outreach service was withdrawn.

4.2.4 Both the leisure organisation and the voluntary sector also needed to work closely with primary health care professionals to ensure that information was disseminated to target groups and to make appropriate referrals. The leisure facility for example, achieved considerable success in reducing obesity among those aged between 5 and 16 years by capitalising on the acceptability of GPs to families within the local population and not only agreeing referral criteria but providing enjoyable experiences which gained measurable results amongst the target group. Concerns of the voluntary sector to improve access to affordable food, engaging with other community workers had resulted in improved dissemination of information.

4.3 Delivery and Management

4.3.1 By the second year, hospital based projects – all evidence based – had become well established, having completed any necessary staff training, and had been considering the advantages/disadvantages of different internal evaluation strategies. One hospital concerned with the prevention of major strokes had found it extremely difficult, for example, to establish a reliable base-line position because of the characteristics of relevant patient records and an absence of agreed criteria for referring a transient ischaemic attack. Some resources during this second year were being diverted to the computerisation of all hospital records as a means to achieve overall improvement and easier access to information relevant to review processes. Other resources were diverted for NVQ training of the clinic based nursing assistant to increase her efficiency by taking on more assessment tasks. This did however result in an increased salary level.

4.3.2 The activities of the team concerned with equal access to quality cardiac services for ethnic minority groups, extended to cover all five hospitals in the locality, both in terms of staff training and in terms of community involvement. They also began to engage with others to develop an electronic record system for target groups and were dealing with predictable resistance to change but with the expectation that GP registration data would become the basis for such a system in the near future. (GP registration would be able to provide a more comprehensive, up to date and reliable picture of the target groups than information obtained from individual hospital admissions).

4.3.3 Like most organisations, personnel movement became an occasional issue but hospitals seem to have found it easier to replace comparable levels of skilled staff in a relatively short period. With regard to the voluntary sector, a steering group meets quarterly to review the day to day management and delivery of projects and although there is some flexibility from sessional workers, the loss of the one funded team member (long term sickness) created a significant delay, as well as having a potentially damaging effect on morale. The second year was, for them, the expected time to utilise what had been learned about the actual and potential stumbling blocks of engaging the ‘hard to reach’ but became a time to re-focus resources in order to optimise initial achievements. With regard to the alcohol counselling service, instead of an open-ended approach to service provision, it was agreed to offer those who met specified criteria during the assessment process a limited number of sessions. It became apparent that most beneficiaries agreed that 8-10 sessions were sufficient to achieve positive results, which meant that an increased number of referrals could be accepted.

4.3.4 With regard to the leisure based organisation, it seems likely that the prevailing business culture familiar with the resource allocation issues to do with changing levels of demand and a team used to responding flexibly to the needs of the general public found it easier to adapt to change, compared with other case study organisations. Staff activities seemed
readily able to change when faced with the need to modify physical activity programmes. For example, school-based programmes were modified to respond to adolescent concerns to be engaged in ‘cool’ activity in a ‘cool’ environment. The available skills base also allowed for a regular review of resource allocation and the employment of someone during this second evaluation year, to focus specifically on ‘hard to reach’ groups. This released others who could focus on other priority groups and the management of unexpected levels of demand, arising for example from the agreement to continue with ‘self referrals’ to physical activity programmes.

4.4 Beneficiaries

4.4.1 The type and characteristics of case study beneficiaries varies according to the organisation and the goals of the funded project. The beneficiaries of hospital based projects concerned with the services for those with a chronic disease can usefully be divided into providers and the recipients; the former benefiting from the further education and training thought necessary to achieve the stated project goals, and the latter comprising the patients and carers. As the projects developed, modifications to service delivery benefited other groups within the local community, such as ethnic minority groups who were consulted and involved in service development. One hospital serving a widespread semi-rural community and focusing on primary and secondary prevention of stroke extended their provision of information and the identification of those at risk into the wider community, involving such organisations as Age Concern.

4.5 Evaluation, Impact and Shared Learning

4.5.1 The three hospital-based case studies were all concerned with overall objectives to do with aspects of treatment, as well as secondary and tertiary prevention of circulatory diseases such as stroke and heart disease. Their more specific objectives varied according to the project focus and these were more concerned with aspects of planning, partnership arrangements, communication, continuing education and training - all as a means to achieve impacts such as improvements in discharge planning and staff/patient communication; standardising referral procedures and record keeping and achieving equity in service provision.

4.5.2 The achievement of more specific objectives is closely linked to the degree to which they are seen to contribute to project stated goals. For example, improving equity is about both patient and carer satisfaction and achieving better outcomes in terms of treatment and prevention; better hospital bed-stay rates and better standards of care can be linked to staff being more culturally aware, more able to communicate effectively and more able to identify risk factors in a specified target group. All these factors were identified by project staff themselves, during the second year interviews.

4.5.3 The likely impact of improving quality standards and recognising the impact of good practice formed part of internal education and training packages. In one hospital based project such a package was extended across five hospitals during the current year. In another hospital a similar outcome was achieved when a clinic provided experiences for other health professionals – in this instance both the efficiency and effectiveness of the clinic was usefully spread around the hospital and into the community. Sharing information amongst other community workers by the voluntary sector partnership also contributed to achievement – extending useful partnership arrangements which increased referral rates, for example.

4.5.4 It was during the second year that those in the voluntary sector providing food and alcohol based services met with primary health care teams to increase their understanding of the purpose of and access to these programmes. This resulted in increased referral rates, particularly from the Health Visiting service, increasing the number of young families making use of food delivery and food preparation programmes.
4.6 **Sustainability**

4.6.1 The Managed Clinical Network in Scotland has usefully been involved with each of the city hospital based projects from the outset, and in the decision-making processes for sustainability. For example, when BIG funding has been completed, financial support has been promised until mainstreaming decisions are ratified. It should however be said that structural re-organisations within the NHS have been mentioned in relation to future priorities and the allocation of scarce resources. One project leader, for example, said that the most recent management re-organisation had resulted in an attitude shift that now regarded heart disease issues as ‘more sexy’ than stroke issues, even though there was little difference in the age range of patients. Another implied that achieving a ‘gold standard’ that resulted in positive outcomes, such as reduced bed-stay rates for a target group, may not become the first choice approach within the Health Board if a health economic approach was applied; i.e. an assessment of the balance between cost and outcome could result in the acceptance of a lower standard (and cost). At this stage, two of the hospital project leaders felt confident that the modified service would continue as part of mainstream service provision and one remained uncertain.

4.6.2 The leisure organisation is operating in partnership with a local council and local authority, an NHS Board and SportScotland. It is reasonably confident at this stage that the successes of the referral schemes will result in continued financial support, but other avenues for financial resources are being pursued.

4.6.3 The community based voluntary agency partnership has diverted more resources this year to seeking continued financial support for their project. This predictably took considerably longer to ‘bed down’ given the characteristics of the target groups and the early loss of the BIG funded staff member with long-term illness. The number of different funding streams linked to each agency seems to have contributed to the difficulty of coordinating a planned funding approach for the future. At this stage considerable uncertainty remains.

4.7 **Successful In Meeting Aims and Objectives**

4.7.1 The case study interviews provided the opportunity to explore aspects of achievement unlikely to have been picked up in referral or attendance rates, particularly ways in which projects expanded as opportunities arose across time. Examples provided below indicate the nature of objectives deemed to be necessary to manage change or modification to service provision. The voluntary sector partnership for example, aimed to fill a gap in existing services by working with local people in a deprived area to find solutions to alcohol and healthy eating problems. Key objectives included reaching and gaining the attention of those ‘hard to engage’ and to this end success was evident in the steps taken (i) to work with other community workers, informing and explaining the purpose and benefits of the programmes on offer; (ii) to modify a programme ensuring wider access or in response to locally expressed needs. The appearance of new shops selling fresh and tinned food also suggested elements of community development in progress.

4.7.2 The ‘Active for Life’ project in Ayrshire is a new strategy for exercise referral schemes, targeting those with CHD and those in disadvantaged areas. This project also aimed to develop new initiatives, to work with others and establish links with comparable projects in the area. Establishing tracking and review measures were also necessary given the characteristics of the target groups. By the beginning of the third year of funding, the CHD referrals were well established from all GP practices bar one, schools programmes had been set up and a new referral scheme for obese children between the ages of 5 and 16 via GPs was achieving measurable success in reducing BMIs. Incentives to participate in physical activity programmes had also spread beyond target groups and self-referrals to include such groups as Weight Watchers and teenage groups. That is to say, for a limited
or introductory period, a reduction in the cost of attendance and/or use of facilities was being offered to those outside the original target groups for this particular BIG funded referral project. Given the measurable success of the referral schemes and their potential for preventing significant circulatory problems in the future, this particular initiative is likely to retain local financial support; and the spread of positive responses to fitness programmes may also influence the attitudes of those most hard to engage.

4.7.3 The three hospital based projects had priorities in common to do with training, communication and equity in access. By the end of the second evaluation year, indicators of success included the one-stop minor stroke assessment clinic increasing efficiency by enhancing the skills of the clinic nursing assistant, reducing the number of inappropriate referrals and developing a reputation for good practice. Agreement had also been reached with the A and E department to ensure easier access to the clinic and to provide information where appropriate to patients and carers. The project concerned with modifying discharge arrangements for stroke patients had not only demonstrated to patients and their carers that a hospital outreach service was acceptable but had established an assessment process to identify those most likely to benefit from such an arrangement. The multi-lingual team designated to improve cardiac hospital services for ethnic minority groups had undertaken cultural education within local hospitals and established links with community leaders. This resulted in a better understanding of need, agreement about the content of information leaflets and an increased potential for local health fairs. It seems reasonable to assume at this stage that each of the hospital based projects are on target to reach the objectives agreed with the Managed Clinical Network (Scotland) and that would mean each of these initiatives could be sustained.

4.8 Case Study 1

Edinburgh: Heart Matters (Second Interview)

4.8.1 This project represents a successful collaborative partnership between the NW Edinburgh Local Health Care Co-operative (NWELCC) and three agencies within the voluntary sector, developing and delivering programmes focusing on ‘the hard to engage’ with reference to alcohol, nutrition and public health.

4.8.2 During the last twelve months national policies have remained concerned with (a) redressing health inequalities and (b) the health impact of relatively high levels of alcohol consumption, smoking and other lifestyle factors. Local policies continue to emphasise the value of partnership arrangements involving the voluntary sector and the importance of targeting the most vulnerable.

4.8.3 As mentioned previously, a project that aims to involve ‘the hard to engage’ can take up to two years to become established and accepted. Working with other community based agencies and adopting a working method that takes account of learning through piloting, and applying best practice, seems to be paying off in terms of embedding the project and achieving targets. This is particularly evident in the Edinburgh and East Lothian Council on Alcohol (ELCA) arm of the programme where the six GP practices and primary health care teams meet on a regular basis, with the alcohol counsellors to receive updating and progress reports. These opportunities are also used to build links with the wider health care team.

4.8.4 With regard to food and lifestyle, there has been improved access to affordable food, as well as evidence that local people are making use of this. Referrals from Health Visitors have now increased across the geographical area and it is evident that families now have a better understanding of the project aims – targets are now being exceeded. In support of changes in demand, there has been a slow but gradual movement of new retailers into the area, apart from in the North Edinburgh Social Inclusion Partnership (SIP), with easier access to a choice of fresh and canned foods. There has also been a steady increase in the attendance of sessions designed to promote confidence in preparing and cooking fresh food.
4.8.5 Of particular interest to the evaluation process is the shaping and flexibility of practice to fit in with the overall aims of the project. For example, rather than offering an open-ended counselling service to those with alcohol problems, a defined number of ‘brief intervention’ sessions are now offered to about 75% of those seeking help, with all receiving a comparable baseline assessment. The majority report feeling that six to eight sessions is about right and that by this stage they can recognise the impact of the counselling on their general well-being, as well as on their own approach to achieving health improvement.

4.8.6 It is now apparent that joining up with others has resulted in greater flexibility and movement of resources, leading to increased availability of key elements of expanded services. It has also ensured that everyone (voluntary agencies, primary health care professionals, community care workers) is now taking responsibility for the dissemination of information and the focusing on target groups.

4.8.7 Examples of good practice include:

- Piloting to assess what works best to meet local need.
- Adopting key principles of effective teamwork – openness, trust, support.
- Adapting practice to achieve improved cost-effectiveness.
- Devising approaches to impact evaluation that take account of different perspectives and a range of potential benefits.

4.8.8 There are, however, factors which have had the potential to compromise project development and these include the implications of long-term sickness of a funded worker. This loss had a major impact on the ability to provide the critical and concentrated lead-up period for a relatively small project that had been developed around a single worker. That is to say that unavoidably, sessions can ‘go cold’ very quickly, which means having to start again from the beginning, with increased pressure on limited resources and the possibility of undermining interest amongst a ‘hard to engage’ community. Additionally, and in relation to welfare benefits, these can be set so low in some cases that families and individuals are unlikely to risk spending money on ‘healthy foods’ which are unfamiliar to them, for fear of wastage. Also, it is much easier to obtain a microwave oven through welfare benefits than it is to obtain a cooker.

4.8.9 In terms of the future and of sustainability, there are some significant issues that have not arisen in other case studies set either within the NHS or within an organisation supported by a local authority, where there is the future possibility of ‘mainstream’ funding arrangements:

- There is inherent funding instability of a particular kind within the voluntary sector, which means that a service generally accepted as tangible, practical and beneficial can still face the regular draining of effort as tensions rise in the face of a variety of funding streams – all with the potential to ‘dry up’.
- During the bidding process there does not appear to have been sufficient consideration given to the management of public expectation within a vulnerable community, nor to the planning or agreeing of an exit strategy.
- There appears to be an overwhelming feeling of being ‘monitored to death’ but with no avenue for feedback and no expression of interest in what has been learned or evaluated from BIG, from NHS Lothian or from the Scottish Health Department.
- Of perhaps greatest concern in the future is the potential for wasting the development of skilled resources associated with capturing the ‘hard to engage’.
More particularly, success results in the creation of a reasonable expectation, together with evidence of shifts in attitude and motivation. If resources cannot be found to sustain key elements of this project, there is a significant possibility of damaging hard earned credibility.

4.8.10 The above mentioned issues suggest that a greater level of responsibility should be in evidence regarding the management of public expectation, by both the lead organisation – in this case NHS Lothian – and BIG, during the planning and bidding processes. That is to say that during bidding processes with voluntary agencies these critical issues should be explored in the light of earlier experiences – if each of the initiatives could be broken down into specified processes deemed important for achievement, it would be easier to see across time what works best and why so that decision-making about sustainability and future funding is better informed about aspects of marketing and communication and about aspects of cost effectiveness, for example.

4.9 Case Study 2
North Ayrshire Leisure Ltd: Active for Life (Second Interview)

4.9.1 The Active for Life project comprises a two pronged expansion of an established initiative involving referrals linked to (a) rehabilitation following myocardial infarction (heart attack) (b) risky lifestyle factors associated with heart disease and (c) reducing the prevalence of childhood obesity. BIG has provided the core funding for the development of the skills and expertise necessary to respond to both local and national strategies relevant to the purpose of ‘leisure’, in terms of the contribution it can make to general well being and heart health.

4.9.2 This project has developed and expanded from a relatively low base and has now spread right across North Ayrshire. It has continued to include self-referrals even though there have been some moderate staffing problems linked to predictable factors such as maternity leave and the project lead leaving to take up a new appointment. These potential stumbling blocks seem to have been seen as more of a challenge than a hindrance to maintaining the goals of the project. In comparison with other case study settings, largely in NHS settings, there seems to be considerably more inherent flexibility within the organisational system.

4.9.3 Over the last ten months changes and modifications have arisen in terms of restructuring resources in order to optimise opportunities for working with other agencies and to focus on the targeting of identified sub-groups such as those living in designated regeneration areas and obese children and their families. A new management appointment linked to activating outreach activity has, for example, resulted in working with community food workers, community based mental health teams and community pharmacists. This has contributed to reaching, and the beginnings of engagement with, the specified target groups. Other aspects of partnership development also now include housing and social services, with beneficial outcomes for those with special needs who use the leisure facilities for a variety of the available physical activities. The project has also extended to include Radio City, a popular local radio station, resulting in links with NHS priorities whereby issues to do with smoking cessation, healthy eating and aspects of mental health are incorporated into programme planning.

4.9.4 In relation to the prevalence of childhood obesity and its long-term implications for health, there are now three inter-related approaches:

- School partnerships and the provision of classes designed to make physical activity both fun and enjoyable for those in primary school.
Working with GP practices, dieticians, schools and families to raise awareness of lifestyle related health risks and the importance of reducing childhood obesity.

A more informal and casual approach to promoting physical activity for children, involving the provision of information to youngsters passing by in the street.

4.9.5 This more targeted approach for obese children between the ages of five and sixteen years can for example, begin with a GP referral and would include a one hour programme three times a week, comprising traditional games, gymnastics, swimming and water exercises. Beneficial outcomes have included BMI rates measurably lowered in sixteen weeks, confidence levels increased and parent satisfaction very high in terms of mood change and the evidence of increased positive self esteem among participating children. It is worth noting here that the BIG standard quarterly report would fail to pick up the overall impact of the benefits mentioned above, by the very nature of standardised questioning and the potential failure by those completing reports, to raise issues about the wider benefits for parents of significant ‘spin-offs’ from children’s positive referral experiences.

4.9.6 With regard to cultural barriers to adopting lifestyle changes, there is likely to be a reasonable level of compliance for a GP referral, and positive experiences will predictably help to ‘spread the word’. Clients’ reported comments following post heart-attack exercise programmes such as “I don’t know what I would have done without this. I’m now back at work and getting on with my life”, should also help to reduce such barriers within the local community. On the other side of the coin however, there are adult referrals (who may pay a notional charge for participating in a programme of physical activity) that provoke comments such as “If I was referred for physiotherapy there wouldn’t be any charge at all”. And there have been those who recognise very quickly that a referral means a lower charge for a three month period of access to the leisure facilities. However, a cheaper admission rate for a specified period may well provide the launch pad for more regular involvement in physical activity and to this end, both Weight Watchers and those who self-refer have been offered the same reduction for a three month period.

4.9.7 Although cultural change must be regarded as a long-term issue, elements of good practice evident across the last year include:

- Flexibility in response to learning experiences.
- More effective communication with GP practices and other agencies.
- Continuous investment in training.
- Partnership developments that result in more effective targeting.

4.9.8 The Active for Life initiative was completed in December 2006 but the Community Planning Team will be continuing the funding of the Activator Manager until March 2008. During this period a mobile Fitness Unit will be used to support the targeting of the ‘hard to engage’. In conclusion, the overall view of this enthusiastic team is probably best left to their own words: “BIG provided us with a sapling from which support and growth has produced many fruitful branches”.

4.10 Case Study 3
Oban: One Stop Assessment Clinic For Minor Strokes (Second Interview)

4.10.1 The project is an expansion of stroke service provision to improve the early recognition and management of those exhibiting risk factors. The composition of the small ‘in house’ hospital based team has remained the same over the last year, comprising one
consultant, one senior nurse, one x-ray technician and one BIG funded part-time nursing auxiliary, in-house trained.

4.10.2 Project development has come under four headings:

- Emphasis on raising professional and public awareness of stroke and the associated risk factors.
- Clinical/service developments.
- Education.
- Impact assessment.

4.10.3 There has been an increased focus on raising awareness relating to the public and to health professionals. Although it is not feasible to target activity, there has been more emphasis on ‘outreach’ to raise public awareness of the links between lifestyle and stroke. Oban town, for example, is the shopping centre for a widespread local population and in a supermarket, for instance, offering information and a blood pressure check, increases the likelihood of catching the attention of men and those less privileged. Outputs have included referrals to GPs for hypertension and to the clinic for the possibility of a previous transient ischaemic attack (TIA) often described by lay people as ‘a funny turn’.

4.10.4 Raising awareness amongst health professionals has also resulted in some beneficial outcomes. The Accident and Emergency department for example, has now agreed to become involved in ‘raising awareness’ and also in referring any TIA to the clinic.

4.10.5 From an educational perspective, the focus continues to emphasise lifestyle factors and the clinic continues to provide a valuable experience for student nurses and other health professionals. In addition there is more evidence of GPs meeting the agreed criteria for clinic referrals, although there is also evidence of an occasional ‘sitting on’ a TIA. Nurses undertaking community based experiences contribute to important aspects of communication by emphasising the role and function of the clinic to GPs and other members of a primary care team.

4.10.6 The initial objectives of the initiative required some modification following the unexpected death of the participating radiologist. So with regard to clinical developments, part of the funding has been re-allocated, going back into the x-ray department to meet new training costs and to improve documentation. The nursing auxiliary has also received further training to match extended duties which means an advance to a B grade level with a commensurate salary increase and some modifications to resource allocation. The relatively low density of the surrounding population for example, means a manageable volume of patients to the hospital based clinic, now operating with increased efficiency, all tests now being undertaken at a single visit.

4.10.7 A system for integrating clinical pathways has now been designed and is currently being piloted within the hospital. This is intended to result in a protocol for all admissions with a view to the early identification of those who might benefit from attendance at the clinic. Although records are still being reviewed with regard to obtaining some baseline position, the available evidence is beginning to suggest that around 80% of those meeting referral criteria and who are picked up early and complete the assessment process, do not go on to have a major stroke. While through-put data is clear, reliable outcome data needs longer term confirmation because the nature of impact in the long-term needs to be examined and interpreted with reference to the use of medication and to the presence/absence of lifestyle changes. The data processing being undertaken for the stroke national audit does however continue to be a drain on limited resources, particularly since it goes hand in hand with the current computerisation of all hospital data.
4.10.8 Aspects of good practice include:
- The emphasis on training as a means to optimise limited resources.
- Recognition that reliable baseline data is critical for outcome evaluation.
- Reinforcing the significance of primary health care professionals in the early identification of those meeting referral criteria.

4.10.9 Sustainability raises a number of connecting issues, largely to do with the continuing changes affecting overall NHS development and the problems to do with assessing the overall impact of a service extension. Within changing management structures, for example, stroke is unlikely to be considered as ‘sexy’ as heart disease, even though the average age of stroke patients may now be similar, or younger than those suffering a heart attack, with the potential effects rather more significant.

4.10.10 This newly established assessment clinic only forms a relatively small adjunct to the overall provision of the local stroke service and its significance could be overlooked. But if in-patient numbers fall over time, the whole service would need review as prevention and rehabilitation become more dominant. At present there is agreement that the funding of the nursing auxiliary will be taken over by the Managed Clinical Network until the clinic becomes mainstreamed and part of the core provision of the hospital based stroke service.

4.11 Case Study 4
Southern General Hospital: Specialist Discharge Support for Stroke Patients (Second Visit)

4.11.1 Originally, a specialist team routinely dealt with discharge and rehabilitation (DART) but it was found that more finely tuned specialist skills were necessary for the particular needs of stroke patients, if their discharge arrangements were to be improved and bed-stay rates reduced.

4.11.2 This extended service was planned, developed and supported by the Managed Clinical Network (MCN), and built into the planning phase was an agreement that MCN would continue the BIG funding during the period prior to a mainstreaming decision. BIG support allowed for the earlier introduction of an evidence-based approach to the early discharge and rehabilitation processes for stroke patients. The overall purpose being to identify those most likely to benefit from early discharge, although remaining in receipt of Consultant led outreach services for a number of weeks.

4.11.3 Of interest is the way differences in the management structure of North and South Glasgow have led to the development and use of two models for stroke patient discharge, reflecting a difference in emphasis on through-put. The Southern General approach seems to be seen as meeting a gold standard but with the added value of the continuing involvement of the stroke consultant and a flexible hospital based team. In practical terms this means that a patient led rehabilitation programme is in place that, with outreach services, can last between six and seventeen weeks. This model is supported by its evidence and outcome base, although there is an acceptance that lowering standards could increase the number in receipt of the programme, a factor likely to influence later decision-making. It is however unlikely that the current ‘gold standard’ level of patient/carer satisfaction could be sustained, given the age and predictable level of health and disability amongst many carers. That is to say, the main reason for the outreach consultant led rehabilitation programme was to promote a sufficient level of confidence amongst stroke patients and their main carers (most of whom will be in the older and less healthy age groups) that early discharge would become more acceptable. It certainly
seems that recipient satisfaction is the key to the acceptability of early discharge following such a potentially disabling condition.

4.11.4 The project has attracted interest from ‘outside’ with special reference to traditional feelings of being ‘let down’ once discharged. The continuing links between home and the ward team have contributed substantially to an acceptance that early discharge does not mean the end of specialist care but the beginning of an established hospital based rehabilitation programme. The flexibility of the system is also evident in the easy movement of specialist skills – that is to say that not every patient needs the skills of the whole team on every occasion.

4.11.5 Given the planned team approach and the clinical evidence to support the model, very little has changed over the last year, with significant beneficial outcomes being sustained for patients, their carers and the NHS. Examples include:

- Patient-led goals agreed on a weekly basis.
- Patient satisfaction and functional levels remaining very high.
- Carer benefits assessed using a measurement of strain index with particular benefits accruing from the specialist skills associated with stroke care.
- Although early discharge tends to be for those of relatively younger age, this approach to stroke discharge has led to the average hospital bed-stay going down from 22 to 16 days.

4.11.6 Process evaluation, reflecting aspects of good practice, has also continued to take on an important role and comprises five elements which appear to contribute substantially to more patients being satisfied with an early return home and bed-blocking being reduced:

- The systematic identification of potential beneficiaries of early discharge.
- Targeted intervention from a range of specialist health professionals, geared to patient-led goals.
- Clinically recognised tools used regularly by the team to monitor severity of condition and rate of recovery.
- Continuous involvement of a consultant-led specialist team.
- Assessment by GP six months after discharge, using agreed criteria concerning capacity for self care, improvement to quality of life, carer benefits and the need or not for readmission.

4.11.7 The above elements of good practice highlight the significance of (a) flexibility in hospital based services in the face of a particular problem and (b) co-operation between primary and secondary health service provision.

4.11.8 The sustainability of the project is ensured by the Managed Clinical Network agreeing to continue the funding arrangements until the service is mainstreamed and agreement reached about the model to be used across both north and south Glasgow.
4.12 Case Study 5
Glasgow Victoria Infirmary: Multicultural Cardiac Rehabilitation Service (First visit to New Case Study)

4.12.1 The Victoria Infirmary is a District General Hospital based on the south side of Glasgow where the majority of the South Asian population reside. The hospital provides a cardiac rehabilitation service for the Greater Glasgow and Clyde Health Board. This service is described as the process by which patients with cardiac disease, in partnership with a multidisciplinary team of health professionals are encouraged and supported to achieve optimal physical and psychological health (SIGN guideline 57 2002).

4.12.2 The aims and objectives are the provision of acute, secondary and tertiary health care, together with accident and emergency services for the local population.

4.12.3 The project consists of a three-year BIG grant to support the provision of a Multicultural Cardiac Rehabilitation Service, commencing November 2004.

4.12.4 The need for a separate component to the established cardiac rehabilitation service arose as a consequence of information gathered about the language difficulties of patients from ethnic minority groups and the lack of knowledge and perceptions of hospital staff about the influences of culture on patient responses in hospital settings. This indicated that the uptake of a significant element of the post myocardial infarction recovery programme, for patients recovering from a cardiac event (such as myocardial infarction, heart disease or heart surgery) was below that of the indigenous population. Evidence suggested that cultural factors were probably involved. Recent evidence indicates that the incidence of myocardial infarction is 60-70% higher in the South Asian community compared with the general population. NHS Scotland is committed to addressing the inequalities in health experienced by minority ethnic populations.

4.12.5 In general terms, the services provided by a multi-disciplinary team of health professionals remains the same for all who are offered the four phases of the cardiac rehabilitation service, three of which involve early discharge arrangements, a structured exercise programme with support and the long-term maintenance of lifestyle change. The main aim of this service development is to promote the uptake of current provision by Glasgow’s South Asian population.

4.12.6 BIG funding allowed for the introduction of bilingual staff to the team that provides stroke discharge and rehabilitation services across the five main Glasgow hospitals. The funded personnel comprise a full time bilingual specialist Cardiac Rehabilitation Nurse to lead the planning and development of the service, a part-time bilingual cardiac rehabilitation physiotherapist and a full time bilingual rehabilitation assistant.

4.12.7 Initially, training and awareness raising formed a key element of the project, highlighting significant communication issues, e.g. a hospital dietician had not grasped that a patient asking for halal food was not requesting a vegetarian diet; patients who smiled and nodded did not necessarily understand what had been said to them; non-attendance at Health Fairs did not necessarily mean lack of interest but could have meant that those involved in planning did not take adequate account of the dates of religious festivals. In addition, focus groups in local communities provided opportunities for priority needs to be identified during the first stages of the project and these highlighted the following key issues for project development:

- Language and communication difficulties.
- Patient focused public involvement.
- The significance of important religious and spiritual needs.
■ Dietary and hygiene factors.
■ Monitoring ethnicity.
■ Staff training.

4.12.8 A steering group sets objectives and reports directly to the Managed Clinical Network for heart disease. Partnership processes were developed with local communities and their leaders, with primary care representatives and with the health promotion unit of the Greater Glasgow Health Board.

4.12.9 Project successes have included:
■ Staff cultural awareness training.
■ Responses to feedback from focus groups, indicating which areas of the service need modification and which do not.
■ Health Fairs planned with support from Asian community.
■ Communication – including improved access to the rehabilitation programme, the clarity of explanation for patients, reducing the incidence of misinterpretation and improving medication compliance. Faster access to interpreting services has also enhanced chest pain assessment and the identification of patients’ priority needs.
■ The setting up of a multi-cultural electronic register to track and audit the service across the city, which is updated weekly.

4.12.10 The loss of the bi-lingual Specialist Nurse has created some predictable difficulties. However, recruitment for the post has been quicker than anticipated and her previous experience and expertise regarding multi-cultural health matters enabled the service to be set up and embedded in a much shorter timescale than anticipated.

4.12.11 Areas acknowledged as requiring improvement include:
■ Access to information and education.
■ The depression assessment tool needs to be available in more languages.
■ The process of ethnic monitoring - this has had some resistance but eventually it will be GP based and transferred electronically.
■ Spreading aspects of good practice across multi-cultural heart services.

4.12.12 Evaluation: the main focus at present seems to be on output measures without adequate reference to factors likely to influence inputs and processes – overall quality standards.
5 Case Studies Wales

5.1 Overview of Projects in Wales

5.1.1 Five case studies have been undertaken in Wales since the commencement of the evaluation. All projects are very closely linked with a number of key strategies within the Welsh health and social policy context.

5.1.2 The projects include: a local authority based exercise referral scheme, two hospital based projects (both of which have their delivery firmly situated within the community), and two charitable/voluntary organisation projects which again deliver to local communities. All projects seem not to have experienced organisational or contextual issues which could have impacted upon delivery of the projects or on internal working structures.

5.2 Partnership Arrangements

5.2.1 Where projects have had to work in partnership with internal agencies this has proved to be extremely effective, with referrals processes and mechanisms being fully bedded in, particularly in the case of the two hospital based projects. There have also been some very good examples of partnership working external to the project, for instance the exercise referral scheme has recently been awarded a Health Recognition Award, acknowledging the good practice inherent within the partnership working element of the project.

5.2.2 All projects (with the exception of one) have maintained excellent working relationships with both the wider community and also primary and secondary care organisations. Relationships to a great extent in this second year of working have become stronger and this has been evident in the levels of referrals projects are receiving. One particular project has lost a key member of staff and has had to severely curtail the work it has so far been able to do, particularly within schools. Word of mouth has clearly been crucial in increasing levels of participation in the projects, and as a result all projects are very close to meeting the targets set out in their original applications made to BIG.

5.2.3 All projects have very effective steering and management groups in place which regularly feed into the practice and delivery element ensuring continuous improvement. Some projects have gone so far as to create user/beneficiary forums which again comment upon a project’s effectiveness and suggest ways in which delivery can be improved upon.

5.3 Delivery and Management

5.3.1 Upon completion of the second visits to all project managers within Wales it was generally acknowledged that delivery and management of most projects was continuing well. All projects have now had ample time to bed in and most project managers have had ample time to become known and, more importantly, trusted, to their target populations. Delivery of one element of a project has had to be brought to an end because a key member of staff has left the project in order to pursue full time employment. As evaluators we suggest that this will start to become more of an issue as projects are nearing completion and projects could start to lose key members of staff as much as six months in advance.

5.3.2 A key success factor in most of the projects has been delivery of services and activities into very localised communities. Where evaluation has taken place beneficiaries have welcomed this provision and as a consequence have been more likely to attend projects. One particular project has worked in partnership with leisure centres where the environment is of an extremely high standard. Patients in these surroundings arguably become clients on the road to recovery, with a firm emphasis on conquering the illness as opposed to concentrating on it.
5.3.3 Some projects have used underspends to make changes to the operation of their projects. For instance, the healthy eating and physical activity project has employed on a part-time basis a horticulturist, whose role has expanded over the past year and now involves both leading and supervising groups within the Erias Kitchen Garden.

5.3.4 A particular rehabilitation and prevention project has been successful in gaining extra financial support from amongst others the Trust and the Local Health Board. This has meant that it has been rolled out to two additional areas, Carmarthenshire and Pembrokeshire, with the addition of two more physiotherapists and two clerical support staff.

5.3.5 A community cardiac rehabilitation project has recently started to hold classes at a local community centre able to take in a larger number of patients and with free parking. It is located centrally and excellent working relationships with the centre staff have been developed over time. Within the same project it was decided to disband the partner support group and this has freed up resources to enable the British Association of Cardiac Rehabilitation (BACR) instructors to contact patients individually by telephone or letter. It has been assumed that if a patient is given the name of a person who will contact them that patient will automatically attend. Analysis as to whether this is the case is currently being undertaken.

5.3.6 An exercise referral programme, which has recently started to engage some harder to reach groups in particularly isolated communities, offers a range of activities including fitball, aqua-aerobics, circuits, boxercise and chair-based movement exercises. All activities are held in local community and leisure centre based venues.

5.4 Beneficiaries

5.4.1 For most projects, intended beneficiaries of the projects have not changed markedly over the past year, as most projects have set very clear indicators for referrals, exclusively so in the case of three of the hospital based projects which all take their referrals from specific surgical or medical departments. The two other projects have been more concerned with targeting more generalised communities in order to improve people’s dietary and exercise habits, with a view to having positive impacts upon people’s health and thereby reducing the likelihood of those individuals developing coronary heart disease, stroke or cancer.

5.5 Evaluation, Impact and Shared Learning

5.5.1 Of the five projects evaluated within Wales only one, the exercise referral scheme, has been externally audited. As a result it has been awarded a Health Recognition Award by the Institute of Leisure and Amenities Management. The assessment was concerned with reviewing the partnership working element of the project. A number of the project managers have been extremely proactive in sharing information and good practice about their respective projects. Examples of this include:

- The Lymphoedema Care project has recently presented a paper at the Chartered Society of Physiotherapy Conference, which was an opportunity to share best practice and also to advise other professionals how similar projects could best be set up.

- The Community Cardiac Rehabilitation project has recently presented at the National Leadership and Innovation Agency for Healthcare conference and the Cardiff and Vale NHS Cardiothoracic conference.

- The Positive Action for Stroke project has recently contributed to the National Service Framework for Older People in Wales, launched in 2006 by the Welsh Assembly Government.
5.5.2 All projects have collected the data which will enable them to measure impact. Most project managers are still in the process of collating/inputting and analysing the data which will have been collected at various intervals throughout their projects. The impact of some projects will be more discernible than others, for instance the project which is working with children will not know how far those early eating and exercise habits have carried on through to adulthood. Some project impacts will be far easier to measure, for example particularly when looking at measurements in blood pressure and weight.

5.6 Sustainability

5.6.1 Only two of the projects have been assured of their future funding. The other projects, although clearly well received and valued by beneficiaries and professionals alike, are currently in the process of putting sustainability plans in place and identifying other suitable funding sources.

5.6.2 The Lymphoedema Care project has so far not been assured of mainstream continuation funding from the health authority but has lodged a joint bid with Macmillan Cancer Relief with the intention of extending the project into other specialty groups, such as gynaecological cancers, with the goal of establishing a cancer rehabilitation scheme for all sufferers.

5.6.3 The Active Living project as part of Blaenau Gwent County Borough Council will receive a further three years of funding equalling £350,000. This funding will be used to sustain the Active Living Co-ordinator post for a further three years. Additionally the funding will be used to employ two full-time and one part-time physical activity facilitators.

5.6.4 The Roots for Healthy Hearts project is currently looking at external funding available through The Children’s Healthy Eating and Exercise Fund, and also by selling the produce grown in the Erlas Kitchen Garden.

5.7 Successful in Meeting Aims and Objectives

5.7.1 All projects assessed within Wales have been successful in meeting their overall aims and objectives. Moreover, the original aims and objectives stipulated in their applications have not changed over time.

5.7.2 The Lymphoedema Care project was developed in response to an identified gap in service provision. It is interesting to note that this project remains unique to Wales although the opportunities to expand throughout Wales are currently in the process of being developed. The project has been extremely well received by all beneficiaries and even individuals who may have experienced the condition some years ago have heard about the scheme and are keen to access it. These individuals are being accommodated wherever possible, more specifically when a cancellation is received, although these opportunities remain scarce.

5.7.3 The Positive Action for Stroke project again has fulfilled a very specific identified need where previously provision was sporadic. Delivering services in local, accessible community facilities has proved very valuable to beneficiaries. The project has been able to contribute to the National Service Framework for Older People in Wales, thereby ensuring that identified needs are reflected in the national priorities. As project managers have commented in the past, “rehabilitation is a long term process which helps individuals
to manage the damage the stroke has caused and the difficulties this creates for daily living.”

5.7.4 The Active Living project has in the last year started working in partnership with a much wider range of agencies, has made links with the Health for Life scheme working with both adults and children, and has made significant inroads into working with a number of disadvantaged, marginalised and hard to engage communities. The co-ordinator has also integrated the Local Health Board Adult Obesity Scheme, which offers nutritional advice, into the Primary Care Exercise Referral scheme. This was achieved by facilitating the exercise component, which offers individuals a two way pathway, into exercise and nutrition. The partnership has been described as one of the key pathways in managing high levels of obesity in the borough.

5.7.5 The Community Cardiac Rehabilitation Project has in the past year started to offer patients individualised programmes of care, including occupational therapy, physiotherapy and dietetic advice. The pathways of care between cardiac rehabilitation and primary care have also been improved upon and an individual link nurse has been identified within twelve Cardiff GP practices. Identifying such an individual has meant that direct contact can be initiated if cardiac rehabilitation staff have any concerns about patients, and vice versa.

5.7.6 The Roots for Healthy Hearts project has recently acquired matched funding which has enabled it to provide a Food Hygiene course; this is accredited by the Open College Network. At a strategic level the project has been included into Wrexham County Council’s “Healthy Schools Scheme” as part of their ten point plan.

5.8 Case Study 6
Blaenau Gwent County Borough Council: Active Living

5.8.1 The project comes under the aegis of Blaenau Gwent County Borough Council’s Leisure Services Department. This department has been formed from an amalgamation of the former Sport and Recreation Division and the Facilities Management Division. The key strategic aim expressed in the Community Plan, from which the Division takes its direction is, “to provide sport and cultural opportunities for all”.

5.8.2 The project provides activities to individuals who may be at risk of coronary heart disease, stroke or cancer. The activities are sport based and are provided at very accessible locations within the community. Referrals are taken from a wide range of internal and external agencies.

5.8.3 The project has a number of key objectives, more specifically:

- To offer a systematic and controlled system of referral to the Active Lifestyles project utilising current programmes across Blaenau Gwent.

- To provide a multi-faceted programme encompassing cardiac rehabilitation and outreach work to both low, medium and high risk services users.

- To work in partnership with key agencies to promote the programme.

- To offer support and guidance to those people with clear risk factors associated with CHD and to educate those members of the population who are sufficiently active and assist them to make healthy positive lifestyle changes.

- To provide training to leisure, health and other staff on key messages around exercise and healthy lifestyles for those people suffering from or at risk of CHD.
Contribute to the Blaenau Gwent Healthier Health, Social Care and Well-being objectives in line with the National Service Framework for CHD.

5.9 Project Development over Past Year

5.9.1 The project has developed in a number of specific areas over the past year, including partnership arrangements. The project staff are now working with a wider range of agencies running both within and external to Blaenau Gwent including: Cardiac Rehabilitation, Diabetes Clinics, Smoking Cessation, Musculoskeletal Department, Reablement Clinic, Expert Patient Programme, Pain Management Clinic, Mental Health Service Providers, Nevill Hall Pulmonary Rehabilitation Department, and the Adult Obesity Clinic.

5.9.2 GP Exercise Referral Instructors (an integral part of the Active Living project) have made links with the Health for Life ten week scheme. The scheme works with both adults and children and the Exercise Referral team have taken responsibility for delivering the exercise component. The team employed by the Local Health Board have taken responsibility for the dietary advice and counselling component. A wide variety of taster sessions are offered and these include: yoga, walking, aerobics, fitball, circuits, gym inductions and cardio-kick.

5.9.3 The development of a Bibliotherapy (Books on Prescription) service: Healthcare professionals complete a form (similar to a prescription) containing the title of a book recommended to suit a patient’s individual needs. The “prescription” can then be taken to any Blaenau Gwent library where a librarian will supply the book on an extended loan. The issues that the books cover can range from overcoming depression to bereavement and are chosen to give patients guidance and a deeper understanding of their condition.

5.9.4 The Active Living Co-ordinator has integrated the Local Health Board Adult Obesity scheme, which offers nutritional advice, into the Primary Care Exercise Referral (PCER) scheme, by facilitating the exercise component which offers individuals a two-way pathway into exercise and nutrition. This partnership is one of the key services in managing high levels of obesity in the borough.

5.9.5 A number of harder to reach communities have recently been engaged into the scheme. The Exercise Referral Instructor has been working with the Cefn Golau, Coed Cae, Srwfydd, Rassau and Cwm areas to deliver a range of activities with the aim of improving general fitness levels for the 16-25 age group and the over 60’s age group. Activities offered included: fitball, cardio-kick, aqua-aerobics, circuits, boxercise and chair-based movement exercises. All activities were held in local community and leisure centre based venues.

5.9.6 There have been a number of opportunities for continuing professional development organised by the Local Health Board (LHB), the National Public Health Service (NPHS) and Blaenau Gwent County Borough Council (BGCBC) Leisure Services Department. The NPHS Dietician has recently run an Open College Network qualification in Nutrition which has been attended by the Active Living facilitators and Leisure Centre staff in the area. Torfaen County Borough Council worked in partnership with the Active Living project to provide training opportunities in motivational behaviour. On a strategic level the LHB and BGCBC jointly held a conference “A Better Future for Health and Social Care in Blaenau Gwent” in March 2006. The conference was used to demonstrate local progress and linkages to key national strategies such as “Designed for Life”.

5.9.7 Following two years of continued growth and partnership working the PCER has been awarded the highest recognition of good practice; The Institute of Leisure and Amenities Management (ILAM) Health Recognition Award. The assessment has evidenced the good partnership working inherent in the Active Living Programme.
5.9.8 The Active Living programme has exceeded Year One referral targets set by the Leisure Services Performance Manager and currently 67% of General Practitioners within Blaenau Gwent are referring individuals onto the programme. The programme has achieved a total of 5517 attendances across all facilitated sessions to date and receives an average of 30 referrals per month from professionals allied to medicine.

5.9.9 Since the referral scheme began in April 2005 there is evidence to suggest the 2% of users have continued to participate in physical activity sessions within a facility or in the natural environment without officer support beyond a twelve week period. However, there is no evidence to suggest that they have continued exercising beyond the six month stage.

5.9.10 Blaenau Gwent has been chosen as one of six local authorities which will receive a further three years of funding (2007-2010) to the sum of £350,000. This funding will be used to sustain the Active Living Co-ordinator post for a further three years. Additionally the funding will be used to employ two full time and one part time physical activity facilitators.

5.10 Lessons Learnt

5.10.1 Over the past year the project has undertaken a significant exercise of mapping out its existing partnerships and there has been recognition that there were many areas of overlap. Partnerships have either been rationalised or existing groups merged to avoid duplication.

5.10.2 The Active Living Steering Group have identified that there is a significant gap between female and male self-referrals, with a female rate of 87% whereas the male rate is 8%. Interestingly the GP referral rates are the opposite with 67% of males being referred compared to 31% female. As a result of this data the steering group are exploring new ways of encouraging more males to self-refer.

5.11 Future Aspirations

5.11.1 As future funding is ensured it is the project manager’s intention to develop a source of mainstream funding from both Blaenau Gwent County Borough Council and the Local Health Board. It is also intended that a more robust method for identifying impact on behavioural change be developed as well as identifying the range of outcomes most suitable to the Active Living Programme. In the future it is additionally intended that explicit links between carers and the Active Living Programme are made in order to improve their quality of life.

5.12 Case Study 7
Cardiff and Vale NHS Trust:
Community Cardiac Rehabilitation Services in Cardiff

5.12.1 Cardiff and Vale NHS Trust is the largest NHS Trust in Wales. It provides day to day health services to a population of around 500,000 people living in Cardiff and the Vale of Glamorgan who need hospital treatment, mental health care, care for elderly people and children as well as a growing range of community-based services, including specialist dental services, and new therapies as alternatives to hospital admission. Patients also attend from across Wales for a range of specialist services, for which the Trust is regarded as a centre of excellence, including paediatric, renal, cardiac, neurological services and bone marrow transplantation.

5.12.2 The project “Community Cardiac Rehabilitation Services in Cardiff” was developed to provide a community focused cardiac rehabilitation programme in Cardiff. The service provides structures and networks that encourage long-term risk factor management and
healthy lifestyle changes. It also provides an individualised multidisciplinary programme of care for patients, consisting of education, stress management and a supervised structured exercise programme. In addition a choice of services are offered consisting of the existing hospital cardiac rehabilitation scheme for higher risk patients, community multidisciplinary cardiac rehabilitation service and a home based cardiac rehabilitation service. It achieves this through the development of pathways of care between cardiac rehabilitation and primary care, the formalising of links and pathways with existing local health initiatives from health, leisure, education and the voluntary sector, by establishing a network of buddies and by acting as a resource and providing training sessions for primary care, the education sector, the leisure sector and the voluntary sector. Partnership working is intrinsic to the success of the project and staff have worked very closely in collaboration with the community in order to best meet the cardiac rehabilitation needs of patients and in order to increase the sustainability of the activities initiated.

5.12.3 The project is overseen by a steering group and is attended by representatives of The British Heart Foundation, Cardiff Leisure, Health Alliance and Cardiff Local Health Board. In addition a patient representative attends, as do the leads of the various departments responsible for delivery of the project. This management structure is supplemented by a working group which has been established by the lead of each discipline. This meets quarterly to discuss the project developments, provide direction and support for the project and most crucially to plan for the future sustainability of the project.

5.13 Project Development over Past Year

5.13.1 The project has developed in a number of key areas over the past year, more specifically, the funding has enabled changes to be made to the services offered, providing a more flexible, individual community focus that builds stronger links with primary care. Patients are now offered individualised programmes of care including access to occupational therapy, physiotherapy and dietetic advice. A patient undergoes an individualised assessment by a member of the cardiac rehabilitation team firstly as an inpatient and then within their home. This includes an assessment of the patient’s risk factors, information regarding recovery and then a plan for the care of the patient. It is at this stage that options are discussed, these options may include any or all of the following:

- **Occupational therapy.** This provides the opportunity to identify physical and psychosocial results of cardiac events and how these may limit the patient’s resumption of purposeful activity. Appropriate interventions are then identified and these can include relaxation training, education, skills building and the provision of equipment which can facilitate function.

- **Physiotherapy:** Provides patients with the opportunity to plan an individualised exercise programme and effective cardiovascular workout for those who may not have attended the cardiac rehabilitation programme.

- **Dietetic:** To provide an individualised dietary consultation for weight maintenance and modification of dietary risk factors.

5.13.2 The project was initially set up to run at the Star Leisure Centre Splott, as well as a number of other venues which are discussed below, but due to the refurbishment of the centre delivery was relocated to the Maindy Leisure Centre. This lasted for a few weeks until a more permanent arrangement could be organised. The project now runs at the Maes-y-Coed Community Centre and a rolling programme operates for eight weeks with patients attending twice a week for 2.5 hours per session.

5.13.3 Patients are then followed up six months from completion of their cardiac rehabilitation programme, or if they did not attend the project, six months post their cardiac event. During this appointment a full risk factor assessment is completed, review of goals and a
Evaluation of ‘Reducing the burden of CHD, Stroke and Cancer’ Programme

long-term plan is made regarding risk factor management and healthy lifestyle changes. A letter of progress is sent to the GP highlighting any risk factors identified. Community clinics continue at three venues across Cardiff ensuring accessibility for patients.

5.13.4 Patients are encouraged to take part in appropriate physical activity. These classes take place in a number of convenient venues throughout Cardiff including Fairwater, Llanishen and Coleg Glan Hafren. The classes taking place at Maes-Y-Coed Community Centre have been singled out for special praise. The venue is able to take in a larger number of patients, there is also free parking available and it is very central and accessible for patients. An excellent working relationship has been fostered with the staff at the centre and this has undoubtedly added to the success of the venue.

5.13.5 The pathways of care between cardiac rehabilitation and primary care have been improved upon. This has been as a result of a telephone audit which was undertaken between cardiac rehabilitation staff and individual practice nurses. Twelve practices across Cardiff were targeted and a link nurse was identified within each practice. Identifying such an individual has meant that direct contact can be initiated if cardiac rehabilitation staff had any concerns about patients, and vice versa. As a result of this audit it has now been decided that it would be useful for the practice nurse to receive patient information following a home visit and at the end of the cardiac rehabilitation programme, highlighting the type of cardiac rehabilitation the patient received.

5.13.6 The Partner Support Group has been withdrawn due to a lack of attendance. It was felt that due to the high level of support that patients and family receive from the onset of admission that adequate support was available if required. In addition relatives are encouraged to attend the programme and this again provides the opportunity to discuss concerns and address any anxieties they may have.

5.13.7 A Pilot Weight Management Programme has been developed in order to benefit obese patients. It is currently being implemented both via a group approach and individual sessions. A comparison analysis is currently being conducted, which will enable the team to determine the approach which works best. The programme emphasises cognitive behavioural methods in conjunction with calorie restriction. This is a joint project with the Inequalities in Health Fund primary care project Heart Ely. Resources to support both of the programmes have also been developed.

5.13.8 The team have regularly taken advantage of opportunities to provide information and education to the general public and other professionals in the health sector. Examples of this include:

- A poster presentation to the NLIAH (National Leadership and Innovation Agency for Healthcare) conference and Chief Nursing conference. An abstract sent for the BACR (British Association of Cardiac Rehabilitation) conference. An article produced for the South East Network Newsletter outlining BIG developments.
- An oral presentation at the Cardiff and Vale NHS Cardiothoracic conference.
- A review of an Ethnic Minority resource pack for dietary management and “Eating for Life”.

5.14 Lessons Learnt

5.14.1 The decision to withdraw the Partner Support group has meant that increased resources have been diverted into parts of the project enabling it to increase its scope and the number of beneficiaries. There was also a decision to instigate a “Meet and Greet” policy from the BACR instructors. This has enabled the BACR instructors to contact each patient individually by telephone or letter. It has been assumed that if a patient is given
the name of a person who will contact them that the patient will automatically attend. Analysis is currently being undertaken to determine whether attendee numbers have increased as a result of this new development.

5.15 Future Aspirations

5.15.1 In the final year of the project continued efforts will be put into developing new activities and consolidating existing activities. One of the main challenges for the year ahead will be looking at ways in which activities can be sustained so that cardiac patients can continue to benefit from the work of the project well into the future.

5.16 Case Study 8

Swansea NHS Trust: Breast Cancer Rehabilitation Recovery And Prevention Of Lymphoedema

5.16.1 Swansea NHS Trust provides services for a population of approximately 250,000 across South and Mid Wales and some specialist services for the whole of Wales. The project is delivered at the Singleton Hospital which has a specialist breast cancer unit involving consultants, oncologists and nurses. All referrals are taken from the unit.

5.16.2 The project delivers activities, support and advice to women who have undergone breast cancer surgery within the Swansea area.

5.16.3 There were several objectives to the project, more specifically they included:

- Establishing collaborative partnerships between users, professionals, Swansea NHS trust and the Leisure Centres to improve breast cancer rehabilitation and recovery.
- Developing a community based rehabilitation and preventative organisational infrastructure which allows for a continuous process of care across traditional health, social service and user boundaries.
- Implementing and evaluating an equitable, accessible and culturally sensitive service.
- To determine and evaluate defined objective and subjective patient outcomes and to evaluate these in terms of their cost effectiveness in care provision.
- Providing a cancer rehabilitation project with prevention of side effects from cancer treatments.

5.16.4 Traditionally rehabilitation and treatment of lymphoedema has been given little focus in treating breast cancer. The emphasis has been on surgery and oncology treatment. Through increasing lymphoedema and shoulder mobility referrals plus growing patient complaints this project was conceived and developed by Melanie Lewis. The scheme is a first in the United Kingdom and focuses on referred patients being given education, exercise, support and advice about a range of issues, more specifically including:

- Improving knowledge/awareness of the risk/prevention of lymphoedema.
- Restoring movement/muscle strength.
- Maximising quality of life.

5.16.5 Referred patients are assessed pre and post-operatively and given daily physiotherapy until discharge home. They are reviewed at three and six weeks as outpatients and are
invited to attend a twelve week exercise and education programme in a local private leisure centre. The twelve week programme offers patients advice on a range of different issues including: healthy eating, genetics, breast reconstruction, complementary therapy, hair loss, sexuality, and body image problems. The exercise programme involves a variety of different activities including: salsa, circuits, aqua aerobic, gym, yoga and relaxation.

5.17 Project Development over Past Year

5.17.1 The project has continued to develop in a number of key areas which are outlined below:

- New Developments:
  - Financial support for the rehabilitation and prevention scheme has been provided by amongst others the Trust and the Local Health Board, the success of the project has now meant that it is being rolled out into Carmarthenshire and Pembrokeshire with the addition of two more physiotherapists and two clerical support staff.
  - The talks given during delivery of the project have continued to evolve in line with beneficiary requests, for instance new talks have been given on Herceptin and insurance.

- Awards and accolades:
  - The project has recently achieved second place in the Health and Well-being category of the Allied Health Profession and Health Care Scientists Award.
  - The Welsh Innovations in Healthcare awards recently awarded Melanie Lewis, Macmillan Lymphoedema Specialist, the Regional Service award for her innovative work in the setting up of the Lymphoedema Clinic.

- Wider interest:
  - The project has continued to receive interest at the very widest level. The project manager recently presented a paper at the Chartered Society of Physiotherapy Conference held in Birmingham. This again was an opportunity to share best practice and also to advise other health professionals how similar projects could best be set up.

5.18 Future Aspirations

5.18.1 A bid has been lodged with Macmillan Cancer Relief with the intention of extending the project into other specialty groups, such as gynaecological cancers, with the goal of establishing a cancer rehabilitation scheme for all sufferers.

5.18.2 The project has not been assured mainstream funding and the project manager is continuing to explore all avenues to assure the future sustainability of the project. As with all NHS budgets money is tight so the project is not at this stage assured of mainstream funding.

5.19 Case Study 9

The Stroke Association: Positive Action for Stroke

5.19.1 The Stroke Association is a national charity solely concerned with combating stroke in people of all ages. It funds research into prevention, treatment and better methods of rehabilitation, and helps stroke patients and their families directly through its community services. These include dysphasia support, family support, information services and
5.19.2 The project offers services and support for people affected by stroke, offering opportunities in developing their quality of life after they have had a stroke. The project aims to provide meaningful, realistic social and occupational integration opportunities. All activities take place within local community facilities and are designed to reduce isolation and aid adjustment to stroke related disability.

5.19.3 The Positive Action for Stroke project offers a comprehensive package with stimulating and motivating activities, delivered in locally accessible venues. It provides long term support to clients and, just as importantly, their carers and families. The programme promotes and provides an opportunity for adults requiring social care support to live as full, active and independent a life as they are able. Rehabilitation is a long term process which aims to enable patients to manage the damage the stroke has caused and the difficulties this creates for daily living. Previously there has been a patchy provision of this type, which was clearly recognised by the developers of the project. Participants are offered a very broad programme of activities including artwork, information technology, music, creative writing/poetry and cookery.

5.20 Project Development over Past Year

5.20.1 Perhaps the biggest development of the project over the past year has been the Stroke Association’s contribution to the National Service Framework for Older People in Wales which was launched in 2006 by the Welsh Assembly Government. The Stroke Association contributed to the section on stroke and outlined the need for: “ensuring that patients can access co-ordinated, community based, specialist stroke rehabilitation services and community based exercise programmes after they leave hospital as and when they need them, in order to achieve ongoing rehabilitation goals, maintain function or to meet a new identified need”. Positive Action for Stroke has a very clear correlation with this particular strand of policy as it provides community based ongoing activities for people which include:

- Art/Craft/Watercolour/Oil Painting. This allows individuals to not only explore and express their feelings about what has happened but also more practically to use their less dominant hand whilst carrying out the activity. Additionally it allows them to exhibit their work demonstrating their capabilities, which helps with their self image and confidence and generates feelings of achievement.

- IT Skills. This allows individuals to communicate by email, access the internet and develop basic word processing skills. Some individuals have been successful in obtaining a qualification equivalent to that of a GCSE. This activity has helped people to communicate with their friends and families, and has helped with basic literacy skills. Confidence gained as a result of the activity has meant that some individuals have gone on to pursue adult evening classes.

- Sports (swimming). This allows individuals to take part in exercise which is an important contributory factor in reducing the risk of another stroke occurring. Some individuals who have become more confident as a result of taking part have progressed onto kayaking with a trained instructor.

5.20.2 The Strategy also states that “the voluntary sector has a particularly valuable role to play in supporting people who have had a stroke, along with their carers and families… there is a need for local authorities and local health boards to work with the voluntary sector to develop services to help individuals to gain confidence and independence following a stroke”. The Positive Action for Stroke project again has clear links with the strategy as demonstrated by the following activities and services:
Cookery. This activity introduces people to being able to create inexpensive, easy to cook and healthy meals. Individuals may live alone and have little or no cookery skills, or they may have previously enjoyed cooking prior to the stroke event but may not now have the confidence to cook. This activity promotes independence and can assist people in feeling useful if they can contribute in the preparation of meals.

Basic Literacy Skills. This activity can help individuals (including those with Dysphasia) to increase their confidence in the areas of letter writing, reading and improved comprehension.

5.21 Future Aspirations

5.21.1 The project will be looking at ways of securing funding to ensure continuity of service. The project manager has been investigating ways to form strategic links with future possible funders; the link with the National Service Framework for Older People in Wales being a prime example. Continued efforts will be made over the next year to ensure all funding possibilities are examined.

5.22 Case Study 10

Groundwork Wrexham: Roots for Healthy Hearts

5.22.1 Groundwork is a federation of trusts in England, Wales and Northern Ireland, each working with their partners to improve the quality of the local environment, the lives of local people, the success of local people and the success of local businesses in need of investment and support. Each Groundwork Trust is a partnership between the public, private and voluntary sectors with its own board of trustees. Groundwork’s aim is to work towards a society made up of sustainable communities which are vibrant, healthy and safe, which respect the local and global environment and where individuals and enterprise prosper.

5.22.2 The Roots for Healthy Hearts project was developed to encourage active living and healthy eating in school children and community groups. Developing basic activity and healthy eating in children is said to act as a template for adult lifestyle. The project has two strands; one is to promote healthy eating and the other promoting physical activity to both school children and community groups. These strands are generally presented as a combination for a healthy lifestyle, rather than as two separate parts.

5.22.3 The project has created a number of community resources, these include:

- The Alyn Waters Trim Trail which has a number of exercise stations for both adults and children.
- The Erlas Kitchen Garden is a resource which has been developed largely due to the efforts of a group of regular volunteers who have been instrumental in cultivating what was essentially a piece of waste-ground into a valuable resource. Community groups frequently help with the continuing maintenance and development of the garden and gain benefits to their health through being physically active. Children also have an opportunity to learn about how food is grown and given the chance to conduct experiments around that theme.

5.23 Project Development over Past Year

5.23.1 The project has been subject to a number of changes which have impacted upon what the project has been able to achieve. Specific changes include:
The Active Lifestyle Officer has recently left the project which has meant that the activities of the project have been scaled back. Currently limited work is taking place within schools and the existing staff are not able to proactively target community groups.

The acquisition of matched funding has meant that the project has recently started to provide a Food Hygiene Course which is accredited by the Open College Network.

The part time employment of a horticulturist with skills in the areas of landscaping, designing and implementing the growing programme has proved, in the judgement of the project manager, to be successful. Additionally his role has expanded over the past year and now involves both leading and supervising groups referred to the garden by project officers.

The project has received much support from the partners. This is due mainly to the fact that regular steering group meetings are held, all partners are kept updated about the project and are also given opportunities to view their ideas or any concerns they may have.

The intended beneficiaries of the project have not changed markedly over the past year and officers have been able to deliver sessions. Although work has been limited since September 2006 all targets set have been met and in some cases exceeded. Due to the amount of work and time it takes for delivery of the schools programme there were fewer opportunities than first anticipated to target community groups.

In the early part of the year when school sessions were being delivered it was thought that they contributed towards the personal and social education area of the curriculum. The sessions also gave pupils the opportunity to use equipment, such as heart rate monitors, that ordinarily they would not have had access to.

At a strategic level the project has been included in the Wrexham County Councils “Healthy Schools Scheme” as part of their “10 point plan”. The Healthy Schools Scheme has a number of strategies most relevant to the Roots to Healthy Hearts Scheme. These are:

- Schools should adopt a whole school approach to the provision of healthy meals and snacks for pupils, staff and visitors.
- Commitment should be demonstrated towards the enhancement of the school environment, a safe environment that is conducive to the promotion of good health.
- Schools should actively encourage staff and pupils to take part in health related activities.

5.24 Lessons Learnt

5.24.1 In terms of marketing both the Trim Trail and the Erlas Kitchen Garden to schools it was acknowledged that this aspect could have been improved upon. It was generally considered that schools had been targeted too late in the term. There were also issues with class sizes (usually around 30 pupils in total) and transport (the project only had access to a sixteen seater minibus).

5.24.2 Three years funding has only been sufficient to get the project to a good level and start to have an impact. The project manager has commented that it will be very difficult to secure
continuation funding because the project cannot demonstrate very high levels of impact at this point.

5.25 Future Aspirations

5.25.1 The project manager stated: “The project has received an abundance of positive responses from schools, community groups and individuals alike. It is apparent that the project has been both successful and enjoyable, and that there is a clear demand for it to continue. Whether it continues in an identical format would of course be subject to any funding available.”

5.25.2 The two strands of the Roots for Healthy Hearts project, the schools programme and the community programme, may sustain themselves independently once funding finishes in February 2007. The school programme being maintained via mainstreaming through education, with the possibility of further expansion of the programme through external funding such as The Children’s Healthy Eating and Exercise Fund. The community programme may be sustained via other funding sources through other environmental projects.
6 Case Studies Northern Ireland

6.1 Overview of Projects in Northern Ireland

6.1.1 Eight case studies have been undertaken in Northern Ireland. Three of these case studies have been in relation to the same project delivered across three separate health and social service board areas. All projects are very closely linked with a number of key strategies within the Northern Irish health and social policy context.

6.1.2 The projects include: a hospital based neurovascular assessment centre, a community based emergency life support training project, a community based quality award scheme in the area of children’s play, a hospital based nurse led prostate cancer information and counselling service, a hospital based/community delivered outreach programme for angina patients and a cardiac rehabilitation programme covering the eastern area of Northern Ireland which involves a range of statutory and voluntary partners.

6.1.3 Northern Ireland is currently undergoing a period of change regarding the delivery and management of health and social care services and a Review of Public Administration is currently taking place, this does not appear yet to have impacted upon the projects discussed in this evaluation and there is some division amongst project managers as to whether it is likely to have a positive or detrimental effect upon future sustainability of their respective projects. Some minor changes in terms of new strategies, guidelines and curricula seem to have impacted upon some of the projects and these have largely been welcomed as they will in the future be used to support funding applications. Other than these changes projects seem not to have experienced any organisational changes which have impacted either upon delivery or on internal working structures.

6.2 Partnership Arrangements

6.2.1 Where projects have had to work in partnership with internal agencies this has proved to be extremely effective with referrals processes and mechanisms being fully bedded in particularly in the case of the hospital based projects. The community-based projects have clearly been particularly successful in engaging the wider community and excellent examples of this can be found in the case studies below.

6.2.2 All projects (with the exception of one) have maintained excellent working relationships with both the wider community and also primary and secondary care organisations, relationships to a great extent in this second year of working have become stronger and this has been evident in the levels of referrals projects are receiving. This has led to some concerns about how best to manage this demand particularly when expectations are being created which might not be fulfilled in the future. Word of mouth has clearly been crucial in increasing levels of participation on the projects and as a result all projects are either very close to meeting or indeed exceeding the targets set out in the original applications made to the BIG.

6.2.3 Most projects have very effective steering and management groups in place which regularly feed into the practice and delivery element ensuring continuous improvement and most projects have at least one user representative on their steering groups ensuring users can comment upon a projects effectiveness and suggest ways in which delivery and content can be improved upon.

6.3 Delivery And Management

6.3.1 Upon completion of the second visits to all project managers within Northern Ireland it was generally acknowledged that delivery and management of most projects was continuing well. All projects have now had ample time to bed in and most project managers have had ample time to become known and more importantly trusted to their target populations.
We found that no members of staff had left projects due to funding being very near to ending but foresee that this will start to become more of an issue as projects are nearing completion, we envisage that projects could start to lose key members of staff as much as six months in advance and this of course will have clear implications for delivery and management of the projects.

6.3.2 A key success factor in most of the projects has been delivery of services and activities into very localized communities, where evaluation has taken place beneficiaries have welcomed this provision and as a consequence have been more likely to engage with projects.

6.3.3 The cardiac rehabilitation project has now implemented 3 of its 4 key phases and has clearly made good inroads into establishing working links with leisure centres, the project staff share good practice and a substantial amount of collaborative working is happening, a sense of cohesiveness prevails with management and delivery staff described by the project manager as “pulling in the same direction”.

6.3.4 One particular project has targeted very rural communities where response times for ambulances are likely to be longer; as a result beneficiaries have fully appreciated the training recognising that they could often be the first respondent to an emergency situation. The project has also continued to target hard to engage groups such as farmers, alcohol awareness groups and single parent groups.

6.3.5 The children’s play project has started a mapping exercise which will look at good practice across all areas which will feed into future development of the project and possibly ensure a more standardized approach to training, it has also engaged with a number of hard to reach groups, such as women and children living within Women’s Refuges, they have also consolidated and built on the work being done with Traveller communities and Eastern European migrant communities.

6.3.6 The Nurse-led prostate cancer information and counselling service has recently completed an audit of users of the service, the findings of which have been extremely positive. It has also reviewed its procedures for dealing with patients whose PSA (prostate specific antigen) test results may be negative, but still may be high. Those patients will continue to be monitored by the project manager. The project manager has also continued to provide up to date information regarding PSA testing to General Practitioners, and staff within both hospital settings and acute hospital settings.

6.3.7 The Outreach Programme for Angina Patients has continued to develop, partnership working both within and external to the project has continued at a pace, the project manager commented: “Referrals are up on the previous year by 100% and there has been a sevenfold increase in the number of clinics that are taking place, that has obviously had a big impact upon time and we are currently looking at ways in which we can keep up with the demand.”

6.4 Beneficiaries

6.4.1 For most projects, intended beneficiaries of the projects have not changed markedly over the past year, as most projects have set very clear indicators for referrals, exclusively so in the case of four of the hospital based projects which all take their referrals from specific surgical or medical departments. The two other projects have been more concerned with targeting more generalised communities in order to improve adults and children’s health in a variety of ways.

6.5 Evaluation, Impact and Shared Learning

6.5.1 Of the eight projects evaluated within Northern Ireland only two projects have been externally evaluated, both project managers were very keen that this should take place to
avoid both the tarnishing of any data and also to support future funding applications. It is important to note that most other projects have been internally evaluated in order to examine both the impact of their projects and also user satisfaction. A number of the project managers have been extremely proactive in sharing information and good practice about their respective projects, examples of this include:

- The Outreach Programme for Angina Patients team have recently presented at a Health Week event organised by a community group in Ballymoney.
- The Community Emergency Life Support team have presented information about the project to an extremely wide range of both community groups and healthcare professionals and this has been reflected in the training that has then been provided.
- The Fit for Play project has been extremely proactive in sharing information about the project to a wide range of health promotion agencies, physical activity partnerships and investing for health partnerships, this information sharing will possibly result in future funding sources being identified and gained.
- The Nurse-led prostate cancer information and counselling member of staff has presented information about the project within conferences at both a national and international level.

6.5.2 All projects have collected data which will enable them to measure impact. Most project managers are still in the process of collating/inputting and analysing the data which will have been collected at various intervals throughout their projects. Some projects impacts will be more discernible than others, for instance the project which is engaging children will not know how far those early eating and exercise habits have carried on through to adulthood. Some project impacts will be far easier to measure particularly when looking at measurements in blood pressure and weight and so on and so forth.

6.6 Sustainability

6.6.1 Only one project has been assured of their future funding. The other projects, although clearly well received and valued by beneficiaries and professionals alike, are currently in the process of putting sustainability plans in place and identifying other suitable funding sources.

6.6.2 All projects are awaiting the completion of the Review of Public Administration in order to determine where best to place themselves in terms of future funding. As has been explained some project managers are viewing the Review very positively, whilst others are viewing it more negatively.

6.7 Successful In Meeting Aims and Objectives

6.7.1 All projects assessed within Northern Ireland have been successful in meeting their overall aims and objectives. Moreover, the original aims and objectives stipulated in their applications have not changed over time.

6.7.2 The Outreach Programme for Angina Care was developed in response to a gap in provision. The project has been extremely well received by beneficiaries who have welcomed the very localised delivery into their communities. The project has now provided a seamless link between primary and secondary care and beneficiaries are now receiving support not only in terms of helping them to mitigate risk factors but also in helping them to deal with the condition.
6.7.3 The Community Emergency Life Support Project has clearly been successful in delivering training to a wide range of groups in some very isolated communities not only in terms of geography but also in terms of hard to reach groups in those communities.

6.7.4 The Fit for Play project has undoubtedly been successful in fulfilling its aims and objectives and has succeeded in reaching some very hard to engage groups, the focus group conducted with the playworkers confirmed this with some very positive findings in terms of the training materials and resources, the training itself and the impact the training was having on practice.

6.7.5 The Nurse-led prostate cancer information and counselling project has succeeded in providing much valued service to beneficiaries and health professionals alike and this has been confirmed by a recent external audit. Additionally it has obtained a Northern Ireland Research and Quality Award for Best Practice in Province and this again is confirmation of the success of the overall project.

6.7.6 The Eastern area cardiac rehabilitation programme has completed phases 1 through to 3 and is currently establishing the credentials for completing phase 4, the project has fostered a more focused working approach, sharing of good practice and collaborative working. The project was initially developed to ensure uniformity of provision and approach, this has been developed further and there is a sense of cohesiveness amongst all staff connected with the project.

6.7.7 The activities of the Neurovascular Assessment Clinic over the past year has continued to progress and the clinic is now seeing double the number of patients per week, in order to meet this increased demand the service is reviewed on an ongoing basis.

6.8 Case Study 11
NICHS (Northern Ireland Chest, Heart and Stroke): Eastern Area Cardiac Rehabilitation Programme (Year 2)

6.8.1 The Northern Ireland Chest, Heart and Stroke (NICHS) is based within Belfast and covers the 4 Health Boards, namely: Northern, Western, Southern and Eastern. Within the Eastern Board BIG funded the Cardiac Rehabilitation Programme in the following areas: Down / Lisburn, North/West, South/East and Ulster Hospital Community Trust. The organisation promotes the prevention of and alleviation of the suffering resulting from chest, heart and stroke related illnesses.

6.8.2 The project was established within the Eastern Health and Social Services Board (EHSSB) area and targeted at those within this area who experienced a cardiac event. This affects approximately 5,500 individuals per year. The aim of the project was to standardise cardiac rehabilitation throughout the six hospital sites, namely, the Royal Victoria, Belfast City, Mater, Ulster, Lagan Valley and Downe. It was acknowledged from the onset of the application process that some hospitals and community trusts had different levels of cardiac rehabilitation services and were in some cases better resourced than others.

6.8.3 The Royal Victoria Hospital, the Mater, Belfast City and Ulster had Phase 1-3 with Phase IV delivered in a variety of settings, Lagan Valley and Downe had developed some aspects of cardiac rehabilitation with the local leisure centre, but was not as far advanced as their counterparts in other hospitals. It was arguably due to the innovation of much of the staff involved that cardiac rehabilitation was within the EHSSB particularly well organised, it was also acknowledged that much of the preparatory work had been carried out without additional funding.

6.8.4 NICHS in partnership with the hospitals concerned developed the proposal under the CHD component of the BIG Fund and under the umbrella of the EHSSB. The
assessment of need was established by the hospitals and the EHSSB and NICHS supported this assessment. The application for funding clearly identified the many gaps and inequities in the service throughout the EHSSB area. The sole aim of the application was to ensure that those who were in need of cardiac rehabilitation were able to access it. It was agreed that if cardiac rehabilitation was to be effective there had to be equity and standardisation across the EHSSB.

6.8.5 At a local level the project ensures that people who have experienced a cardiac event will have access to:

- Telephone support on discharge from hospital.
- A home visit where the person’s condition necessitates it.
- Advice and support about medication.
- Issues of general health.
- Pain control.
- Information about their condition.
- Changes they can make to their lifestyle.

6.8.6 A real benefit of this project is the telephone back up service which people can contact if they are experiencing any anxieties about their condition. Those anxieties can be fed back to the surgeon, directly bypassing the GP, which means a more effective and efficient use of resource.

6.9 Development of Project Over Past Year

6.9.1 The project has made very good progress over the past year and the following have been achieved:

- All of the components of Phase 1 and Phase 2 have now been implemented, all staff are now very well embedded in their jobs and all of the Cardiac Rehabilitation Officers are now delivering the service as specified in the standards for cardiac care.
- The last phase to be implemented will be looking at the work which will take place within the leisure centres and establishing the protocols for this.
- The project over the past year has developed a much more focused working approach. Good practice is being shared extensively and significant collaborative working is taking place. The project initially was about developing a uniformity of provision and approach and that has been developed further. The project manager commented: “There is much more a sense of cohesiveness with everybody pulling in the same direction”.
- On discharge from hospital patients receive a telephone call and one third of patients in the EHSSB who have had an acute cardiac event will receive a home visit. The whole system of referrals has been strengthened and information about patients is circulated as a matter of course.
- Some problems still exist with duplication and overlap but those problems have been greatly reduced in comparison to what occurred before. Duplication will take place, for instance, when a person has to attend two different hospitals for different
treatments and they may be seen by two different cardiac rehabilitation officers who will share information about the patient.

■ A key stage of the project has been the development of the framework for measuring the success of the project, this is now fully implemented and a whole range of data has been collected about individual beneficiaries, that information is currently in the process of being input onto a database and analysed. The analysis will be collated into a readable document in order to support the evidence base and in order to demonstrate the impact the project is having.

■ In terms of beneficiaries finding the service of benefit, the project manager commented: “People are very grateful for the service and I haven’t heard anything which would suggest that the service is not being received or that it is not being delivered to a high quality standard, I can say that other groups (such as the carers or partners of those who have had cardiac events) are also valuing the service and even other nursing personnel are learning from the experience”.

■ A particular challenge facing the project centred on the steering group. As with many steering groups which bring together diverse groups of individuals with differing ideas and ways of doing things there can sometimes be considerable barriers between them and this was certainly an issue for the project throughout its early stages. This situation has been significantly improved with most though not all of the barriers being eradicated.

■ Another issue affecting the smooth running of the steering group has been the inclusion on it of the Cardiac Rehabilitation Officers. These officers, whilst vital to the project because of their technical expertise, do not have sufficient seniority to be able to make decisions on behalf of the project regarding funding and future strategy. The inclusion of more senior personnel would allow speedier and more adaptive decision making.

■ The project manager mentioned a number of issues in relation to the development of protocols for referrals which had been initially slow to implement because of the need for agreement. However, the project management are confident, on the basis of their monitoring data, that a service is being delivered (telephone contact and visit) within the agreed standard time. She comments “I think referrals are being dealt with pretty quickly, and as far as I am aware there are no waiting lists”.

■ Over the past year a number of new strategies have also influenced and impacted upon the project, these include, the National Service Framework for Cardiac Rehabilitation, the Cardiology Review carried out within Northern Ireland and more recently the CREST Guidelines, a strategic document aimed at improving cardiac services and more specifically cardiac rehabilitation.

■ The Review of Public Administration will also undoubtedly have an impact upon the project. The Review is expected to result in the reduction of the number of Health and Social Care Trusts from the current nineteen to five “supertrusts”. This will mean that many of the cardiac rehabilitation staff will be working within one trust area thereby increasing the opportunities to share good practice and learn from each other.

6.10 Lessons Learnt

6.10.1 The development and evolution of the project has taught all staff many lessons in the following specific areas.

6.10.2 Assisting the hospitals in the Down Lisburn Area to establish their phases has been beneficial and has afforded staff the opportunity to review what was occurring elsewhere.
6.10.3 The innovative approach of setting up the telephone support and home visits into the phase of cardiac rehabilitation has strengthened the programme and has created a support network for patients newly discharged from hospital and the carers of those patients, additionally the project is well on target to meet overall beneficiary numbers.

6.10.4 Lessons have also been learnt in terms of engagement with the leisure centres. A proportion of candidates put forward for the Phase 4 exam failed to pass first time, no financial allocation had been put aside to ensure candidates could resit the exam. The project manager stated that this would have to be borne in mind when putting together future funding applications.

6.10.5 In terms of the overall project it was felt that a key opportunity may have been missed regarding utilisation of resource. It was felt that if a centralised cardiac rehabilitation facility could have been developed then that would have allowed for more impact, savings on resource would have been accrued and it would have allowed for a rotational approach.

6.11 Future Aspirations

6.11.1 The future funding of the project has not yet been assured. Project staff are currently lobbying various key individuals at all board levels to ensure that the project is kept at the forefront. Key staff have also been presenting information and findings to the Managed Clinical Networks. Ideally, staff are keen for the project to become mainstream funded, without mainstream funding it is highly likely that the project’s activities will have to come to an end. All staff would view that as a huge loss and obviously are concerned.

6.11.2 Staff have also been engaging in dialogue with key agencies such as the Eastern Health and Social Services Board whose members are now aware of the work of the project and also of what it is achieving. It is envisaged that in the future it will become possible to bring the work of the project to the attention of the Northern Ireland Assembly and also to Westminster Parliament.

6.12 Case Study 12
Causeway Health and Social Services: Outreach Programme for Angina Patients (Year 2)

6.12.1 The Causeway Trust provides a range of acute hospital, community health and social care services. The Trust serves a population of approximately 100,000 people resident mainly within a rural area. Acute hospital services are provided from the 235 bed Causeway Hospital in Coleraine.

6.12.2 The project “An Outreach Programme for Angina Patients” was developed to provide services away from the hospital and into people’s own environments. The stated aims of the project are to:

- To raise awareness of the causes and treatments of angina.
- To prevent further deterioration of symptoms.
- Where possible, to avoid unnecessary admissions to hospital.
- To provide a seamless service between primary and secondary care.
- To provide both dietary and psychosocial support to individuals.

6.12.3 The service receives referrals from the hospital setting and an initial assessment is carried out prior to discharge. Patients who are referred from other sources such as other
hospitals or community facilities are visited at home or seen at a primary health care location. Each patient is individually assessed as to frequency of further contact and follow up.

6.12.4 The project was developed following extensive consultation with individuals who were accessing support from the Cardiac Support Group and also members of primary and secondary care teams. It was felt that some individuals experiencing angina were “slipping through the net” and did not receive sufficient support to help them mitigate risk factors and help to deal with the condition. A substantial amount of mythology had built up around the condition and services were not equalised across the Northern Health and Social Services Board area. Patients’ conditions were being exacerbated and some individuals were going on to have heart attacks because of a lack of information and continuing support.

6.13 Development of Project Over Past Year

6.13.1 The project is continuing to receive referrals from all routes targeted initially, where they felt they were missing referrals from medical investigations, that situation now seems to have resolved itself and the team as a whole feel more integrated within the various departments in the hospital.

6.13.2 The work within the community has continued to progress well and the project team have established excellent working relationships with the primary care establishments they work with, this is to the extent that in some of the clinics they are considered to be part of the internal team, as a consequence the project team never experience any difficulties in accessing accommodation within which to hold sessions with patients, with regard to this the project manager stated, “they know that we follow up on patients and that we will share findings with both the GP and the practice nurses outlining the appointment with the patient and what has taken place”.

6.13.3 Further evidence of the extent to which they are embedded within the community has been their inclusion into a number of health events where they have been asked to give talks and presentations regarding the project and the issue of angina. The events have been targeted towards the disadvantaged areas including one in Ballymoney where they have been invited to speak again.

6.13.4 Demand for the project has been increasing over the past year and referrals have grown by 100% in comparison to the previous year, this has meant that there has been a sevenfold increase in the number of clinics taking place and this has had a substantial impact upon time. The situation has been alleviated to a degree because a given level of increased demand was envisaged and accounted for at the application stage, it was also anticipated that staff would be recruited onto the top end of the pay scale whereas in actuality staff were employed on the lowest increment. The resulting underspend has allowed a number of options to be considered. These include:

- Increasing the hours of the dietician from 34 to 37.5 hours to lessen the backlog.
- Employing another person (hospital based) for 2.5 hours per week again to help with the backlog.
- Having less frequency of contact with patients who are symptom free.

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2 The Northern Health and Social Services Board is the commissioning body required to assess the health and social care needs of local people and plan, secure and pay for services to meet those needs.
6.13.5 A database is currently in the process of being developed and this will enable the team to automate some of the processes particularly when letters are sent out to patients regarding their appointments and follow ups. This will hopefully free up some of the team’s time in terms of administration.

6.14 Lessons Learnt

6.14.1 What has proved to be extremely problematical has been the team’s ability to keep up with levels of demand for the service. As has been explained earlier, there has been a 100% increase in the levels of referrals and clinics have been increased sevenfold. This has had very real implications for the time demand on the team. A number of strategies are currently being considered and the evaluation team will ask about this issue again when the next round of visits take place. The project manager stated: "Because we are so busy it is very hard for us to keep abreast of new policies and strategies which perhaps we could have fed into the project to improve practice. We are currently undertaking an audit of the project and obviously we are measuring our performance against the current British Heart Foundation recommendations for the treatment and alleviation of angina". This is obviously an area of concern for the whole team and the evaluators will seek an update of this situation when the next round of visits takes place.

6.15 Future Aspirations

6.15.1 Due to the Review of Public Administration the management and delivery of health and social care is in a considerable state of flux and this is having a significant impact on the future sustainability plans of projects. Despite the “climate of uncertainty” the project manager is preparing to develop a business plan in the hope that the “pathways and funding streams” become apparent once the “process of change has been completed”.

6.16 Case Study 13

Altnagelvin Hospital: Nurse Led Prostate Cancer Information and Counselling Centre (Year 2)

6.16.1 Altnagelvin Hospital is the largest acute hospital outside the Belfast area and provides services and support to 200,000 people for general hospital services and 400,000 people for specialist services such as fractures, orthopaedics and ophthalmics. It employs around 2,200 staff and has 484 inpatient beds and 54 day case beds. Around 26,000 patients are admitted every year and the Trust treats approximately 150,000 outpatient attendances, 14,000 day cases and 49,000 accident and emergency attendances each year. In addition, Altnagelvin is one of Northern Ireland’s five cancer units.

6.16.2 The Nurse Led Prostate Cancer Information and Counselling Centre project has a number of key objectives, more specifically, these are:

- To develop a set of relevant information materials.
- To share up to date, standardised correct information to staff within the Western Health and Social Services Board areas.
- To conduct a baseline study with questionnaires distributed to all General Practitioners (GP’s) and nursing staff.
- Delivering educational sessions to GP’s, practice and treatment room nurses in the Western Board regarding prostate specific antigen testing and prostate cancer.
- To conduct a follow up survey with the same GP’s and nurses assessing the effect of the education provided on the knowledge, attitudes, and practice of the primary health care professionals and develop evidence based practice in this area of care.
To develop educational material for patients which reflect all aspects of the prostate cancer journey.

To develop and subsequently run a Prostate Cancer Information and Counselling Centre.

To ensure the project is monitored through regular meetings of the steering group.

To set up a telephone helpline for patients who were unable to travel to the centre.

6.17 Development Of Project Over Past Year

6.17.1 New developments within the project over the past year have been very much in evidence and have included:

- Supplying updated information to GP’s regarding prostate specific antigen (PSA) testing and prostate cancer, also utilising a GP internet service to disseminate information.

- Providing updated information regarding the PSA test and prostate cancer to other hospitals and particularly in acute hospital settings.

- Following up all patients utilising a recently developed database including patients who have had a negative result but who have had a high PSA and therefore still need monitoring.

- Presenting information about the project at both national and international conferences.

- Obtaining a Northern Ireland Research and Quality Award for Best Practice in Province.

- Conducting an audit of patient satisfaction with the service, the findings of which have proved to be extremely positive.

6.18 Lessons Learnt

6.18.1 The project manager commented: “I think the fact that we are now following up all patients has been something extremely positive. Not just those who have had positive results, but those who have had negative results, but may still have quite high PSA results and may require monitoring and follow up. That is something which we have had the benefit of experience to learn from.”

6.19 Future Aspirations

6.19.1 According to the recently completed customer satisfaction audit, services at the centre are being extremely well received by both patients/families and significant others. The telephone service is being widely utilised by the same group and also by other healthcare professionals, patients have stated that they now feel empowered to participate in shared decision making and can make informed choices about their care. A current external evaluation is being conducted by evaluators commissioned by the Western Health and Social Services Board. This will be used to provide the evidence supporting an application to the Trust for mainstream funding. It is hoped that the service will extend to other cancers such as testicular, renal and bladder cancers.
6.20 Case Study 14
PlayBoard: Fit For Play (Eastern/Western/Southern) Year 2

6.20.1 PlayBoard is the lead agency for children's play in Northern Ireland, working to improve the quality of children's lives by increasing their opportunity to play. This case study refers to all 3 projects and the findings detailed are as result of discussions with the Regional Manager and the three Training and Development Officers for the Eastern, Western and Southern areas.

6.20.2 The Fit for Play Quality Award can be obtained once a project is deemed "Fit for Play". The project provides a training programme as part of the quality award scheme. The training programme is delivered by the Training and Development Officers based in the Eastern, Western, Southern and Northern regions and comprises of three modules which are:

- Out 2 Play – this module is a play based programme which encourages play providers to enable children's physical free play, especially outdoors.
- Top Play/Active Clubs – this module is a physical activity programme developed by the Youth Sports Trust. Active Clubs is again a physical activity programme developed by 4Children (previously known as the Kids Club Network) and the British Heart Foundation.
- Food 4 Play – this module has been developed in partnership with the Health Promotion Agency, Community Dieticians and Environmental Health Officers. The training focuses on the provision of healthy snacks and drinks, with children's participation.

6.20.3 The award has been designed to tackle the obesity crisis which is affecting children in today’s society and gives them opportunities to enjoy physical and outdoor play thereby helping to prevent heart disease and health related problems in later life.

6.20.4 The Training and Development Officers will have an initial visit with the playworkers to conduct a baseline assessment to initiate the process of reflective practice in meeting the minimum standards, which are:

- Half an hour of physical activity per day
- One session of five outdoors.
- Healthy snacks with children involved in the preparation.

6.20.5 The children will amass a lot of skills during play including teamwork, co-operation, negotiation skills and risk assessment.

6.21 Development of Project Over Past Year

6.21.1 The project has been conducting a lot of the preparatory work necessary to secure future funding and this has involved:

- Application to and a Green Book appraisal by the Sports Council for Northern Ireland which has agreed to provide extra funding for the coming 2 ½ years ending December 2008.
- Examining the strategies currently in development such as the Play Policy, also looking at “Fit Futures” and “Investing for Health” to make assessments about where the project is likely to secure more long term funding.
The project manager is currently developing the format of the next Fit for Play project which will involve:

- Still keeping the same name and staying with an emphasis on health and welfare but emphasising the physical literacy element.
- Developing training for parents and management committees and trying to challenge some of the barriers to outdoor and physical play.
- Exploring options to deliver Top Outdoors to ensure that playworkers can draw on even more ideas of what to do when outdoors.
- Exploring the possible development of a physical literacy training programme specifically for playworkers to take the place of Top Play.
- Developing and supporting playworkers to help them deal effectively with management committees, parents and inspectors of childcare facilities.

6.21.2 The Fit for Play project has achieved the following targets. See Table 7 below:

**Table 7: Achievements by Fit for Play Project**

<table>
<thead>
<tr>
<th>Board</th>
<th>Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>173 playworkers</td>
</tr>
<tr>
<td></td>
<td>2482 children</td>
</tr>
<tr>
<td></td>
<td>Three groups working towards award</td>
</tr>
<tr>
<td></td>
<td>18 groups fit for play</td>
</tr>
<tr>
<td>Western</td>
<td>147 playworkers</td>
</tr>
<tr>
<td></td>
<td>1814 children</td>
</tr>
<tr>
<td></td>
<td>No groups working towards award</td>
</tr>
<tr>
<td></td>
<td>10 groups fit for play</td>
</tr>
<tr>
<td>Southern</td>
<td>219 playworkers</td>
</tr>
<tr>
<td></td>
<td>3919 children</td>
</tr>
<tr>
<td></td>
<td>No groups working towards award</td>
</tr>
<tr>
<td></td>
<td>18 groups fit for play</td>
</tr>
</tbody>
</table>

6.21.3 The Training and Development Officers have been quite successful in engaging with a number of partnerships and agencies across all areas including a number of health promotion agencies, physical activity partnerships and investing for health partnerships. In terms of beneficiaries the co-ordinators have also engaged with some hard to reach groups including individuals who are living in women’s refuges, they also have built on and consolidated some of the work happening with both traveller communities and Eastern European migrants.

6.21.4 The project manager is currently in the process of trying to recruit a research and administrative support person who will contribute to the evidence base for the project.
Their role will involve collation and analysis of all the data which has been collected for the project as well as developing methods of building more robust evidence.

6.21.5 The project has recently received an award for its training resources from the Northern Ireland Council for Voluntary Action and the Youth Council has recently awarded the project a commendation in respect of its health category.

6.22 Lessons Learnt

6.22.1 There have been many lessons learnt in terms of where improvements could be made to training and these have been discussed earlier in the report, particularly in terms of addressing barriers. The project manager expanded by saying: “We have had opportunities to talk to social workers and we have taken advantage of those opportunities but now we need to make a more concerted effort by setting up a training day for all inspectors”.

6.23 Future Aspirations

6.23.1 Although the project has been successful in attracting future funding from the Sports Council for Northern Ireland, it will be necessary to secure additional, longer term funding from other sources. This will involve scrutiny of a number of strategies currently in development, including, the Play Policy, “Fit Futures” and “Investing for Health”.

6.23.2 The evaluators took the opportunity of conducting a focus group with four playworkers from the Eastern Board area. The playworkers were asked to comment about the training, the training materials and the impact on their practice. Material gathered has been included as appendix which can be found at the rear of this report (Appendix B, Fit For Play Focus Group Feedback).

6.24 Case Study 15
Homefirst Community Trust: Community Emergency Life Support (Year 2)

6.24.1 Homefirst Community Trust is the largest community trust in Northern Ireland. The Trust employs over 5,300 staff and provides health and social services to approximately 327,000 people in the Borough and District Council areas of Antrim, Ballymena, Carrickfergus, Cookstown, Larne, Magherafelt and Newtownabbey. The aim of the organisation is to work with communities to provide the best care and to provide them with the information and support to make informed choices which promote health and well being.

6.24.2 The project aims to raise awareness and deliver training in Emergency Life Support Skills to schools, community based groups and the three Health and Social Services Trusts within the Northern board area. The project team continue to work in partnership with the British Heart Foundation’s Heartstart (UK) Initiative. The training has several key elements which include: procedures for getting help; dealing with an unconscious breathing person; giving rescue breathing; performing cardio-pulmonary resuscitation; dealing with serious bleeding; dealing with choking; dealing with a suspected heart attack casualty.

6.25 Development of Project over Past Year

6.25.1 Overall the project has developed rapidly over the past year and there have been a number of changes:
The three project workers have continued with the project, and one member of staff has increased her hours from part time to full time to cover an extra geographical area.

When evaluators spoke to project staff the project was nearing its second year of completion. Target figures for beneficiaries for the three years of the project had already been exceeded by approximately 6,000. Project staff estimate that they will in all probability exceed their target figures by as much as 100% or possibly more. What is apparent is that the volume of beneficiaries is currently outstripping the ability of the project staff to provide training. In relation to this the project manager commented, “the project has and will continue to create an expectation for training which cannot be fulfilled and this will be compounded by the lack of permanent funding available for projects like this”.

All project workers have also connected with a number of hard to engage groups which have included:

- Single parents where again modification is required because they are not able to attend without their children. The project has linked in with agencies such as Barnardos and Surestart to facilitate that aspect. Training also covers childhood emergencies which is not a formal part of the programme but was considered a necessary element in order to attract single parents in the first place.

- Farmers remain as a particularly difficult cohort to reach.

The project has continued to target more schools and has recently been asked to provide training in partnership with the community paediatric team for staff dealing with children who may have allergic reactions. The project has provided a specific training programme working with their clinical colleagues to ensure best practice.

Increased demand has also had an extra pull on the project’s resources, particularly the training materials and the project manager has had to approach the British Heart Foundation and apply for a grant of £15,000 in order to purchase the training materials and resources necessary to provide some extra training and make the project more widely available to schools.

The project staff are continuing to target rural communities, this is a vital element of their work as these communities tend to be remote, as a consequence ambulance response times tend to be long, because of this it is considered that individuals within these communities could be the first responders in an emergency situation and indeed the project has received some confirmation via feedback from internal evaluation that this has been the case. Individuals have cited instances where they have had cause to utilise the training particularly where cases of choking have occurred.

The project staff have also been conducting training with a number of clinical and medical staff. The project manager commented that they have been providing staff training and supporting their clinical colleagues in the resuscitation training teams: “The project workers are providing training for health care professionals from community and primary care settings and acute care. In Year 2 of the project a total of 618 staff have been provided with training and this is set to increase this year”.

In addition they have provided training to receptionist staff within General Practice. The training provided has promoted best practice and encouraged practitioners to adopt new and innovative ideas within primary care which could be considered to be a tremendous achievement. The project manager commented that what has to be remembered is that “this training is really fulfilling a need in terms of developing best practice.”
In the last year new guidelines have been issued by the Resuscitation Council UK, the organisation responsible for governing the work of the project. This has meant that the training packages and other materials have had to be revised. The revisions have had to be explained to the many volunteers who take responsibility for delivering training, in relation to this the project manager commented “the British Heart Foundation have been very proactive looking at their own materials, but equally, we have had to be proactive in ensuring that the new guidelines are adhered to”.

Changes to the educational curriculum have also impacted upon the project, this has happened within both the primary and post primary sectors, this revision has meant that the project now has very good fit with some of the key elements within the curriculum and project staff have been able to exploit further opportunities to interact with school children, the project team commented, “for some pupils who are less able academically getting the Heartstart training has given them a sense of achievement and for some of the more academically able the training has been used to develop their interest in medicine, or nursing or the paramedic service”. In addition to this the children are given an opportunity to participate in a range of situations which in turn improves their communication skills and their confidence, they are also encouraged to use their creativity whilst inventing new scenarios and roleplays.

There is a great deal of internal monitoring and evaluation work happening currently and the team are in the process of conducting an audit, this will result in the production of several individual area reports and a general report and will outline findings around user satisfaction and impact.

6.26 Lessons Learnt

6.26.1 Project workers have acknowledged that they need to do more to engage migrant workers and men onto the project and they have looked at developing a number of strategies to help attract these groups, these include:

- Providing male only training sessions
- Providing awareness sessions for public sector workers
- Providing snapshot sessions where key issues and risk factors particularly relevant to men’s health are discussed

6.26.2 The project manager commented “men’s health is very important and they are under under-represented so anything that the project can do to redress the balance is a very good thing”.

6.27 Future Aspirations

6.27.1 The project is clearly meeting an identified gap within provision and also seems to be targeting those isolated communities most in need of the service. It is clearly engaging hard to reach individuals and is doing so cost effectively because it is very well supported by volunteer members. It provides a very good model for partnership working which can be problematical particularly if the involved members have their own agendas and find it difficult to work out the commonality.

6.27.2 Despite all these factors it will be a significant challenge to raise the funding necessary to maintain continuity of the project. The project manager has already approached the British Heart Foundation regarding funding for staffing but they have made it clear that they will only fund resources. The project manager is also considering the option of looking to BIG to fund the added value element of the project, she is also attempting to
lobby both at a board level and at a trust level but the agencies themselves are going through a period of change at the moment and that is further complicating the issue, the project manager commented that because of the massive changes taking place “it is a very difficult time to looking for funding of any kind”.

6.28 **Case Study 16**

**Craigavon Hospital: Neurovascular Assessment Clinic (Year 2)**

6.28.1 The main acute hospital in the Southern area of Northern Ireland, Craigavon Area Hospital provides a full range of acute services and is the designated cancer unit for the Southern Board. The hospital has 429 beds with a further 36 made available in January 2003. In November 2002, the first purpose built out-patients cancer facility in Northern Ireland opened and a £1 million extension and refurbishment programme in Accident and Emergency was carried out during 2002.

6.28.2 The aim of the project is to establish a neurovascular assessment clinic to ensure that patients with a suspected transient ischaemic attack (often described as a temporary stroke) can be referred rapidly for specialist opinion with the overarching aim to minimise the risk of occurrence of stroke, early referral allows for the accurate diagnosis, modification of risk factors and identification and treatment of any specific disease.

6.29 **Development of Project over Past Year**

6.29.1 The project has continued to progress satisfactorily and there have been a number of new developments over the past year, which include; the number of new patients seen at the clinic each week have almost doubled and in order to meet this increased demand the service is continuously being reviewed to bring down waiting times; a revised proforma with a scoring system has been developed and circulated to general practitioners in the area to allow more appropriate prioritisation of patients. The project continues to have the same contingent of staff, including a specialist nurse, some administrational support and 2 consultants both of whom are employed on a whole time equivalent of 0.1 each.

6.30 **Lessons Learnt and Future Aspirations**

6.30.1 The project is currently looking at ways to secure future funding but the project manager did not expand further on that statement.
7 Discussion and Conclusions

7.1 Questionnaires

7.1.1 There were 134 completed questionnaires from the 218 originally sent out. Although the response rate was well over half, at 61.5%, it should be borne in mind that those projects not returning a questionnaire may not have been as positive in their comments and opinions as those contained herein.

7.1.2 The reasons why some projects did not complete or return questionnaires can only be surmised. However, taking some of the comments into account from those projects that did complete questionnaires, some of the following reasons may have applied (points 7.1.3. to 7.1.6). Such comments may be useful in considering the methods used to maximise responses for future questionnaires.

7.1.3 Many projects were in the process of endeavouring to find future funding, and the questionnaire may have arrived at a period when a project was already working to maximum capacity, and were therefore unable to respond.

7.1.4 Some projects commented that they were understaffed, had lost key staff, were not resourced for extra administrative work, or were at the end of their project. Any of these factors could have determined a project's non-response.

7.1.5 A small number of projects (less than ten in number) commented that the questionnaire was being completed by an individual who felt under-qualified to answer some of the questions. A typical example of this being an administrative worker completing a questionnaire on the project's behalf but unable to comment on the project impact on people's lives or access such information from an appropriate colleague.

7.1.6 A small number of projects (fewer than twenty), commented that the questionnaire actually required far longer to complete than the twenty minutes stated in the introduction. The length of the questionnaire and the time required in order to complete it by hand may have been factors that prohibited some projects from returning it.

7.1.7 There are alternative or additional methods to consider using for future questionnaires. Whilst the paper based questionnaire appeared to work well for many projects, other electronic options may elicit a higher response rate. These additional methods could include a web-based form to complete online, a downloadable template, or an e-mail request for a Word (or similar) document template. A non-electronic alternative method to a paper based questionnaire could be telephone or face to face interviews.

7.1.8 Many projects have developed over time in relation to what they deliver. There has been an increased demand in some project services. An example being the Training for Palliative Care project, due to an increase in referrals in palliative and terminal cases.

7.1.9 Some projects have needed to take on board additional training and areas of expertise. A typical example is a project whose aim is to stop young people smoking. When discussing smoking cessation with parents and/or older young people it was necessary to discuss other diet and nutrition and exercise at the same time. This in turn led to increased training and education for the development workers.

7.1.10 As some projects have evolved there have been various changing demands on the skills of staff. Many projects have proven themselves to be adept at changing and evolving over the project lifespan, as new areas of expertise are required and new skills that were not originally envisaged are required. Examples of this are given in 7.1.10 to 7.1.14.
7.1.11 For instance, staff on a breast cancer rehabilitation scheme that aims to improve quality of life of patients gained qualifications as pilates instructors. This enabled the project to offer an additional course that had not been anticipated at the project outset.

7.1.12 Another example is where a clinical nurse specialist for breast cancer on a community cancer partnership project wanted to commence a lymphoedema clinic. The partnership agreed funding for training from project slippage monies.

7.1.13 A telemedicine project found itself in higher demand than expected to present at conferences. This in turn led to more staff being trained on the usage and set up of the equipment than originally planned. A significant proportion of staff are now familiar with setting up the equipment for use and have become more comfortable in front of camera and when contributing at a conference.

7.1.14 On a Kickstart project aiming to reduce CHD, the project coordinator needed to develop an understanding the issues for the client group and how best to motivate the objectives. At the same time there was been a significant increase in general promotion of healthy lifestyle issues, which required the coordinator to research into a new area of knowledge.

7.1.15 These increased staff skills can be categorised as follows:

- Marketing.
- Presentation and public speaking.
- I.T skills, including website development.
- Development of facilitation, leadership and project management skills.
- Education and training in the project area of expertise (clinical and non-clinical), including gaining expertise on statutory, legislative and policy implementation in the relevant field.

7.1.16 There are many positive examples of partnership working across projects. Partnership working has flourished in many different ways. This is best illustrated by the following examples. (7.1.17 to 7.1.20).

7.1.17 The Actively Preventing Cancer project saw key creative ideas generated from all sectors at the project board meetings. For example, the representatives from the Gorbals Healthy Living Network and the Scottish Nutrition and Diet Resources initiative combined to suggest a schools’ design competition that was taken through to final completion with local pan-Glasgow publicity.

7.1.18 A project providing easy and accessible information on services for cancer patients and their families provides a typical example of how partnership working has generated wider input and levels of expert knowledge. The steering group of a charity and voluntary organisation, a local council and the project itself led to greatly improved website content.

7.1.19 Several projects aiming to promote nutritional awareness amongst children have developed good relations giving access to schools, educational departments, health professionals and with the private sector. For instance, with improved marketing of promotional materials and with local fruit and vegetable suppliers.

7.1.20 There may be scope for projects to target a wide range of potential partners who can provide knowledge and resource as well as support through involvement. One such project targeting a healthy lifestyle and prevention of CHD across the whole community had a wider range of partnerships than most. These partners included an anti -drugs
community youth rugby initiative, a religious tolerance initiative, a local ambulance society and local traders and private companies providing contributions and resources, a grocers, the local police, a car showroom, local and national sports bodies and a national pharmacy.

7.1.21 There are many statutory, voluntary and private partnerships that have been well established within projects and are expected to continue to flourish after projects come to an end.

7.1.22 A key issue for the final year of the evaluation appears to be how to ensure future funding after the end of a project’s life. There are many projects that report highly successful take up of their services and have achieved or exceeded targets.

7.1.23 Although many projects are identifying and moving towards potential future funding, there is a level of great concern amongst many that this is not guaranteed. Having increased the knowledge of and shown the impact of reducing CHD, there is a feeling that the education training and awareness achieved may all cease at the end of the project.

7.1.24 Some projects have found demand has exceeded expectation and although that is a sign of success and measurement, there is apprehension that without funding there may be negative future outcomes.

7.1.25 The majority of projects that completed a questionnaire report that they are meeting targets, have good working partnerships, and in most cases are looking for future funding.

7.2 Case Studies

7.2.1 Taking an overview of the 16 project managers evaluators interviewed in the course of the evaluation it can be concluded that all project managers considered that they have successfully met their originally intended aims and objectives of their projects.

7.2.2 Most project managers agreed that they had addressed inequalities in provision both geographically and in terms of standards of provision, some project managers believed that they had provided activities and services where previously there had been obvious gaps in provision.

7.2.3 All project managers agreed that they had linked successfully with both local and national strategies. Most project managers cited strategies developed in the past year which would be used to support future funding applications.

7.2.4 All project managers considered that their services had positively impacted upon the intended beneficiaries and that furthermore they were targeting their services towards communities and localities which had hitherto been uncatered for. Some project managers considered that their projects had reached and benefited individuals who were not the intended beneficiaries project managers had originally envisaged.

7.2.5 Most projects managers believed that they had developed new and innovative methods of delivering services and activities and that this was to the benefit of individual beneficiaries.

7.2.6 Opportunities to speak to beneficiaries confirmed the positive impact projects were having on them in a wide variety of ways.

7.2.7 All project managers have in the last year been very active in determining how their projects can be sustained, however, only one project has been successful in gaining funding for a further three years. Within the separate countries involved with this evaluation there were obviously different contextual issues to consider, these include:
Within Northern Ireland a Review of Public Administration is taking place and most project managers consider that this will have major consequences for funding streams in the future. There was division amongst project managers as to whether the review would have a positive or detrimental effect upon the future sustainability of their respective projects.

Within Scotland the Managed Clinical Networks will sustain hospital based projects until mainstream funding sources can be identified and accessed, in contrast projects based outside of the hospitals still face considerable uncertainty as to where their funding is likely to come from in the future.

Within Wales, one project has been successful in gaining funding for a further three years, all other projects managers are persevering at identifying suitable funding options in readiness for BIG funding coming to an end.
Appendix A: Survey Questionnaire
Introduction

Thank you very much for completing this questionnaire. It should take no longer than twenty minutes to complete. The questionnaire has been designed to help us assess:

- The extent to which the Big Lottery Fund funded programmes have succeeded in meeting their overall aims and objectives;
- The extent to which each projects has addressed inequalities in provision; and
- How far projects have linked with relevant local and national strategies.

The questionnaire is divided up into the following nine sections:

1. **Organisational detail** – this is to help us identify the project being evaluated.
2. **Your project** – this will identify the activities your project is undertaking and whether these have been modified since implementation.
3. **Partnership arrangements** – to help us identify any partnerships that have been made as a result of the programme.
4. **Delivery and management** – to look at the systems and processes in place to deliver the projects aims and objectives.
5. **Beneficiaries** – to help us identify your target group and how successful you have been in reaching them.
6. **Evaluation, impact and shared learning** – to help us identify what evaluation systems are in place and what perceived impact your project has had. Also to help us identify lessons that have been learnt and any innovative ways of working that have been developed and shared.
7. **Sustainability** – to help us look at systems in place to move forward.
8. **Conclusion** – this is a self-assessment to determine how successful you feel you have been in meeting your aims and objective etc.
9. **Any other comments**.

We are aware how busy you are and are extremely grateful to you for finding the time to complete this questionnaire. Please follow the instructions carefully as the response options are varied.

If you have any questions or queries about this questionnaire, please contact Chrissy Brand on 07913 213246 or at chris.brand@tribalsecta.co.uk

Please return the survey by 06th October 2006 to Chrissy Brand. We have enclosed a SAE for this purpose. Thank you very much for your time and we look forward to receiving your response. **If completing electronically please just double click on the tick box to insert a tick.**
1. Organisational Detail

1. Name of Organisation: ______________________________________________________

2. Country: (please tick) Wales ☐ Northern Ireland ☐ Scotland ☐

3. Person completing this form:
   
   Name: _________________________________________________________________
   
   Job Title: _______________________________________________________________
   
   Date form completed: _____________________________________________________

2. Project

4. Project Title: _____________________________________________________________

5a. Please outline your aims and objectives in bullet points if possible:

   •
   •
   •
   •
   •

5b. Have these been modified since your project began? (Please tick)

   Yes ☐ No ☐ Don't Know ☐ N/A ☐

   If so, how and why?

   _______________________________________________________________________
   _______________________________________________________________________

6a. Does your project target the following (Please tick all that apply)

   Cancer ☐ CHD ☐ Stroke ☐ Other ☐ Please specify ________________

   _______________________________________________________________________
   _______________________________________________________________________
6b. Does it include any of the following activities? (Please tick all that apply).

- Screening and Diagnostics
- Rehabilitation
- Education and Information
- Targeting of lifestyle risk factors

If so, which ones:

- Smoking Cessation
- Nutrition and diet advice
- Exercise
- All
- Other

- Improved access to services
- Equipment
  - Non-medical
  - Medical
- Continuing care and support
- Community Development
- Other (Please specify)

6c. Have these activities changed over time? (Please tick)

- Yes
- No
- Don’t Know
- N/A

If so, in what ways?

3. Partnership arrangements

7a. How would you rate the effectiveness of how successful your engagement with a) statutory sector, B) Voluntary and community sector and C) Private sector? (Please circle)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Partially</th>
<th>Totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Statutory Sector</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B. Voluntary Sector</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>C. Private Sector</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
7b. Please comment on your experience:

_________________________________________________________________________________
_________________________________________________________________________________

8. Have local partnership(s) been developed in order to meet your aims and objectives? (i.e. deliver Big Lottery Fund activities). (Please tick)

Yes ☐ No ☐ Don’t Know ☐ N/A ☐

If so please provide an example
_________________________________________________________________________________
_________________________________________________________________________________

9. Have there been any changes to these partnership arrangements? (Please tick)

Yes ☐ No ☐ Don’t Know ☐ N/A ☐

If yes, please explain the changes and why
_________________________________________________________________________________
_________________________________________________________________________________

10. Has the project resulted in more local people being involved, for example in the running of the project, volunteering or other ways? (Please tick)

Yes ☐ No ☐ Don’t Know ☐ N/A ☐

If yes, please provide an example
_________________________________________________________________________________
_________________________________________________________________________________

4. Delivery and Management

11a. What management arrangements are in place to ensure that the project is effectively managed and delivered?
11b. Do your management arrangements include representation from: *(Please tick)*

Staff ☐ patients/users ☐ carers ☐ others ☐, please specify

___________________________________________________________________________

12a. Does the project currently have the full complement of appropriately skilled and qualified staff necessary for successful delivery? *(Please tick)*

Yes ☐ No ☐ Don't Know ☐ N/A ☐

If no, please explain:

___________________________________________________________________________

_______________________________________________________________

12b. Have the skills required by staff to deliver the programme changed over time? *(Please tick)*

Yes ☐ No ☐ Don't Know ☐ N/A ☐

If so, please explain:

___________________________________________________________________________

_______________________________________________________________

5. Beneficiaries

13a. Who are your target beneficiaries? *(Please tick all that apply)*

People with CHD ☐ People at risk of developing CHD ☐
People recovering from Stroke ☐ People at risk of a Stroke ☐
People with Cancer ☐ People at risk of developing Cancer ☐

Do you target particular groups? If so, please tick all that apply

BME groups ☐
Low income groups ☐
Homeless ☐
People with poor access to services ☐
Carers ☐
Evaluation of “Reducing the burden of CHD, Stroke and Cancer” Programme

Children and Young People (0-18) □
Adult (18 – 64) □
Older People (65+) □
Special needs groups □
Other (please specify □

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

13b. Has the service been as successful as predicted/hoped in reaching your target groups? (Please tick)

Yes □  No □  Don’t Know □  N/A □

Please explain:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

14. Do you have a procedure or system in place to help identify and target the most vulnerable groups in the local area? (For example research, reviews of literature, data monitoring) (Please tick)

Yes □  No □  Don’t Know □  N/A □

If Yes, Please explain:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

15. Do you have a procedure or system in place to help improve access to services and facilities for the local population? (Please tick)

Yes □  No □  Don’t Know □  N/A □

If Yes, Please explain:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
6. Evaluation, Impact and Shared Learning

16a. Has the project undertaken any of the following internal or external evaluations? (Please tick all that apply)

<table>
<thead>
<tr>
<th>Evaluation Type</th>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient/user satisfaction surveys</td>
<td></td>
<td></td>
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<tr>
<td>Staff satisfaction surveys</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If so, please specify___

16b. Have the results/findings of the evaluation(s) been disseminated? (Please tick)

- Yes
- No
- Don’t Know
- N/A
- N/A

If so, who to?

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

17. Have you seen any impact of your project in reducing the risk or incidence of CHD/Stroke/Cancer? (Please tick)

- Yes
- No
- Don’t Know
- N/A
- N/A

If so, Please provide an example:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

18. Have you seen any reduction in the impact that CHD/Stroke/Cancer has on people’s lives as a result of your project? (Please tick)

- Yes
- No
- Don’t Know
- N/A
- N/A

If so, Please provide an example:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
19a. Has the project resulted in the development of any innovative (new) approaches to meeting the needs of the target population? *(Please tick)*

- Yes  [ ]  No  [ ]  Don’t Know  [ ]  N/A  [ ]

If so please provide an example.

_________________________________________________________________________________
_________________________________________________________________________________
______________________________________________________________

19b. Could you provide up to 3 benefits for users that have resulted from your programme?

1.

2.

3.

19c. Has this learning been shared (disseminated) with other projects or organisations? *(Please tick)*

- Yes  [ ]  No  [ ]  Don’t Know  [ ]  N/A  [ ]

If so please provide an example.

_________________________________________________________________________________
_________________________________________________________________________________
______________________________________________________________

20a. Could you provide up to 3 examples of challenges and lessons learned from the project.

1.

2.

3.

20b. Has this learning been shared (disseminated) with other projects or organisations? *(Please tick)*

- Yes  [ ]  No  [ ]  Don’t Know  [ ]  N/A  [ ]

If so please provide an example.

_________________________________________________________________________________
_________________________________________________________________________________
______________________________________________________________
7. Sustainability

21. Does the project have plans in place for service continuation? *(Please tick)*

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
<th>N/A</th>
</tr>
</thead>
</table>

If so, does this include: *(Please tick)*

- Secured funding
  - Yes
  - No
  - Don’t Know
  - N/A

If so, from whom ____________________________________________________________

- Activities taken on by another organisation
  - Yes
  - No
  - Don’t Know
  - N/A

If so, by who_______________________________________________________________

- Other (If so please describe your situation)
  - __________________________________________________________
  - __________________________________________________________
  - __________________________________________________________

8. Conclusion

22. To what extent do you believe you have met your overall aims and objectives? *(Please circle)*

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Partially</th>
<th>Totally</th>
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<tbody>
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<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Please explain:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
23. To what extent do you believe you have addressed inequalities in provision? (*Please circle*)

Not at all  Partially  Totally
0 1 2 3 4 5 6

Please explain:
_________________________________________________________________________________
_________________________________________________________________________________
______________________________________________________________

24. To what extent do you think your project has linked in with local and national strategies? (*Please circle*)

Not at all  Partially  Totally
0 1 2 3 4 5 6

Please explain:
_________________________________________________________________________________
_________________________________________________________________________________
______________________________________________________________

9. Any additional comments

25. Any additional comments?
Appendix B: Fit For Play Focus Group Feedback
Fit For Play Focus Group Feedback. (See Also Case Study 14)

The Evaluator also took the opportunity of conducting a focus group with four playworkers from the Eastern Board area. The playworkers were asked to comment about the training, the training materials and the impact on their practice. The following comments were then gathered:

- **Training Materials And Resources.**
  - “Training materials are very good and just enough, they are ideal for giving you ideas and helping with planning, they are also fairly straightforward to explain.”
  - “The Spirals with their quality criteria allow you to assess your practice, the programme is child-friendly and child focused. Playboard staff come out to the project/group and ask the children what the playworkers provide and do, the children will always be honest.”
  - “The venues are good spaces, they give you ideas for the space required and the resources you are likely to need, they are usually in good surroundings for being silly.”
  - “The training is innovative and is not always delivered in a room, you get the opportunities to go outdoors, and there is very much a hands on approach, importantly the course is actually fun!”

- **Training.**
  - “Tutors deliver the content at the right level and their enthusiasm is good, the practical element is good because it gives you the confidence to be able to do it with the kids.”
  - “Evaluation is always done at the end of each session and at the end of any full course, the informal opportunities for networking also increase learning.”

- **Training And Impact On Practice.**
  - “Practical knowledge is important, we get a certificate which means we have learnt about the child’s right and need to play, it challenges you to reassess your role as a playworker.”
  - “Because of the training parents have started to trust us.”
  - “Spirals convince the Management Committees of the need to do certain things, particularly if you are to attain the award, the training also gives you the arguments to use with parents about what children will gain from play.”
  - “Our approach has changed, we allow children to resolve their own problems and this means they learn to work together, in terms of inclusion it has opened our mind and changed our attitudes towards the children, changed the way we involve all children and the way we play games.”
  - “They now see that we are doing it not just because we have to but to get the best for the children, its ok to go beyond, we enjoy the work, the team work better together and we have become more efficient.”
  - “This year 70% of the children came back from school sports day with medals, last year none of them took part.”