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

Year 1 Report
Evaluation of ‘Reducing the burden of Coronary Heart Disease, Stroke and Cancer’ Programme in Wales, Scotland and Northern Ireland

Year 1 Report

February 2006

Martin Spollen
Director, Tribal Secta Ltd

Andrew Rix
Director, CRG

Paula Shinton
Consultant, CRG

Paul Dixon
Consultant, Tribal Secta

This report was researched and written for the Big Lottery Fund by Tribal Secta in partnership with CRG. The authors of the report are Martin Spollen, Andrew Rix, Paula Shinton and Paul Dixon.

Copyright: Big Lottery Fund 2006
Published by: Big Lottery Fund
1 Plough Place,
London, EC4A 1DE
Tel: 0207 211 1800
Fax: 0207 211 1750
Email: e&r@biglotteryfund.org.uk

Use of material in this report must be appropriately acknowledged.

© The Big Lottery Fund
CONTENTS

Executive Summary  i - iii
Summary of Projects  iv - viii

Introduction  1 - 5
Evaluation Methods  6 - 8
Case Study Selection  9 - 12
Case Study Report Update  13 - 70

Northern Ireland  13 - 32
Scotland  33 - 50
Wales  51 - 70

Country Overview  71 - 72
Next Steps  73 - 74
EXECUTIVE SUMMARY

i. This report is about the evaluation of the first year of 200 projects funded by BIG, all of which have as their focus “Reducing the burden of Coronary Heart Disease, Stroke and Cancer” in Northern Ireland, Scotland and Wales

ii. A total of £37m is available over a three year period (£26.6m in Scotland, £9.4m in Northern Ireland and £10m in Wales) and the report describes the different focus in each of the three countries.

iii. 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. The report, as a report of the first year of operation focuses on the case studies as it is too early to draw conclusions for a tracking study. The report describes a standardised approach to case study data collection which highlights:

   - “progress”
   - “what works”
   - “fit with other initiatives”
   - “issues of development and sustainability”.

iv. The programmes to be evaluated are:

   - new opportunities for health – coronary heart disease, stroke and cancer (in Scotland and Northern Ireland), and
   - coronary heart disease, stroke and cancer (in Wales).

   This evaluation will not cover any of the programmes operating in England and all case studies were carefully selected to ensure a spread of projects by type of intervention and activity.

Links with public policy and local strategies

v. All of the Northern Ireland, Scottish and Welsh project managers without exception outlined strategies both wider and more local that their particular projects had fit with – as evaluators we were not
surprised by this as there is a requirement in the initial application to demonstrate a fit with relevant strategies. It was generally acknowledged by all that although projects had continued to evolve, their basic aims and objectives remained the same and therefore they continued to fit with those strategies. As expected, most strategies mentioned by project managers were health related and were either internal to the trust or were linked to wider strategies.

**Partnership working**

Examples of partnership working, through interviews with project managers, were extremely strong. These included:

- The Scottish “Heart Matters” project which has been wholly planned and delivered in partnership between three voluntary agencies.
- The Fit for Play project in Ireland, which has an established network of coordinators who are working with a very wide range of agencies and groups including both Catholic and Protestant groups and traveller groups, which it is widely accepted are one of the most challenging groups to be able to reach; in addition they have also made significant inroads into working with newly migrated Eastern Europeans.
- In Wales, the Breast Cancer Rehabilitation project works in partnership with a range of agencies both internally and externally and has developed a series of user forums aimed at different age groups, all of which have spokespeople who can feed in user views and experiences to the Management Development Team. Additionally, informal communication channels exist to encourage debate about the project.

**Project delivery, management and development**

Projects in all three countries appear to have done a great deal of work in terms of informing individuals and other agencies what it is they have to offer. In addition they continue to make themselves known to other groups and individuals who they feel would benefit from their services/support. Word of mouth clearly has had an important part to play in this scenario and sometimes projects have found themselves overwhelmed by the level of interest in their projects – this has proved
to be one of the more challenging aspects of project management and certainly some projects have found it quite difficult to keep up with the level of demand.

From a targeting perspective we found that most projects in Scotland and Wales have continued to aim their services and support towards those most in need and appear to have appropriate referral mechanisms in place to ensure that happens. In Northern Ireland there appeared to be a greater desire to deliver projects which are of equal standard in all of the communities they serve.

**Difficulties and good practice**

Overall, most project managers across all three countries do not appear to be experiencing any major difficulties in either the delivery or management of their projects with only minor exceptions, largely due to staff inexperience of staff shortages. Examples of good practice have been evident in nearly all projects in all three countries, the most notable include:

- training and assessment processes which meet recognised clinical standards
- improved assessment processes which result in more appropriate referrals from primary care.
## SUMMARY OF PROJECTS

### NORTHERN IRELAND PROJECTS:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Project</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Ireland Chest Heart and Stroke Association (Charitable/Voluntary Organisation)</td>
<td>Eastern Area (Phase 1) Cardiac Rehabilitation Phase 1 Programme</td>
<td>The project objectives centre upon: developing a steering group; agreeing standards for Phase II cardiac rehabilitation home visits in the EHSSB area, criteria for selecting patients for a home visit and developing clear links with the various elements of the Eastern Cardiac Rehabilitation Programme.</td>
</tr>
<tr>
<td>Homefirst Community Trust (Voluntary and Community Organisation)</td>
<td>Community Emergency Life Support</td>
<td>To develop and integrate training programmes in the NHSSB key areas which are: schools; cardiac rehabilitation; Northern Neighbourhoods Health Action Zone; and Community Development Initiatives. Networking with key agencies to develop a co-ordinated approach to Emergency Life Support (ELS) training in the community; increasing capacity for ELS training throughout the community by providing training for trainers involving both health and social services staff, teachers and local volunteers; providing quality standards for the provision of ELS training and to monitor and evaluate progress under the direction of the project steering committee.</td>
</tr>
<tr>
<td>Causeway Health and Social Services Trust (Public)</td>
<td>An Outreach Programme for Angina Patients</td>
<td>The project is a prevention-focused programme for people who have Coronary Heart Disease. The initiative will raise awareness of the problem, provide community outreach services; establish a service to address the needs of patients who have angina, including education and information about diet and psychosocial support.</td>
</tr>
</tbody>
</table>
Organisation: Craigavon Area Hospital (Public)
Project: Neurovascular Assessment Clinic
Focus: The project provides a specialist service with the aim of improving and maintaining the health and wellbeing of patients with stroke and transient ischaemic attack (TIA is a transient stroke which occurs when the blood supply to part of the brain is briefly interrupted).

Organisation: Altnagelvin Hospitals Health and Social Services Trust (Public)
Project: Nurse led prostate cancer information and counselling centre
Focus: The project provides a comprehensive information and counselling service for patients with prostate cancer or those seeking advice regarding prostate specific antigen (PSA is a protein produced by the cells of the prostate gland, the test is used to measure the amount of PSA in the blood) testing and screening.

Organisation: Playboard (public sponsored body)
Project: Fit for Play (Across three regions)
Focus: Project focuses upon play deprivation by implementing a quality award scheme with the overall aim of improving the long term health and wellbeing of children and to improve play services by increasing physical play opportunities and healthy eating habits. The legacy of the conflict has meant that fears of violence and divisions between Protestants and Catholics have unsurprisingly affected children’s freedom to play; in the past a lack of public space also affected where children were able to play.

SCOTLAND PROJECTS:

Organisation: North Ayrshire Leisure Limited
Project: Active for Life
Focus: Two part project aimed at both adults and children and developing dedicated exercise schemes involving
<table>
<thead>
<tr>
<th>Organisation:</th>
<th>Project:</th>
<th>Focus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lothian NHS Board</td>
<td>Heart Matters</td>
<td>A voluntary agency partnership programme addressing the issues of healthy eating and alcohol consumption amongst hard to reach groups and areas of deprivation within North Edinburgh. The scheme has been developed to meet a gap within existing provision and works with people to identify health concerns and find solutions.</td>
</tr>
<tr>
<td>Argyll and Clyde Acute Hospitals NHS Trust</td>
<td>One Stop Assessment Clinic for Minor Strokes</td>
<td>The purpose of the project is to provide equitable access to services which ensure diagnostic procedures meet current guidelines, increase access to information for patients, carers and health professionals, improve early recognition and management of a stroke, and raise public awareness of risk factors.</td>
</tr>
<tr>
<td>Greater Glasgow Health Board</td>
<td>Black and Minority Ethnic Groups in Heart Health Information Resources</td>
<td>The translation of standard advice given to all appropriate patients and their carers into a number of ethnic minority languages and also to develop a website for improved access.</td>
</tr>
<tr>
<td>South Glasgow University Hospitals NHS Trust</td>
<td>Specialist Discharge for Stroke Patients</td>
<td>Identifies stroke patients who would benefit from early discharge from hospital utilising a number of tools to monitor severity and recovery. Interventions are available in physiotherapy, adaptation, diet, and nursing and includes GP input.</td>
</tr>
</tbody>
</table>
**WALES PROJECTS:**

<table>
<thead>
<tr>
<th>Organisation:</th>
<th>The Stroke Association (Charitable/Voluntary Association)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project:</td>
<td>Positive Action for Stroke</td>
</tr>
<tr>
<td>Focus:</td>
<td>Offering services and support for people affected by stroke and for their carer, including offering opportunities in developing their lifestyle post 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, aid adjustment to stroke related disability and improve quality of life for the participants.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organisation:</th>
<th>Blaenau Gwent CBC (Statutory Body)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project:</td>
<td>Active Living</td>
</tr>
<tr>
<td>Focus:</td>
<td>The primary focus of the project has been to establish links between Blaenau Gwent CBC, the local Health Board and Primary Care Staff to develop a referral scheme for individuals at risk of coronary heart disease, stroke and cancer conditions. Individuals who may be physically inactive or experience low risk medical conditions are referred to the dedicated staff who can advise and support them in adopting a healthier lifestyle.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organisation:</th>
<th>Swansea NHS Trust (Public)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project:</td>
<td>Breast cancer rehab recovery and preventative lymphoedema care programme</td>
</tr>
<tr>
<td>Focus:</td>
<td>Pioneering and innovative project – the first of its kind within the UK establishing collaborative partnerships between users, professionals, Swansea NHS Trust and private leisure centres to improve breast cancer rehabilitation and recovery.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organisation:</th>
<th>Cardiff and Vale NHS Trust (Public)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project:</td>
<td>Community Cardiac Rehabilitation Services in Cardiff and the Vale</td>
</tr>
<tr>
<td>Focus:</td>
<td>The service offers cardiac patients a range of accessible and co-ordinated services through individualised plans linking primary and secondary care. The proposal aims to</td>
</tr>
</tbody>
</table>
develop pathways of care between health, leisure, education and voluntary organisations.

<table>
<thead>
<tr>
<th>Organisation:</th>
<th>Groundwork Wrexham (Charitable/Voluntary Organisation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project:</td>
<td>Roots to Healthy Hearts</td>
</tr>
<tr>
<td>Focus:</td>
<td>The project promotes healthy eating and active lifestyles for school children and vulnerable groups in disadvantaged communities in a bid to reduce the likely incidence of coronary heart disease or cancer later in life. The project provides access to a community “trim trail” and a child friendly “kitchen garden” for schools, voluntary and community groups.</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

Introduction

1.1 The Big Lottery (BIG) has commissioned Tribal Secta Ltd and partners CRG Research Ltd to conduct an independent prospective evaluation of the 'Reducing the burden of Coronary Heart Disease, Stroke and Cancer' grant programme. The programme is funding around 200 projects across three UK countries - Northern Ireland, Wales and Scotland – over the period 2004-2007.

1.2 This is the first report produced by the evaluation team and covers:

- background to the programme
- overview of the programme in each country
- terms of reference for the evaluation
- evaluation strategy and methods
- findings to date
- time scales and forward work plan.

An appendix has been produced to accompany this report. It describes the burden of relevant morbidity in each country, and local policies to tackle such ill health.

Background to the programme

1.3 The programmes to be evaluated are:

- new opportunities for health – coronary heart disease, stroke and cancer (in Scotland and Northern Ireland), and
- coronary heart disease, stroke and cancer (in Wales).

This evaluation will not cover any of the programmes operating in England.

Northern Ireland & Scotland

1.4 Of the £26.6 million available in Scotland, 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.

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

1.6 Together, the two programmes aim to reduce the risk of coronary heart disease, stroke and cancer through the provision of effective evidence-based prevention programmes, and 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.

1.7 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 agreed clinical priorities – encouraging a healthy lifestyle and tackling smoking, poor diet and inactivity will be key parts of the strategy.

1.8 In Northern Ireland, the programme has responded to consultation by prioritising a minimum of 60% of funding to support evidence-based prevention programmes. Projects should also build on existing expertise and cross-sectoral partnerships, and target disadvantaged communities as well as groups at risk from coronary heart disease (CHD), stroke and cancer.

Wales

1.9 In Wales, the programme has committed £10 million to projects that 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;
1.10 In order to achieve this, the programme covers two strands:

- community-based prevention and rehabilitation (about £4 million for cancer and £5.5 million for CHD)
- stroke support via the Stroke Association (£500,000).

1.11 An additional £5m is available in Wales for projects that improve access to specialised services for the detection and diagnosis of coronary heart disease through provision of angiography equipment for detecting and diagnosing CHD. These projects, however, are not included in the evaluation.

**Timetable**

1.12 In Scotland and Northern Ireland, awards were announced from August 2003, and projects will run for up to three years. In Wales, awards were made in October 2003 for projects that will run for up to three years. Most funded projects did not begin work until early 2004.

**Terms of reference**

1.13 This evaluation covers the programmes running in Scotland, Wales and Northern Ireland. It focuses on:

- how far the programmes have succeeded in meeting their overall aims and more particularly those relating to the provision of evidence-based health prevention and promotion services and to addressing inequalities in provision
- how successful selected individual projects are in delivering their own aims and in conforming with wider programme aims
- how far projects have linked with relevant local and national strategies.

1.14 As well as identifying issues that are specific to each country, the evaluation draws together issues and lessons that are common across the programme in all three countries.
1.15 This evaluation does not cover projects focused on providing diagnostic or other equipment, or buildings and similar capital provision.

1.16 Specific issues addressed include:

- the effectiveness of the engagement of statutory and voluntary bodies in the programmes in line with specific country priorities (and any added value that doing so has achieved);
- approaches to tackling health inequalities and how projects have balanced this with considerations of mortality and morbidity rates within the population as a whole;
- the development of innovative approaches, and particularly those that help to meet the needs of new target populations;
- evidence of good practice.

1.17 These areas may be expanded or re-focused in the light of emerging themes and interviews with stakeholders – and will be covered in each of the annual evaluation reports to the extent appropriate at that time. Some topics, for example, may be more relevant at the outset of the programme period, others relevant once projects are established or at the end of the three year period.

1.18 The evaluation will consider the sustainability of gains made by individual projects, including how projects address the question of sustaining their work after the BIG support ends.

1.19 The evaluation will take account of differing national policy contexts in the three countries.

1.20 The evaluation commenced in early 2005, and will end in 2007. An interim evaluation report will be produced in each of the first two years, and a final evaluation report at the end of the three-year period.

1.21 This evaluation is funded by BIG. Three additional case studies are being undertaken in Northern Ireland with funding provided by the Department of Health, Social Services & Public Safety (Northern Ireland).
1.22 Any individual who wishes to know more about any aspect of the evaluation is welcome to contact the authors using the weblinks which follow:

http://www.crgresearch.co.uk/projects.php?ptype=1
http://www.tribalsecta.co.uk
2. EVALUATION METHODS

2.1 The evaluation follows a structured methodology as agreed with the Evaluation Steering Group.

2.2 Outline progress of all funded projects is being tracked across the three year period. A database of key information on each project has been developed, initially comprising application and other information provided to the evaluators by BIG. This database is updated periodically with information provided by BIG from their normal monitoring activity – and by contact with BIG programme administrators in each country.

2.3 Tracking projects (largely by exception) allow the evaluation to capture emergent issues that lie outside of the selected case study projects (see below) that may, nevertheless, be relevant to our view on the overall performance of the programme. It is not intended that this should have any major resource impact on the overall approach to the evaluation.
Case studies

2.4 The main evaluation tool agreed with BIG is ‘case study’. A sample of 18 case study projects is being followed throughout the three year period.

2.5 Case studies are designed to inform issues of:

- progress of projects to stated aims and objectives
- enablers / inhibitors to progress, and partnership arrangements
- targeting on regional priorities to address health inequalities
- additionality of BIG funding
- likely sustainability of projects after funding ends
- tangible and intangible benefits
- development/implementation of good practice models of care
- transferability of work / dissemination
- before and after comparison across 3 years (as far as possible) in terms of impact on health inequalities.

2.6 Case studies will be conducted to a common format to ensure comparability across projects. This will be undertaken by:

- identifying the key stakeholder for each project
- site visits to see work in action
- semi-structured interviews with project leads and other stakeholders;
- write-up of case study notes
- repeat contact each year of the three year evaluation period.

2.7 The time input to each case study is managed flexibly to cater for different complexities and sizes of project in the sample. Liaison is maintained as appropriate with project case workers/managers for case study projects.

2.8 Together with the tracking activity, the case studies will:

- inform an overall opinion as to how well the Initiative has delivered on its own aims and objectives
- how the Initiative has delivered on the wider mission, aims and needs of BIG
- showcase the impact of BIG programme funding on people’s lives – celebrate success
- highlight models developed to tackle inequalities – for dissemination
- identify areas where performance could be improved – lessons for future funding programmes
- provide material that can be used to inform the public and other stakeholders of the value of BIG initiatives.

2.9 The first round of visits and interviews took place between October 2005 and December 2005. The findings from these visits are presented later in this report.
3. CASE STUDY SELECTION

3.1 A sampling frame provides a means of selecting case studies for this evaluation from the total number of grant-funded projects under this Programme. The frame helps to ensure a spread of projects by type of intervention/activity.

3.2 Classification is based on the descriptions of projects provided by BIG.

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>Projects whose main aim is to build service capacity, introduce new technology or ways of working and provide support and training to professionals in the field. These projects are mainly concerned with the service providers, though they may also provide patient care during the course of service development.</td>
</tr>
<tr>
<td>ER</td>
<td>Projects to provide rehabilitation, advice, support and continuing care to people who have had strokes or heart attacks - and to support their carers. Often involves developing exercise regimes. The projects are mostly staffed by health care professionals and take place in a wide range of settings including hospitals, day care centres and the community.</td>
</tr>
<tr>
<td>RR</td>
<td>Projects aiming to reduce risk taking behaviour: to encourage lifestyle changes in people who are potentially at risk from CHD, stroke or cancer, and more widely in the general population. Mostly run in the community, but also in schools. Often led by PAMS (Professions Allied to Medicine: for example chiropody/podiatry, dietetics, occupational therapy, physiotherapy and speech and language therapy) but can involve lay volunteers.</td>
</tr>
<tr>
<td>CC</td>
<td>Continuing care and support services for people with cancer and their families.</td>
</tr>
<tr>
<td>SCR</td>
<td>Projects with the main aim of improving or extending screening and diagnostic activity. May also involve initiatives to reduce risk taking behaviour, as above. Mostly involves health care professionals in hospital and primary care.</td>
</tr>
<tr>
<td>SGC</td>
<td>Projects designed for generally improving access to health care and</td>
</tr>
</tbody>
</table>
related services for groups, such as the homeless, that have traditionally had difficulty accessing services.

| GO  | Work to develop the life opportunities of specific groups. E.g. a project to appoint a disability development officer. |
|     |                                                                                                                     |
| EC  | Community emergency life support                                                                                 |

3.3 We further group projects by the types of people intended to benefit:

- adults
- children and young persons
- people with special needs
- minority ethnic groups.

3.4 These groupings are not applied to the ER projects as these mostly address the needs of older adults only.

3.5 Both sets of classifications are not definitive or exclusive. Many of the projects can be assigned to more than one of these groups.

3.6 Potential candidates for case studies were identified using the sampling frame. The final selection was made in conjunction with BIG Operational Staff and a total of 18 projects were agreed. Listed below are the title of each case study and the respective lead grant recipients.

3.7 Initially, five schemes were selected as case studies in Northern Ireland. This was expanded to eight case studies with additional evaluation monies being provided by the Department of Health, Social Services & Public Safety (Northern Ireland).

3.8 **Northern Ireland** (n=8)

- Eastern Area (Phase 1) Cardiac Rehabilitation Programme
  Northern Ireland Chest, Heart and Stroke Association
- Community Emergency Life Support
  Homefirst Community HSS Trust

- Nurse Led Prostate Cancer Information and Counselling Centre
  Altnagelvin Hospital HSS Trust

- An Outreach Programme for Angina Patients
  Causeway HSS Trust

- Fit for Play (Eastern)
  Playboard

- Fit for Play (Western)
  Playboard

- Fit for Play (Southern)
  Playboard

- Neurovascular Assessment Clinic
  Craigavon Area Hospital

3.9 **Scotland** (n=5)

- Active for Life
  North Ayrshire Leisure Limited

- Heart Matters
  Lothian NHS Board

- One Stop Assessment Clinic for Minor Strokes
  Argyll and Clyde Acute Hospitals NHS Trust

- Black and Minority Ethnic Groups in Heart Health Information Resources
  Greater Glasgow Health Board

- Specialist Discharge for stroke patients.
  South Glasgow University Hospitals NHS Trust
3.10 **Wales** (n=5)

- Positive Action for Stroke  
  The Stroke Association

- Roots for Healthy Hearts  
  Groundwork Wrexham and Flintshire

- Breast Cancer Rehabilitation Recovery and Prevention of Lymphoedema Scheme  
  Swansea NHS Trust

- Active Living  
  Blaenau Gwent County Borough Council

- Community Cardiac Rehabilitation Services in Cardiff  
  Cardiff and Vale NHS Trust
4. CASE STUDY REPORT UPDATE

Introduction

4.1 This section of the report is divided into the three countries. Each case study is described, covering:

- organisation(s) involved in project delivery
- description of the project being grant funded
- potential benefits
- comment on project delivery and management
- what works well/learning points
- progress reports
- sustainability.

NORTHERN IRELAND

NI1 CASE STUDY 1 – EASTERN AREA (PHASE 1) CARDIAC REHABILITATION PROGRAMME

Organisation

The Northern Ireland Chest, Heart and Stroke Association (NICHSA) is based within Northern Ireland 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. The service is targeted at the 5500 residents with cardiac events admitted to hospitals in the EHSSB areas. The partners/families of these individuals are also offered support.
Project

The project was set up initially to equalise and standardise cardiac rehabilitation services throughout the Eastern Board area. A number of the trusts were at different stages in both the development and delivery of cardiac rehabilitation services. More specifically, Down and Lisburn Trust had started working with the local leisure centre but did not have the funding for Phase 1, 2 and 3\(^1\). The Royal Victoria Hospital, Belfast City Hospital, Mater Hospital and Ulster Hospital had all started to develop cardiac rehabilitation services but none of those trusts had any specific funding in place. NICHSA in partnership with the EHSSB assessed the need for Cardiac Services within the EHSSB area. Initially a thorough assessment was made of all services and during this phase NICHSA worked extensively with the various trusts to ensure that what they delivered in terms of cardiac rehabilitation services was improved upon and developed. This phase also helped to ensure that people who needed the service received it regardless of their geography.

At a local level the project ensures that people who have experienced a cardiac event, either in the form of a heart attack or heart failure, have access to:

- telephone support on discharge from hospital
- a home visit where the person’s condition necessitates one
- advice and support about medication and issues of general health
- pain control
- information about their condition
- advice concerning changes they can make to their lifestyle

The project has ensured the development of a 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 resources.

\(^1\) The British Association for Cardiac Rehabilitation outlines three distinct phases of cardiac rehabilitation, Phase 1 refers to the inpatient stage, Phase 2 refers to the early post discharge period and Phase 3 refers to the structured exercise training phase which is undertaken in the community.
Potential benefit

It was estimated that 5500 people would benefit from this service. The project has also started to work with the Leisure Centres and Councils in terms of providing their leisure staff with British Association Cardiac Rehabilitation (BACR) training which will enable those staff to deliver a Phase Four Programme\(^2\). They will also be able to deal with people who have quite exacerbated heart conditions.

The project has also given opportunities to both relatives and carers to train in resuscitation and to give them support and advice about cardiac events and conditions more generally.

Delivery and management

The project is now well underway with the establishment of a steering group in 2003 and also all staff now being in post. Some problems were initially encountered with recruitment of some staff within some of the Trusts but these have been resolved, in one instance a lower grade staff nurse was recruited into post to fill for the nurse who actually had the skills and expertise the role required. The project has had to bring together diverse groups, all working within varied specialties and localities, and this has proved to be quite challenging, particularly when asking individual organisations to look at a bigger more strategic picture and not necessarily at their “own corner of activity”.

The Steering Group is now fully functioning and has representation from the Cardiac Rehabilitation Nurses, Council Employees and Patient/User Representatives. An evaluation framework for the project has been developed and encompasses several key elements, more specifically: the development of a cardiac alliance/network to increase awareness of cardiac rehabilitation issues; audit of standards implemented across all Trusts; assessment of patient satisfaction with the service, as well as the need for rural outreach assessed. Plans are developed accordingly, together with a database of existing cardiac support groups to ensure that those groups have input to the Project Steering Group.

---

\(^2\) BACR Guidelines describes a Phase 4 Programme as “a community based programme which equips exercise instructors to prescribe and deliver exercise for individuals with coronary heart disease who have already been through a hospital based rehabilitation programme”
The project is staffed primarily by the Cardiac Rehabilitation Nurses but also receives input and support from physiotherapists, dieticians and pharmacists. All of the staff have a key role to play in terms of giving information to patients about a range of issues including: their medication, diet, change of lifestyle, and appropriate physical exercise activity.

The project has also established a Multi-Disciplinary Alliance Network, the first meeting taking place in September 2005 where a wide range of individuals attended, including: cardiologists, cardiac rehabilitation nurses, physiotherapists and cardiac support groups. A whole programme of events took place generally focussing upon coronary heart disease and sharing information about the project. Results from a patient satisfaction survey were also disseminated and all individuals focused upon how the project can positively work with professionals to raise the profile of cardiac rehabilitation more generally. Feedback from cardiac event individuals was also sought as to the future development of the alliance.

**What works well/not so well/what has been learned**

All acute cardiac event patients will receive a telephone call upon discharge and one third of those will receive a home visit, more importantly all individuals will be receiving the same high quality of service and will be receiving the same advice about their condition. In the past cardiac event individuals have lamented that “it was terrible when you got home from having had a cardiac event having to wait four to five weeks before you met a cardiac rehabilitation class”. The project manager also commented about the level of partnership working and that “although it has been a steep learning curve for everyone and although we are bringing people together with very diverse practice ideas we are now at the stage where everyone within that group is singing from the same hymn sheet, obviously that has taken time but I consider that to be a wonderful accomplishment”. The project has also ensured the development of good practice, ensured that everybody is working at the same level and sharing the information, and also ensured that all literature is standardised.
The project over time, has also facilitated the development and strengthening of Cardiac Support Groups where people who have had cardiac events can come together and develop social networks where they can share information, and where there are opportunities for educational and social interaction. Each of the groups has developed and has begun to debate all sorts of key issues, for instance, defibrillators in the community, questioning where they are and why certain places do not have them. The project manager commented “I feel that they have begun to address some very important and key issues, and that the development of these networks has empowered them to take responsibility not only for their own health but actually for looking at other people’s health, and what can they do for other people’s health”.

The project has not changed that much over time as cardiac rehabilitation is quite standardised. The project manager commented, “we would have picked up on the Clinical Resource Efficiency Support Team (CREST) and Scottish Intercollegiate Guidelines Network (SIGN) guidelines to determine what those standards should look like – where we have brought a more standardised programme forward is in the adoption of the BACR programme which everybody across the board is using now, and all Cardiac Rehab. staff are trained in”.

The project steering group has also put in place an Evaluation Framework which will be implemented by the members of the steering group. Any data gathered will be written up by an external person therefore ensuring independence and as a consequence untarnishing of the data. The project manager was also keen to stress that a number of focus groups will be independently held involving individual users of the service with the results being written up again autonomously. There is much audit material which will advise of quantitative issues, as well as a client satisfaction survey being carried out.

The project manager was keen to praise the involvement of BIG, she commented “our involvement with BIG has helped us to get services into areas where services were badly needed, the service may also have prevented admissions, of course we don’t know that for sure but it may have done. Obviously it will be further down the line before we know that”. She further commented that “the involvement of BIG has
really stressed to us the importance of monitoring and evaluation and that will play a very key role when it comes to future sustainability of the project”. In terms of the project she was keen to stress “the service has become much more streamlined and it is seamless in terms of hospital into the community”.

Progress reports

The last monitoring return for Year 2 of the project confirmed that 674 individuals had benefited from the service, this was an increase from Year 1 which confirmed that 563 individuals had benefited from the service.

The project manager stressed that any information that became available in the future, such as independent evaluation material, would be made available to the evaluators. Focus group material would also be included.

Sustainability

The project manager commented “evaluation is obviously key to the sustainability of the project and we really do need to showcase what we are doing, I have told the other staff involved with the project about that, that they need to be pushing themselves forward onto other funders …………. I suppose ideally we are talking about mainstreaming the project”.

NI2. CASE STUDY 2: COMMUNITY EMERGENCY LIFE SUPPORT

Organisation

Homefirst Community Trust is the largest community trust in Northern Ireland. Community Trusts are essentially part of the Health Service within Northern Ireland and in tandem with the Hospital Trusts are the main providers of services. The Homefirst Community 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 wellbeing.

Project

The project aims to raise awareness and deliver training in Emergency Life Support Skills to schools, community based groups and the various NHS Trusts. The project team have and 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 and dealing with a suspected heart attack casualty.

The project so far has worked with a very wide range of individuals and voluntary and community groups including:

- young people who have hearing and speech impairments
- people who have visual impairments
- young people who have behavioural difficulties
- a group of community addiction staff who work with drug users and their carers
- a community cardiac rehabilitation group working with those who have experienced cardiac events and their carers
- young people who were experiencing problems with stress and whom they were able to refer onto another type of support to help them with that
- a number of parenting schemes located within Health Action Zones.

The project has also worked with staff in a workplace setting (Michelin).

Potential benefit
It was estimated that 10,000 individuals would benefit from this service. Monitoring returns from January 2004 to June 2005 show that the project has currently worked with 8,403 individuals. The end date for the project is September 2007 so the project is well on track to not only meet, but in our estimation, exceed its originally stated target.

Additionally the project has targeted some very hard to reach groups all of which have been outlined in the previous section. Although the project has some very clear objectives the project manager was keen to stress that she has tried to build some flexibility into those defined objectives and this has meant that the staff have been able to help individual groups in other ways, for instance by referring them onto other types of support or by innovating the training so that it best met the needs of individuals or groups, such as those with visual, hearing or speech impairments.

**Delivery and management**

The project is now well underway and all staff are now in situ. The induction process for the three community project workers was extremely comprehensive and included meetings with:

- key link organisations such as the British Heart Foundation’s Heartstart initiative
- The ELS Co-ordinator and Resuscitation Officers in Causeway and United Hospitals Trust
- The North-Eastern Education and Library Board
- Key local community and voluntary groups and individuals

All community project workers also undertook a number of professional development courses including:

- further specialist resuscitation training in both immediate and paediatric life support
- a community development course
- a user consultation course

Each Community Project Worker is locally based and has developed individualised specific action plans for their areas covering the two years of activity.
There has been an increased demand for both the Schools Heartstart Initiative training, Heartstart Community Initiative training and more general training around cardiac rehabilitation. Requests have come from the usual mix of schools and community organisations; in addition Volunteer Walk Leaders have requested training.

The project has consulted with a number of Heartstart groups, namely Newtownabbey Heartstart, Heartstart Ballymena Road Club; Sperrins Heartstart and Heartstart Glens Alert and have produced a number of reports outlining the findings. Early indications would seem to suggest that individuals are very pleased with the training generally and feel that they gain a lot from the training. An independent evaluation has also been conducted around the Heartstart Schools Programme, this evaluation covered both staff and pupils. Findings on the whole were very complimentary.

**What works well/not so well/what has been learned**

Clearly the project has been very successful in equipping individuals with emergency life support skills. One recent user commented that “the project brings real benefits to the community, especially in rural isolated areas where emergency services may not always be immediately to hand”. Through the trainers, the knowledge permeates down to the communities where it is needed most. The further development of the scheme is viewed as crucial, particularly in areas of high social deprivation or in rural, isolated communities.

The project manager also commented on the effectiveness of partnership working, saying that “our partnership working with the British Heart Foundation has been particularly successful; they have provided us with a resource in the form of the Heartstart training package which is very cost effective. They have given their time free of charge and have provided us with professional advice and support, they have also provided us with equipment as we have required it”. The project manager was also keen to reiterate the strength and effectiveness of the voluntary and community groups which interact with this project, she commented “without that network of volunteers the project would struggle …….. we really don’t know what we would do without them”.

Tribal Sector Ltd & CRG Research Ltd
The project manager was also particularly pleased that there has been an increased demand for training and that contact had been made with new groups presenting particular challenges for the ways in which the training is delivered and encouraging project workers to develop new and innovative ways of delivering training.

**Progress reports**

The project is well on track, not only to meet its stated targets but to exceed them. The project manager was keen to stress that any future evaluation material would be made available to the evaluators. The project manager was also trying to develop new ways of evaluating the impact of the project but this was proving to be a challenge. Impact assessment she felt was central to the future sustainability of the project. As evaluators we are obviously fairly familiar with different methods of evaluation and will work with the project to develop a suitable methodology for future impact assessment work.

**Sustainability**

Please see above.

---

**NI3 CASE STUDY 3: NURSE LED PROSTATE CANCER INFORMATION AND COUNSELLING CENTRE**

**Organisation**

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 arranges approximately 150,000 outpatient attendances, 14,000 day cases and responds to 49,000 accident and emergency attendances each year. In addition, Altnagelvin Hospital is one of Northern Ireland’s 5 cancer units.
Project

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 and nursing staff
- to deliver educational sessions to GPs, 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 GPs and nurses assessing the effect of the education provided, on the knowledge attitudes and practice of the primary health care professionals and to 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 are unable to travel to the centre.

Potential benefit

It was estimated that there would be several groups who would be potential beneficiaries of this project:

- patients
- all GPs and nursing staff within the Western Health and Social Service Board area
- the wider health community, more specifically the Royal College of Nursing research conference.

In addition to these groups, the project staff have also supported and counselled a number of patient relatives/carers.
Delivery and management

The lead worker for this project is the consultant urologist and delivery is largely performed by the specialist nurse. The project appears to be progressing smoothly with patients seeming to find the services valuable in terms of options for further treatment.

The project has worked in partnership with a large number of GP practices at the initial stages and continues to work with them to share recent developments and best practice.

Various information leaflets have been developed and will be updated when appropriate.

What works well/not so well/what has been learned

The individuals who utilise the service seem to find it extremely valuable in terms of providing them with the full range of treatment options, post diagnosis. All of the information leaflets have been awarded a Clear English Standard by the Plain Language Commission, again this benefits the patients a great deal as they have clarity of information. The centre, although within the hospital grounds, is based away from the main clinical environment and the patients seem to find the non-clinical welcoming environment very beneficial. A number of patients have been able to bring their close relatives/carers along when seeking advice and support.

Progress reports

The latest annual monitoring report for 2005/2006 indicates that 85 men diagnosed with prostate cancer have contacted the centre which is broadly in line with what was expected. This would seem to indicate that the project is currently on track to meet the original targets set out in the application. Up to date monitoring information will be gathered when the next round of visits take place.

Sustainability

Evaluators will discuss the future sustainability of the project when the next round of interviewing takes place.
NI4. CASE STUDY 4
OUTREACH PROGRAMME FOR ANGINA PATIENTS

Organisation

Causeway HSS 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.

Project

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:

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

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.

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 to help 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 myocardial infarctions because of a lack of information and continuing support.

**Potential benefit**

To date approximately 250 individuals have accessed the support of both the Angina Nurse and the dietician. Individuals who may have missed the opportunity to receive cardiac rehabilitation, support and advice are currently receiving that support and a number of community groups have received informal educational and information sessions.

**Delivery and management**

The project is primarily delivered by the Angina Nurse and the Dietician. A steering group has been developed and this takes forward the development of the project. The steering group involves both members of the clinical team and user representatives.

Key to the success of the project is the extensive partnership working which takes place both within and outside of the Trust. Effective referral mechanisms are in place internal to the hospital and the project team have worked in partnership with a number of GP practices throughout the region targeting suitable patients.

The project also works in conjunction with the Causeway Cardiac Support Group providing information to its members and canvassing them on the services and support they have received. Suggestions for improvement are fed back into the project, therefore contributing to its overall development.

In addition the project works with the staff at the British Heart Foundation, these individuals act as advisors to the programme. Educational support materials have been bought in using funds donated by the Cardiac Support Group. The materials come from York University and are entitled “The Angina Plan”. They have been designed to assess people’s knowledge about the condition as well as providing answers to the questions people may have around issues such as: what causes angina; how will it affect my life; how will it
affect my future; what will make it better; and what will make it worse. The materials also explain to individuals the things that reduce angina, the things that can increase it and how to reduce the risk of having further problems. The project team also continue to publicise the project to groups and individuals they feel might benefit from the services and support.

**What works well/not so well/what has been learned**

The evaluation work that has been undertaken has shown that patients continue to value the service finding it very beneficial, supportive and informative, particularly where individuals have been able to access the service within their own homes.

The staff continue to work very hard at establishing links within the community and primary care services; they also continue to work hard to publicise the scheme at appropriate venues. The partnership working within the hospital has continued to progress, although at one stage it was felt that perhaps some referrals from medical investigations were being missed or referred late. It would now seem that these initial teething problems have been eradicated. There were also difficulties in getting rooms allocated within health centres to hold community clinics but these problems have largely been ironed out with the service being well received by those working in primary care.

**Progress reports**

The project has continued to make good progress toward its targets set out in the original application. Evaluators will obtain up to date, accurate participant numbers in the next round of project visits. The project manager stressed that any future aggregated evaluation material would be made available to the research and evaluation team.

**Sustainability**

Evaluators will discuss plans for future sustainability in the next round of project visits.
NI5. CASE STUDIES 5, 6 AND 7: FIT FOR PLAY (EASTERN, WESTERN AND SOUTHERN)

Organisation

Play Board 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.

Project

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 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 the Kids Club Network and the British Heart Foundation.
- Food 4 Play – a diet and nutrition programme encouraging play providers to empower children to choose as well as prepare healthy foods. This module incorporates the Cookit programme (a healthy eating and cooking skills programme produced by the Health Promotion Agency aimed at individuals for whom cost is an important consideration when buying and cooking food) and a fruit scheme.

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.
The Training and Development Officers will have an initial visit with the playworkers and will then conduct a baseline assessment to assess what the playworkers need to do to achieve the standard, the criteria include:

- Half an hour of physical activity per day including one session outdoors
- Healthy snacks with children involved in their preparation
- A commitment from playworkers to continue the programme in order that the award can be achieved in subsequent years.

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

**Potential benefit**

**EASTERN BOARD** - 
- 130 Play Workers involved
- 1800 children involved
- 13 groups currently working toward award
- 13 actual groups “Fit for Play”

**WESTERN BOARD** - 
- 123 Play Workers involved
- 1654 children involved
- 29 groups working towards award
- 3 actual groups “Fit for Play”

**SOUTHERN BOARD** - 
- 153 Play Workers involved
- 2968 children involved
- 10 groups working towards award
- 11 actual groups “Fit for Play”

The project has also succeeded in establishing links with hard to reach groups such as the Travelling community and the Eastern European community.

**Delivery and management**

The project comprises a Fit for Play Manager based at the Playboard offices in Belfast and four Training and Development Officers based in the Northern, Southern, Eastern and Western regions. The Fit for Play
project is concerned with establishing a quality standard for playworkers across the whole of Northern Ireland and is also concerned with making the project as accessible as possible to as wide a range of groups as possible. The project focuses upon play deprivation and the legacy of the conflict by implementing a quality award scheme with the overall aim of improving the long term health and wellbeing of children and to improve play services by increasing physical play opportunities and healthy eating habits. The Training and Development Officers are working with a very wide range of agencies and groups including groups of both Catholics and Protestants and traveller groups and have succeeded in bringing them together thereby encouraging community cohesiveness and breaking down barriers between groups.

What works well/not so well/what has been learned

It is clear from the success of the project that partnership working has blossomed over the life of the project. Playboard and the Training and Development Officers have been involved in a range of partnerships which include:

- The Childcare Partnerships based within each of the Board areas
- Various Training and Development groups, again regionally based
- The Health Promotion agencies
- Environmental Health groups
- Sports Development officers and agencies.

Within the Health Promotion partnership, working relationships have changed over time because play was viewed as an educational activity rather than a health promotion activity. The project manager commented “we have learnt a lot about them and they have learnt a lot about us”.

---

3 The Playboard website mentions the legacy of conflict as being a key factor in determining children’s access to play. It is estimated that a number of factors have been responsible for play deprivation, more specifically: lack of safe facilities for children within which to play; limitations on children’s actual mobility; fear of violence; and negative stereotypical images which both Catholics and Protestants may hold about each other.
Another very positive impact to have come out of the project has been the professionalisation of the individual playworkers involved with the scheme. They have become more empowered as a result of the project. An individual Training and Development Officer commented “we teach playworkers the skills to be able to engage parent and management committees more. In the past, playworkers would not have engaged and had discussions with parents, whereas now they are presenting more challenges and trying to change policies and mindsets, not only of the parents but also within their organisations”.

Progress reports

The evaluators will source up to date progress reports when speaking to project staff in the next round of interviews.

Sustainability

The project is very much about prevention rather than intervention and it is very hard to try and prove that the project is actually making that difference and establishing whether childhood activity patterns follow on into adulthood. There is no doubt that the project has had quite a marked impact upon Playboard itself. Prior to this project happening, quite a lot of the funding streams centred upon childcare and so activities and project were skewed in that direction. Because of this project, the organisation started to re-focus on play. Where the project seeks funding in the future is a matter of some debate, future funders likely to be approached centre around either the area of sport or health promotion. The evaluators will gather more information about this subject when the next round of interviews takes place.

NI6 CASE STUDY 8: NEUROVASCULAR ASSESSMENT CLINIC

Organisation

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.

**Project**

The aim of the project is to establish a neurovascular assessment clinic to ensure that patients with a suspected transient ischemic attack 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.

**Potential benefit**

The project application states that the project will benefit 800 individuals and the project manager concurred with this estimation.

**Delivery and management**

The project employs a specialist nurse, some administrational support and two consultants, both of whom are employed on a part time basis. The project manager did not indicate whether any partnership working was conducted.

**What works well/not so well/what has been learned**

The project quite clearly has a vital role to play in the secondary prevention of stroke and all that is associated with a stroke occurring. The project manager did not expand on that statement.

**Progress reports**

Beneficiary numbers will be obtained when the next round of interviews takes place.
Sustainability

The project manager did not outline a sustainability strategy – the evaluators will attempt to gather more detail about this when the next round of interviews take place.
**SCOTLAND**

### S1. CASE STUDY 9: ACTIVE FOR LIFE (AFL)

**Organisation**

North Ayrshire Leisure Ltd. - a charitable trust based in Irvine, on the west coast of Scotland about 7 miles north of Prestwick. It provides leisure services to a population of around 130,000 on behalf of the local authority, North Ayrshire Council.

**Project**

*Active for Life* is a BIG funded two pronged expansion of an established initiative. The first part involves the development of a GP exercise referral scheme designed for patients following myocardial infarction, or patients perceived to be at significant risk of CHD. The extended programme not only responds to referrals from GPs and other relevant health professionals but uniquely from individuals themselves who consider that their health could be improved by participation in regular physical activity. The second ‘prong’ was introduced to assist in reducing the prevalence of childhood obesity by the provision of a *Children’s Fitness Centre* with supporting dedicated fitness staff and activity programmes.

The programme commenced in February 2004 following a limited trial of exercise referrals and a ‘full mapping exercise’.

An important overall purpose of AFL is to promote equity in access to exercise programmes for the primary, secondary and tertiary prevention of CHD, that is to say increasing exercise opportunities for designated target groups within the local population which would contribute to ‘building a culture of life-long physical activity’.

The grant total of £112,266 included staff costs, training, rent, travel/transport, equipment, promotional activities and administration.
Rationale and Development

Scotland’s death rate for heart disease is the highest in Western Europe and CHD mortality rates in Ayrshire and Arran are 9% higher than the national average. Obesity contributes to the risk of CHD and physical activity is protective through a combination of effects on recognised risk factors. The project as a whole ties in with similar initiatives throughout Ayrshire eg ‘Paths to Health’ where the Walking Co-ordinator can take referrals from an Exercise Referral Officer. The North Ayrshire strategy for physical activity also draws on the Scottish Executive’s first physical activity strategy following the establishment of a Physical Activity Taskforce.

Partnership

Active for Life was developed collaboratively with NHS Ayrshire and Arran and in association with South and East Ayrshire Councils. A preliminary and comprehensive consultation process included public meetings involving around 700 organisations. Small group seminars and one to one interviews with Key Stakeholders including Local Health Care Co-operatives were also conducted and, particularly in areas of disadvantage, the voluntary sector was also involved.

Community based facilities contributing to AFL include Radio City (Kilburnie), Kilwinning Sports Club and the Auchrannie Hotel for those living on the island of Arran where an Exercise Referral Consultant provides opportunities for target groups to take part in AFL. In addition to these, North Ayrshire Leisure Ltd. deliver the programmes through four leisure facilities spread throughout the area.

During the run up to the launch of AFL the lead Health and Fitness Officer was a member of the CHD New Opportunities Fund (NOF) planning group (now BIG), which included representatives from North, South and East Ayrshire and a cross section of health professionals from NHS Ayrshire and Arran. A successful bid to BIG provided the launch pad for AFL and subsequently both the Health and Fitness Officer and the Exercise Referral Officer represented N.Ayrshire Leisure Ltd on the NHS Ayrshire and Arran Managed Clinical Network (MCN) group, within which there is a sub-group specifically for physical activity.
Although self-referral for an exercise programme is accepted, the significance of communication, reliability, training and ‘working with others’ is reflected in the whole basis of the exercise referral scheme which depends upon GPs and other health professionals, particularly those involved with cardiac rehabilitation, referring suitable patients to a designated Health and Fitness officer for assessment and an individualised exercise programme with a three monthly review.

With reference to childhood obesity, a Health and Fitness Officer works with Active Schools Co-ordinators and provision is made for primary schools to take part in physical activity sessions both at school and at leisure centres.

Potential Benefit

The number of anticipated beneficiaries for the exercise referral scheme was initially 1000 and for schemes related to childhood obesity, the number was 4,400.

Delivery and Management Mechanisms

The delivery of the two schemes involves i) self-referral and referral processes from health professionals to the designated Lifestyle Officer for assessment and a three monthly monitored exercise programme ii) outreach physical activity programmes in areas of disadvantage iii) working with schools and other community groups to establish exercise programmes in local leisure centres, where voucher schemes vary access costs and where the needs of those with a disability are given particular consideration. Links to other schemes such as the Better Neighbourhood Social Fund areas have been developed to enable access to exercise facilities free of charge. Exercise Referral Officers also provide the means for those living on the island of Arran to take part in AFL.

A Steering Group is responsible for the agreed standards of the referral process and is linked to the National Quality Assurance Framework, an ‘Active Living Co-ordination Group’ and the Managed Clinical Network.
A ‘smart card’ tracks the use of facilities by participants as well as being the follow-up mechanism for those entering an exercise referral programme.

**What works well/not so well and what has been learned**

As in other comparable projects, some issues are essentially predictable:

- Those delivering the project do not always participate in the planning processes – which means that some of the practicalities may not have been given adequate consideration (see below)
- Personnel involved in programme management or delivery can move on, or become unexpectedly unavailable - which means that some initiatives can be delayed or impossible to deliver in the timescale unless there is unusual skill and resource flexibility within the organisation
- Inconsistencies in data collection - which means that resources can be used up sorting out the related difficulties or that there is inherent unreliability in the evaluation of results.

As an example of one of the above predictable problems within AFL, the Chief Executive and Lifestyle Officers took over (in the short term) the administration and management of AFL following the early departure of the Project Lead. Restructuring was subsequently agreed to include a new Health and Fitness Manager. This kind of skill based flexibility seems unlikely to be so easily achieved within organisations such as the NHS.

The success of marketing and communication is evident in both the number of referrals from health professionals and the number of school age children attending exercise activities. All but one GP practice agreed to participate and interestingly, the unexpected level of response to the ‘Exercise Referral Scheme’ has already had resource implications for future planning and development. It may for example mean that ‘self referral’ will have to be discontinued as priorities are identified and subsequently agreed. It seems reasonable to suppose that without effective links with the Managed Clinical Network and other groups concerned with quality assurance, the response rate would not have been so high – see below.
The volume of response from other target groups may also create pressures on limited resources in the future. For example, decisions may have to be made regarding the popularity of some outreach exercise programmes provided in rented accommodation in local communities. That is to say, that as numbers increase so the requirements for suitable accommodation have to be modified for safety and other reasons and that inevitably has cost implications for future planning and service development.

Progress Reports

The format for data collection makes it rather difficult at this stage to separate the results from the overarching project *Active for Life*, in a reliable way. However in relation to the number of anticipated beneficiaries for each of the two schemes, recent quarterly reports indicate that around half of the anticipated number of exercise referrals have been achieved to date, although the self referral rate is more variable than that from health professionals.

With regard to *Challenging Childhood Obesity*, quarterly reports show a steady increase in attendances at the *Children’s Fitness Centres* as well as the launch of a new six week programme; at this stage the number of beneficiaries is now about 40% of the anticipated number.

Sustainability

The potential sustainability of the two schemes (1. exercise referral for those with relevant medical conditions and 2. exercise programmes to prevent or reduce childhood obesity), the partnership approach and community involvement may result in increasing the uptake of overall participation in *Active for Life* at the facilities provided by North Ayrshire Leisure Ltd., making self-funding a distinct possibility.
S2. CASE STUDY 10: HEART MATTERS

Organisation

The lead organisation is the Lothian NHS Board; the bid organisation is N/W Edinburgh Local Health Care Co-operative (NWELCC) which serves a population of around 140,000, geographically widespread, including areas of both affluence and deprivation.

Project

‘Heart Matters’: a new programme addressing alcohol consumption and healthy eating among ‘hard to reach’ groups, in the North Edinburgh Social Inclusion Partnership (SIP) and other areas of deprivation within NWELCC. It has been developed to meet a gap in existing services and aims to work with local people to identify relevant health concerns and then work with them to find solutions. A community consultation exercise and a substance misuse audit have been undertaken to identify the priorities for action.

‘Heart Matters’ has been wholly planned and delivered in partnership between three voluntary agencies:

- Edinburgh and Lothian Council on Alcohol (ELCA) which has a 33 year track record of providing specialist advice, information and counselling by staff supervisors and trained volunteers.

- Edinburgh Community Food Initiative (ECFI) a voluntary organisation with experience in setting up food co-operatives, working with children and undertaking research. Other relevant experience includes issues to do with alcohol consumption and nutrition in deprived areas.

- Pilton Community Health project, a community development and health project in the SIP which develops services and resources with local people, to meet their health needs and includes Barri Grub a community health project.
The Grant obtained from BIG included an agreed and specified division of financial resources between partners.

Rationale

Evidence clearly indicates the relationship between CHD and Stroke and lifestyle factors including diet and alcohol consumption. The particular focus of health maintenance and prevention is also linked to concerns of The Scottish Executive regarding the culture of alcohol consumption and the related impact on both the NHS and the Scottish economy. Nutritionally based food initiatives are also closely linked to national policies for CHD and Stroke.

A community health needs assessment undertaken in 1997 within the SIP and using both focus groups and individual questionnaires identified diet and alcohol as major concerns. In addition, a participatory appraisal exercise took place in 2001 to contribute to the business plan for the North Edinburgh SIP Healthy Living Centre and again the significance of diet and support for the reduction of alcohol misuse were identified as priorities.

Key objectives related to primary and secondary prevention, include establishing contact with ‘hard to engage’ groups by offering services on an outreach basis while recognising the diversity of need and developing community capacity to maintain sustainable change.

Potential Benefit

*Heart Matters* operates on ten different sites with 2,400 expected to be beneficiaries on three sites and 295 on the remaining seven sites.

Development and Management

A core management group of clinical directors and primary care professionals has overall responsibility.

The day to day delivery and management is undertaken by a Steering Group comprising representatives of the partners who meet quarterly to review progress and development and to date feel no need to meet more frequently. Each partner agency has promoted the benefits of
expanded services, offering greater flexibility or availability as a means to increase acceptability of alcohol counselling or modifications to diet. For example alcohol counselling is now available in local GP practice premises rather than in the city centre; food delivery has been extended and the ‘Barri Grub’ shop has developed new services.

With reference to reaching potential beneficiaries, all those involved in the provision of primary care have been encouraged to disseminate information about *Heart Matters* to target groups. A number of existing community based networks, as well as established links with the voluntary sector, also offer the means to reach potential beneficiaries. Other avenues of communication include a free local newspaper, posters and leaflets are also available in local Post Offices and Churches.

**Progress Reports**

Each partner has produced an individual quarterly progress report which is divided into two sections one for achievements and one for the identification of problems. For the period April to June 2005 for example, Pilton Community Health Project reported additional and pilot sessions (without the number attending), as well as examples of outreach work and the production of a recipe book.

ELCA reported the continuation of counselling sessions in 6 Medical Centres and the addition of evening sessions – with only a short waiting list. Referrals from GP Practices remained slow in the SIP area and in response to this a more detailed letter about the availability and benefits of the service was sent to them.

ECFI reported that targets had been exceeded for delivery services and that organic produce continues to feature - 51 beneficiaries were identified. Of special interest was a subsequent report about the inclusion of recipes for unfamiliar produce that subscribers wished to try out. Health promotional events continued to raise awareness of *Heart Matters*.

Problems identified at this time included the absence of one project worker for the whole period with no information about a date for
resuming work. This inevitably put pressure on limited resources and delayed the commencement of a new initiative.

ELCA has a system in place called ‘Orion’ to collate numerical data.

**What works well/not so well and what has been Learned**

With regard to the overall experience of the BIG it was a little surprising to find that no-one seemed to be clear about the aims and objectives of the BIG and there was also an inadequate understanding of why this might be particularly important when approaching the bidding process.

Smooth working relationships seem largely to do with the partnership process which is reported to have been especially effective because of the level of trust already established between the agencies concerned – the Project Lead being well known to both NWELHCC and the voluntary sector. All mentioned the absence of any feelings of competition, with no concerns about reliability regarding who would take responsibility for what. Unlike one or two other centres, the bidding process was said to have been completed without any difficulty, all believing they are likely to achieve more in partnership than as an individual organisation. It was also believed that successful partnership working was a lot easier outside the NHS.

Of some interest with reference to the relationship between the NHS and partners, a BIG Projects Co-ordinator coming new to post well after the project had commenced, found little support and insufficient clarity about what was wanted from her post.

As in other comparable projects, planning processes, personnel movement and inconsistencies in data collection have some predictable consequences.

Experiences to date have highlighted three issues:

- a new project designed to engage the ‘hard to reach’ is unlikely to demonstrate significant impact within 3 years, given the time needed to find the most effective marketing and communication strategies to break down resistance, to build an acceptable reputation and to modify initial arrangements in response to
locally expressed needs. Positive ‘word of mouth’ reports are seen to be absolutely critical and can take up to eighteen months to circulate effectively.

- an evaluation strategy that meets requirements of BIG may not be the most relevant for a community development approach

- long term sickness in a grant funded development worker can significantly affect the commencement and continuity of a newly planned service and over-stretch resources.

**Sustainability**

This issue is currently at the top of the agenda.

---

**S3. CASE STUDY 11:**
**ONE STOP ASSESSMENT CLINIC FOR MINOR STROKES**

**Organisation:**

The lead organisation is Argyll and Clyde Acute Hospitals NHS Trust and the bid organisation is Lorn and Islands District General Hospital serving a widespread and diverse rural and island population of around 45,000.

**Project:**

The absence of any budget to develop new NHS services has meant that BIG has contributed to closing a significant gap in the local stroke service, although forming only a relatively small part of the overall service for stroke patients. It does however respond to the concerns of the Scottish Executive about circulatory diseases, the potential for preventive strategies and the long term impact of a serious stroke. It also has an established link with the Scottish Stroke Audit.

Research based evidence supported the development of this important adjunct to stroke service provision which has the potential for reducing the risk of a more serious stroke, providing a rationale for a small
expansion to a well recognised hospital based stroke service where there had been some examples of mis-recording of ‘funny turns’, as well as initial diagnostic difficulty.

The primary purpose of the project is to provide equitable access to a new service that (1) ensures diagnostic procedures meet current guidelines (2) increases access to information and support for patients, carers and health professionals (3) improves the early recognition and management of a stroke and (4) raises public awareness of risk factors.

The assessment clinic commenced in the Spring of 2004 with a requested grant total of £69,691.

**Potential Benefit**

It was estimated that 300 people could benefit from this one stop assessment process although it has been difficult to gauge the potential of this project because of coding difficulties that had reduced the accuracy and reliability of available data.

Secondary beneficiaries would include others that would benefit from increased knowledge and understanding of a stroke and its implications, including carers, hospital and primary care health professionals.

**Delivery and Management**

Apart from the Trust and DGH, there are established links with primary care and the voluntary sector, ensuring that information about the benefits of this clinic has been transmitted across a geographically widespread largely rural area. Considerable help and support was obtained from the CHD Project Management group during the planning phase.

The success of the Project depends largely on the co-operation of General Practitioners, and it began with a carefully orchestrated ‘marketing’ strategy to encourage participation from GPs. This includes each practice receiving a ‘flier’ about the purpose and benefits of the clinic as well as an annual ‘Newsletter’.
In-house training was provided for a nursing auxiliary to complete a small team comprising a Specialist Medical Consultant and a Senior Nurse Stroke Co-ordinator, supported by the Radiology Department – representing many years experience of stroke management.

The sudden death of the Radiologist, whose services formed a significant part of the grant, resulted in a restructuring of radiology reporting in the area, which was subsequently transferred to Paisley. A technician from the Radiology Department continued as a member of the assessment clinic team.

The one half day per week clinic responds to both referrals from primary care health professionals and to self referrals and initially highlighted the problem of definition for ‘a minor stroke’ and the need to work with primary care professionals to improve the appropriateness of a referral.

Both the consultant and nurse co-ordinator are members of the Managed Clinical Network and Standards Board which provides opportunities for peer review and an evaluation strategy is in place involving a review of clinical records.

**What works well/not so well and what has been learned?**

Issues to do with ‘good practice’ have positively affected the reputation of this clinic and include:

- ensuring that training and assessment processes meet clinical standards;
- improvement in the appropriateness of referrals from primary care;
- educational benefits for both patients and carers and for visiting health professionals such as trainee doctors, nurses and physiotherapists

As in other comparable projects some issues have been essentially predictable including:

- problems during the planning phase;
- personnel becoming unexpectedly unavailable;
- inconsistencies in data collection.

Grappling with the politics and management resistance of the NHS appeared to make the process of the bid application an uphill task for very busy clinical and medical personnel and the BIG information requirements appeared to them to focus on centres of population and to ignore the special difficulties of providing a service for a widespread rural population.

The unexpected demise of the Radiologist and the necessity for subsequent re-structuring of local radiology services inevitably resulted in some delays in setting up the clinic.

Unavoidable problems to do with definition and standardising information have contributed to a substantial increase in the paper workload to improve the consistency and reliability of recording a 'minor stroke'. It appears to be an onerous if necessary task in order to obtain a reliable baseline position and contribute to the Scottish Stroke Audit. For the Senior Nurse Stroke Co-ordinator, the Project has taken over much of her usual work.

With regard to attaining evidence of patient satisfaction and involvement, it was a little surprising to discover the use of a patient questionnaire ‘several pages long’. This was thought to be inappropriate by the clinic assessment team but assumed (erroneously) to be necessary to meet the requirements of BIG; it was undertaken by the local Research and Development group.

In relation to other aspects of overall ‘impact’ there appears to be growing evidence that ‘word of mouth’ experiences of the clinic have raised both public and health professional awareness of its potential benefits, as well as considerable interest from trainee health professionals and students who have increasingly visited the clinic.

**Progress Reports**

For the most recent reporting period there were 31 new referrals and 10 secondary beneficiaries with a total to date at mid 2005 of 60
referrals, 10 secondary beneficiaries and 29 benefiting from Outreach Stroke Services.

The re-location of Radiology reporting probably means that for some islanders it would be quicker to receive a comparable service by flying directly to Paisley where a comparable service exists, making the original estimate of potential beneficiaries slightly higher than might be expected.

**Sustainability**

Sustainability may depend on any further restructuring of NHS services but given the ‘in-house’ training and growing reputation of this clinic to provide an effective service, as well as contributing to important aspects of training and education, there is a degree of optimism.

### S4. CASE STUDY 12: BLACK AND MINORITY ETHNIC GROUPS IN HEART HEALTH INFORMATION RESOURCES

**Organisation**

This project is based within the Greater Glasgow Health Board’s Health Promotion division and falls within the unit dealing with Heart, Stroke and Diabetes. It is a response to the Scottish Executive’s “Health Challenge” and more specifically its “CHD & Stroke Strategy for Scotland.”

**Project**

The project aimed to translate the standard advice given to all appropriate patients and their carers into a number of ethnic minority languages and also to develop a website to improve access.

The need was identified following an examination of uptake levels for post diagnostic services which showed low levels of uptake amongst groups with known high incidence – for instance high levels of diabetic diagnosis amongst the Chinese community, but little attendance at community based exercise classes or awareness raising events.
The £36k has largely been spent on translation costs over a three year period, paying particular attention to cultural sensitivities in relation to examples of healthy eating and sexual health to make them more acceptable to each community.

There was also the need to revalidate text and to update content as well as to retain the loose leaf format to allow for future updating. An audio version in each of the six languages is about to be launched.

**Potential benefit**

There are believed to be 27,300 potential beneficiaries for the project although this may be a significant underestimate as carers and health and social service workers may indirectly benefit also.

**Delivery and management**

The main problems encountered have been getting a “sympathetic” translation and having an understanding of the cross-cultural issues. There is good evidence of partnership working both with other health and social services agencies and also with communities themselves. Feedback on materials was sought from focus groups of patients and carers.

**What has been learned**

The website development has taken longer than expected but it is about to be launched. Here the translation and other problems have been compounded by the need to develop new delivery systems and content which matches the delivery system – straight page by page translation does not work, or at least it fails to optimise the messaging opportunity.

Also, because the medium is more “immediate”, there is the need for more frequent updates involving expert contributions to ensure accuracy and inspire confidence from users and health professionals.
Progress reports

The project has been substantially completed. So far there has been limited internal evaluation but further work is anticipated in this area including testing content against formal quality standards.

Sustainability

There are no sustainability issues as the Health Board has undertaken to provide translations of updates as they occur in the main cardiac care publication.

S5. CASE STUDY 13: SPECIALIST DISCHARGE SUPPORT FOR STROKE PATIENTS

Organisation

Greater Glasgow Health Board already had a specialist team dealing with Discharge and Rehabilitation (DART) and this project extends and enhances their work by systematically identifying those who would benefit from early discharge from hospital and a targeted intervention from a range of health and social work professionals delivered in the patient's home and closely monitored via a team approach.

Project

Assessment begins on admission and uses a number of clinically recognised tools to monitor severity and recovery. Interventions are available in

- physiotherapy
- adaptation
- diet
- nursing and GP input.

Patients are reassessed at six months against agreed criteria by their GP.
Processes are designed to enhance the patient's capacity to develop self care and rely on a clinical evidence base.

Potential benefit

Last year, of the 800 stroke discharges around 130 received this enhanced service. Benefits include an earlier discharge from hospital, quicker rehabilitation and early return to work for some. Carers also benefit through a system which gives them confidence and support and there are wider benefits to the health of others because beds are unblocked to be used by those with greater need.

What has been learned

It is widely recognised in the literature that a “one size fits all” service inevitably over-treats some patients and drains resources so that others have less treatment than they optimally need. Early prioritisation through on-going and clinically proven risk assessment tools makes sure patients get the care they need rather than a more general service. Staff training in the use of assessments means that discharge recommendations are not confined to consultants.

Progress reports

The project is the subject of an ongoing evaluation which is based on clinical reports and other assessments at patient level as well as evidence from carers. An evaluation report is due very shortly.

Sustainability

The long term aim is to mainstream the activity based on its ability to improve quality of life and save bed costs, although of course this is offset by greater costs in home based care.

Prioritisation of services in Scotland

An interesting feature of the Scottish Health care system is the use of Managed Clinical Networks in decision making with regard to the
prioritisation of new services and disinvestments in services that no longer best meet need.

These MCNs were set up by the Scottish executive and are funded to, typically have a clinical lead and a coordinator and administrator and to receive inputs from other clinicians, nurses, GPs, patients, voluntary bodies and carers. They conduct evaluations of “what works?” and can add value to local decision making as well as spreading best practice across Scotland. These bodies make a considerable contribution to making sure that new projects are aligned to strategic goals and also have the backing of communities through their involvement in them. They fulfil the role of ensuring public engagement and properly testing innovation since they are required to critically review any development.
Organisation

The Stroke Association is a national charity concerned with combating stroke in people of all ages. The organisation funds research into the prevention and treatment of stroke and better methods of rehabilitation. The role of the Positive Action for Stroke project plays a key part in this strand of activity and helps stroke patients and their families directly through its community services. The organisation also strongly campaigns at a local and national level to increase knowledge of stroke and acts as an effective voice for everyone affected by stroke. The charity recently launched the “Stroke is a Medical Emergency” campaign which was prompted by a lack of awareness of the symptoms of strokes in the general public, misdiagnosis by health professionals and a lack of coherent organisational structure to deal with stroke patients. This has caused a massive and regular failure to the emergency response to stroke.

Project

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.

Stroke is an extremely isolating illness and in the past there has been very little support to counter the social and psychological disabilities which stroke can cause. Rehabilitation is crucial to the process which helps individuals overcome and cope with the damage the stroke has caused. In the past there has been a patchy provision of this type and the developers of the project clearly recognised that when developing the project.
Participants are offered a very broad programme of activities including: art work, information technology, music, creative writing/poetry and cookery. The community service which is provided at Maesteg has recently produced two examples of mosaics, one female and one male golfer which are outstanding examples of this particular craft and which demonstrate what it is possible to do after having a stroke, particularly when the intricacy of the work is considered.

The information technology activities have also proved to be very popular with participants and most individuals have been encouraged to communicate by e-mail, access the internet and develop basic word processing skills. Clients have felt the introduction to email to be most valuable because it has enabled them to keep in touch with family and friends.

The art work activities have also been very successful as it has enabled individuals, in some cases, to be able express feelings which they may not feel able to express in words. Frequently they have been able to express some of the more negative emotions they may have experienced when first realising what has happened to them, such as the feeling of helplessness, bewilderment, isolation and anger. Participants are able to work through those emotions and come to terms with what has happened to them. This acceptance frequently acts as a catalyst for the gradual rebuilding of their lives.

Potential benefit

The application originally estimated that approximately 1,740 individuals would benefit from this project and the most recent monitoring information dated June 2005 states that to that date 195 beneficiaries had been inducted onto the project. More up to date figures will be obtained when the project is followed up in the middle of 2006. The project is also providing valuable benefits to close relatives/carers of the stroke individuals in terms of respite time and also in providing support where people have requested it.

Delivery and management

The project encountered a number of challenges in the initial stages, these included:
Despite these initial challenges the project is now progressing well and all co-ordinators are in post. The project has also attracted good levels of volunteer support and continues to attract higher levels of participants primarily due to word of mouth. A comprehensive action plan for 2005/early 2006 was developed and this included a number of key activities, more specifically:

- to encourage self referral onto the package of support offered by Relate, and to ensure that the support is targeting those most in need. For many couples and individuals living with stroke the emotional, physical and psychological trauma can have a devastating effect on relationships. Relate provide a specialised service across the principality which includes providing relational and psychosexual counselling
- to hold a meeting at which all co-ordinators were present to exchange ideas encouraging the continued development of the project and also to encourage peer support
- to carry out reassessments of all participants in order to ensure satisfaction with the services and support received
- holding an event held at the National Assembly for Wales to publicise the project
- providing training and support to both newly recruited volunteers and those who had been in post for some time to ensure continued development
- canvassing opinion from a range of key stakeholders to ensure the continued development of the project
- producing an end of year report facilitating planning for the next stage of the project.
What works well/not so well/what has been learned

Project activities continue to be very successful and have evolved in response to participant needs and requests. Some of the practical courses now offer certificates which have helped to focus participants’ attention and demonstrate achievement of goals. A good example of this has been a number of participants engaged with Information Technology activities who are studying towards their European Computer Driving Licence qualification.

Despite a slow start and a number of problems at inception, the project has continued to build and has attracted increasing numbers of regular participants. On an individual level, after speaking with a number of participants, it was clear that the project had made a substantial difference to their lives, particularly in bringing them out of that very isolated state which characterises a stroke.

An individual participant commented that the activities had been a lifeline for her and had enabled her to come to terms with what had happened; talking to other people who had been through the same types of experiences was definitely a great help for her and she in turn felt that she could help other people, thereby increasing her own sense of empowerment. She also showed me quite a substantial portfolio of art work completed over a long period and which she said was a fair reflection of the emotions she had felt over that period of time.

I also spoke to another participant who was very complimentary about the project in general. He had been participating in the IT activities and considered learning about email to be very valuable as it had enabled him to keep in touch with family and friends, thereby countering that very real sense of isolation he had felt over a period of time.

Progress reports

As has been stated in previous sections the project has continued to attract growing numbers of participants, we therefore see no reason why it would not meet the original targets set out in the application. The project continues to publicise its activities and a number of events have been held to further publicise the project to key groups and organisations. At a more local level the project has become more
known via word of mouth and this undoubtedly has contributed to the growing numbers of participants. Accurate data about numbers of participants will be gathered in the next round of project interviews.

**Sustainability**

With the launch of the National Service Framework for Older People in March, Local Health Board’s and Local Authorities will be expected to meet the objectives set in the standard on stroke. For example, Objective 30 states that - people and the carers of people who have had a stroke receive longer term care and support as appropriate to their needs, which enable them to maximise their recovery and independence.

The Positive Action for Stroke Programme supporting people over a long time, with rehabilitation continuing until maximum recovery has been achieved, may be an attractive stroke service to be commissioned by either LHBs or LAs, or perhaps joint commissioning. Such a service is likely to help meet the targets set by the Welsh Assembly – that the NHS, working in partnership with other agencies will provide appropriate longer term care for the stroke person and their carers.

The Stroke Association is optimistic that it is well placed to market this programme to health and social care commissioners of stroke services in the community.

### W2 CASE STUDY 15: ROOTS TO HEALTHY HEARTS

**Organisation**

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.

Groundwork Wrexham (registered charity number 1004132) has existed since 1991, expanding into Flintshire in 2001. It currently employs 24 full-time staff and 6 part time, as well as 2 full-time and 50 part-time volunteers. Of the 15 members of the committee, two are users of the organisation.

Groundwork Wrexham & Flintshire are currently working on a multitude of different projects; from the weekly walks carried out by the ‘walking the way to health’ scheme which has benefited over 6000 people since the scheme began, to more traditional projects such as community gardens and information boards. Groundwork Wrexham & Flintshire help approximately 8925 young people and 7386 adults annually both directly and indirectly through first-hand contact, and as a result of projects which we have worked on.

**Project**

The Roots for Healthy Hearts project was developed to encourage active living and healthy eating in schoolchildren and community groups. Developing basic activity and healthy eating in childhood, 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 among both schoolchildren and community groups. For the most part, these strands are presented as a combination for a healthy lifestyle, rather than as two separate parts.

The project has employed both an Active Lifestyle and a Healthy Eating Officer. The Healthy Eating Officer is a registered nutritionist with the Nutrition Society, his role in schools involves teaching nutrition to children using interactive sessions such as food tasting sessions, the balance of good health game, play your fats right games plus other quizzes and games. There are also educational trips to the kitchen garden, where children can see how food is grown and how it looks in
its pre packed form, in addition to participating in planting crops and harvesting.

The Healthy Eating Officer’s role in the community involves leading a weight management course, promoting the use of the garden as a form of physical activity, growing healthy wholesome food in the garden and developing healthy recipes using in-season crops. This role also includes presentations about the balance of good health and the consumption of fruit and vegetables to community groups.

The Active Lifestyle Officer’s role includes sessions with school and community groups, in a variety of settings including classrooms, community centres, day centres, the Trim Trail, and local country parks. Indoors, educational topics covered might include; types of exercise, recommended amounts of activity, the heart and lungs (including use of heart rate monitors), and playground/parachute games. Practical outdoor sessions run by the Active Lifestyle Officer include healthy walks and Trim Trail exercise sessions, as well as general promotion of walking, running, cycling, etc.

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, 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 are given the chance to conduct experiments around that theme.

Both Officers also regularly give talks and presentations about their individual specialisms such as the benefits of eating healthily and following an active lifestyle, perhaps in the future reducing the incidence of coronary heart disease, stroke and cancer.
The Healthy Eating Officer also delivers a food hygiene course to individuals who fulfil certain criteria. On successful completion of the course individuals will be issued with a certificate from the Chartered Institute of Environmental Health.

**Potential benefit**

The most recent monitoring return for this project states that 1950 people have benefited directly from the scheme, a more recent estimation of actual beneficiaries is currently in the process of being formulated. The evaluators will request up to date beneficiary numbers when the project is revisited in the middle of 2006.

The project has clearly been successful in engaging schools and community groups but the project manager could not identify any unforeseen groups which may have benefited from the project.

**Delivery and management**

The project is managed by the Healthy Living Manager and delivered by a Healthy Eating Officer and an Active Lifestyle Officer. The project is supported by a horticulturist/gardener. The Healthy Eating Officer is required to develop, pilot, evaluate and deliver a healthy eating school based programme, assist with the development of the kitchen garden and liaise with partners and users in providing community based programmes. The Active Lifestyle Officers role is very much the same with the emphasis being on delivering an activity programme and assisting with the development of the Trim Trail.

The team are supported by a Senior Management Team who report on a regular basis to the Board of Management regarding progress. The project team work in conjunction with a number of other partners who all feed in to the ongoing development of the project, these partners include: Countryside Services; Cardiac Rehabilitation Services; and an Education Manager who quality controls the programme and provides evaluation. The project also works quite closely with the Healthy Schools Co-ordinator and tries to co-ordinate activities/educational elements to ensure that there is no duplication.
The project initially was fairly reliant upon voluntary support to develop the kitchen garden but voluntary support has been progressively more difficult to engage (particularly since the bulk of the work has been completed), the role of the volunteer has changed into one of supervision and assisting people and that again is deterring volunteers from participating.

The dedicated horticulturist/gardener was employed and this ensures that somebody is always on hand to provide supervision and assistance and keep the kitchen garden in good order.

What works well/not so well/what has been learned

The project has continued to evolve and learn from experience and minor changes to the project have been instigated in response to what has been learned, more specifically, the changes include:

- Neither Officer realised in practice, how time-consuming the schools element of the project would be, they have therefore decided to use some underspend in the project to pay for additional staff resources that will be dedicated to the school project, this will free up some of their time during which they will be able to concentrate upon their community activities.

- Although comprehensive amounts of baseline and secondary data have been collected from both the schools and community groups, resources have not been available to analyse any of this valuable data. The project manager commented “for each of the sessions a register is taken and we have designed a questionnaire which was distributed as a baseline and then one designed for the end of the session to measure how far their knowledge had increased about food and fitness – we have not aggregated all the results yet, again it is a question of time – we may be able to utilise some support outside of the project in the future to be able to input all the data and aggregate all the results from that but again we have no immediate plans to do that but it will obviously be important to do that because what we discover then will be fed back into the future development of the project”.
Progress reports

Based on current monitoring and evaluation reports we would estimate that the project is very likely to meet its original targets. The project manager stressed that any future aggregated evaluation material would be made available to the evaluation team. Obviously this aggregation of material could play a key role in decision making about the future sustainability of the project.

Sustainability

The sustainability of the project is obviously not assured; the project manager commented “obviously the kitchen garden is not yet 100% up and running but what we were hoping is that in the future we would be able to put a small charge on everything that the garden produces. Regarding the trim trail, that is a community resource and that will be there for the community for some time to come. We hope that the kitchen garden will continue to be used by the community and that there will be a demand for what the kitchen garden produces”.

The project manager is hoping to secure some resources to help with the inputting and analysis of all the data that has so far been collected, this will obviously act as a good evidence base for any future funding, although it has to be remembered that they are just one organisation seeking funding amongst many other organisations.

W3. CASE STUDY 16: BREAST CANCER REHABILITATION RECOVERY AND PREVENTION OF LYMPHOEDEMA SCHEME

Organisation

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

---

4 Lymphoedema is the swelling in the arms or legs which is caused by blockage or damage to the drainage of the lymphatic system. It can happen as result of some treatments for cancer or by the cancer itself.
involving consultants, oncologists and nurses. All referrals are taken from the unit.

**Project**

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 service, social service and user boundaries
- implementing and evaluating an equitable, accessible and culturally sensitive services
- determining and evaluating defined objective and subjective patient outcomes and to evaluate these in terms of their cost effectiveness in care provision.
- providing a cancer rehabilitation project to help reduce the impact of the side effects of cancer treatments.

Traditionally rehabilitation and treatment of lymphoedema has been given little focus in treating breast cancer, the emphasis has been on surgery and oncology treatment. This project was conceived and developed as a result of the incidence of increasing lymphoedema and shoulder mobility referrals plus growing patient complaints. The scheme is the first of its kind 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

Referred patients are assessed pre and post operatively and given daily physiotherapy until discharge home. They are reviewed at 3 and
6 weeks as outpatients and are invited to attend a 12 week exercise and education programme in a local private leisure centre. The 12 week programme offers patients advice on a range of different issues including: healthy eating; genetics; breast reconstruction; complimentary 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.

**Potential benefit**

The project application stated that 2100 patients would benefit from the scheme the most recent monitoring return dated June 2005 indicates that from May 2004 to April 2005, 250 individuals participated in the project. Evaluators will source accurate up to date participant numbers when the next round of project visits take place.

**Delivery and management**

All staff are now in situ and initially underwent a very comprehensive induction process which included: orientation, stakeholder meetings, training covering breast cancer pathways and current lymphoedema protocols. In addition, a very intensive public relations campaign took place informing the public of the commencement of the project.

The partnership working between the service and the local leisure centres has been very successful and the partnership working between the service and the specialist breast cancer unit is again working very well. Effective referral process procedures have been put in place to ensure everyone who would benefit from the support of the project is given the opportunity to participate.

**What works well/not so well/what has been learned**

This is an extremely innovative project which is unique not only to Wales but also to the United Kingdom. The project is innovative on a number of levels these being:

- the project has worked very successfully in partnership with a number of leisure centres where the surroundings are of an extremely high standard; the partnership is invaluable as
patients arguably become “clients on the road to recovery” and will concentrate on getting better as opposed to concentrating on the illness

- the project has facilitated the development of a number of patient forums and ‘buddying’ groups which are age orientated - in effect individuals have formed their own networks of support
- the project recently won an award in the Welsh NHS Confederation “Celebrating the role of Innovation in Improving Patient Care in Wales” awards
- results of the scheme have been extremely positive with 99% of patients feeling they have benefitted from the exercise sessions and 97% of patients feeling that their quality of life has improved due to the scheme. 95% of breast cancer patients involved in the scheme, now have full range of movement in their affected limbs and have regained their muscle strength
- the uniqueness of the project has meant that the project manager has been asked to give a number of talks about the programme both at a national and an international level
- very importantly a degree of flexibility has been built into the project and if patients are too ill to attend then they can defer and attend the next set of sessions.

Progress reports

The project manager stressed that any information that became available in the future such as independent evaluation material would be made available to the evaluators.

Sustainability

The future sustainability of the project is virtually assured and will be mainstreamed. A range of monitoring and evaluation material will be used to support this transition.
W4 CASE STUDY 17: ACTIVE LIVING

Organisation

The project comes under the aegis of Blaenau Gwent County Borough Council’s Leisure Services Department. This department is newly formed and is 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 it direction is, “to provide sport and cultural opportunities for all.”

Project

The Active Living project primarily is about setting up accessible activities for people and giving people a supported pathway into activity – concentrating on the conditions of coronary heart disease, stroke and cancer and preventing those conditions through the promotion of lifestyle changes. The project is helping both people at risk and those who may already be experiencing those conditions. In terms of those who may already have those conditions, they are being helped to manage those conditions and possibly prevent a further reoccurrence. The project currently has an exclusively adult contingent but future development of the project will involve targeting juniors as well.

The scheme is heavily promoted through the network of GP services in the Blaenau Gwent area and the GP will refer patients to a number of services including:

- physical activity
- weight management
- counselling
- smoking cessation

Participants will be supported for a minimum of 12 weeks and will utilise services throughout the Blaenau Gwent area such as the leisure centres or the community centres.
Potential benefit

When the project originally started in March 2003 there were approximately 6 or 7 exercise classes operating per week attracting 188 individuals. The evaluators spoke to project staff in October 2006 and were told that approximately 27 classes were operating at that time and that those classes were attracting approximately 850 individuals.

Delivery and management

The actual project staff comprise: The Active Living co-ordinator responsible for good practice, the development of the programme, the evaluation tools, referral mechanisms, intervention package and key resources for use with the project. Additionally she is responsible for the collation of relevant data from key partners and analysis and report writing. The Head of Leisure Services also contributes to the project and provides managerial accountability for the evaluation process. The initial British Association of Cardiac Rehabilitation (BACR) instructor was brought into post and the success of the scheme has meant that 2 additional BACR instructors have been seconded to deliver the outreach activities.

What works well/not so well/what has been learned

Partnership working is key to the success of this project and there have been a range of partners involved with this project. More specifically these include:

- the various GP practices throughout Blaenau Gwent who have been instrumental in identifying suitable participants and thereafter referring them onto the project
- the nurse facilitators working out in the community who can again identify and refer suitable participants
- mental health counselling services within Blaenau Gwent
- other support staff such as dieticians and physiotherapists

The project also has links with the “Green Gym” project operated by British Trust of Conservation Volunteers now recognised as BCTV and currently refers suitable participants. The “Green Gym” project offers
participants the opportunity to work in the open air through local, practical environmental or gardening work.

The project has also established very good links with the Blaenau Gwent Local Health Board and has linked the Active Living project with the various Healthy Living strategies arising out of the Board.

The project manager has developed an extensive marketing strategy for this project and as a consequence there is now a strong brand image associated with the project.

The project manager stated that considering they had come from a very low base in terms of general active living initiatives they had made considerable progress in the 18 months since the inception of the project.

**Progress reports**

Progress reports would seem to indicate that the project is very likely not only to meet the initial targets set out in the application but also to exceed them. The project manager has very good systems in place to ensure the collation and analysis of the very comprehensive data coming out of the project in terms of mental health and wellbeing, social wellbeing and physical wellbeing.

**Sustainability**

Future sustainability is of concern to the project, any data collected will obviously be used to provide evidence for future applications to either external or internal bodies. Ideally the project manager would like to see the project being mainstreamed but whilst there is an ever increasing demand for scarce resources, he acknowledged this will prove to be a very real challenge.
Organisation

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.

Project

The project “Community Cardiac Rehabilitation Services in Cardiff” was developed to provide a community focused cardiac rehabilitation programme in Cardiff. The service offers cardiac patients a range of accessible and co-ordinated services through individualised plans linking primary and secondary care, whilst developing pathways of care between health, leisure, education and voluntary organisations.

The project targets individuals within Cardiff and the Vale of Glamorgan who have experienced a cardiac event either in the form of a heart attack or heart failure. The project provides an individualised multidisciplinary programme of care for patients consisting of education, stress management and a supervised structured exercise programme. In addition, higher risk patients are offered a choice of services around existing hospital cardiac rehabilitation services, community multidisciplinary cardiac rehabilitation services and a home based cardiac rehabilitation service.

The individualised multidisciplinary element based in the community allows for a range of services which include:

- Occupational therapy which provides the opportunity to discuss anxiety issues related to the cardiac event either in the form of a heart attack or heart failure and also to discuss goal setting which encourages the patient to return to purposeful activities
- Physiotherapy which provides an opportunity to plan an individualised workout and effective cardiovascular workout for those who may not have attended the sessions at the various fitness centres throughout Cardiff and the Vale
- Dietetic provision which provides an individualised dietary consultation for weight maintenance and modification of dietary risk factors.
The participant also receives a six week facilitated home cardiac rehabilitation programme, during which time a nurse will visit the patient and together they will plan the cardiac rehabilitation required by working through the heart manual. The heart manual is a 6 week facilitated self help rehabilitation programme for people recovering from a heart attack. The heart manual has three elements and these are:

- The facilitator spends time with both the individual who has had the heart attack and their partner/carer and explains the system to them, in particular they check that the patient can understand and complete the simple exercise programme
- The workbook consists of a phased programme of health education, home based exercise and stress management that the patient works through over 6 weeks
- The audiotapes provide a programme of relaxation training and also explanatory dialogue between a patient and doctor outlining what has happened and what they can do.

The nurse then contacts the patient over a six week period to ensure progress and offer support. Following this, the option is available to join the standard hospital or community programme.

**Potential benefit**

The original application stated that approximately 6240 people would benefit from this scheme. The last monitoring return for the period April 2004 to March 2005 shows a total of 176 participants had directly benefited from the scheme. This number does not include the 319 patients who had received a home visit or the 140 patients who had benefited from community cardiac rehabilitation services. The evaluators will continue to monitor this and will ascertain whether there have been any unforeseen benefits to come out of the project in the next round of interviews.

**Delivery and management**

The project is currently staffed by 2 part time nurses, an occupational therapist, a physiotherapist, a dietician and a pharmacist. Both community cardiac nurses were involved in the four month initial start
up period, confirming venues with leisure centres, primary healthcare clinics and forming links with the multidisciplinary team and other partner groups. The occupational therapist works across the two BIG funded projects across Cardiff and the Vale, as does the physiotherapist and the dietician.

Progress to date includes:

- the establishment of several satellite clinics across Cardiff
- the development of three exercise classes across Cardiff as well as the development of a phase 4\(^5\) exercise group in Splott and the development of a phase 4 exercise group in the Trowbridge area
- the establishment of a meet and greet system where the instructor contacts each individual by telephone or letter highlighting the time, who and where to meet
- links have been established between the project staff and the practice nurses across Cardiff highlighting the cardiac rehabilitation service and the BIG funded project
- the development of a weight management pilot programme incorporating intensive one to one support, four appointment at two weekly intervals and the option of two further appointments at monthly intervals
- the development of partner support groups to provide support, education and the opportunity to meet others in a similar position
- a number of publicity events highlighting the project.

**What works well/not so well/what has been learned**

The project continues to progress well with its stated aims and objectives, in addition the project manager is collecting very comprehensive sets of data about individual participants.

After internal staff discussion it was decided that a number of patients were still not benefiting from the individualised programmes of cardiac rehabilitation, it was therefore decided to offer further reviews at 6 and 14 weeks post cardiac event either in the home or to coincide with the

---

\(^5\) BACR Guidelines describes a Phase 4 Programme as “a community based programme which equips exercise instructors to prescribe and deliver exercise for individuals with coronary heart disease who have already been through a hospital based rehabilitation programme”
hospital outpatient appointment or in a community clinic. Evaluation data is being collected as to the success of this change of delivery.

Early indications would seem to suggest that the project is providing a valued service to its recipients. Patients views about the service were evaluated via anonymous questionnaires, comments included “thank you for the visits – I found them useful in as much as talking through my feelings – I walk now about 1½ miles per day and am not depressed” and “thanks to the therapist I feel confident enough to return to work in the near future.”

Progress reports

The evaluators will source up to date progress reports when speaking to project staff in the next round of interviews.

Sustainability

The future sustainability of the project lies in the current sets of data it is collecting about current beneficiaries of the project. The evaluators will ascertain more detail about contingency plans when speaking to project staff in the next round of interviews.
5. OVERVIEW ACROSS ALL COUNTRIES

5.1 Meeting the overall aims of national policies and associated local strategies concerned with reducing the impact of coronary heart disease, cancer and stroke, provides the linking thread between a variety of BIG funded projects from Northern Ireland, Wales and Scotland. Central concerns have included primary and secondary disease prevention, health improvement, treatment and rehabilitation, as well as some particular aspects of child health and development. Public consultation has contributed to the prioritisation of projects in each country.

5.2 While most projects have been successfully embedded into existing structures, their development and sustainability seems to have been significantly influenced at this stage, by innovation and flexibility, communication and marketing initiatives, and the ability to balance supply and demand – some Projects seeming to have become victims of their own initial success, with the subsequent necessity for decision-making about, for example, targeted and open access to the available services.

5.3 Although different in many respects, the focus of project activity across the three countries, has been largely to do with:

- increasing service capacity – for example by improving co-ordination; by standardising referral processes; by involving the voluntary sector.
- improving and maintaining quality standards – for example by ensuring equal access to ‘user friendly’ information; agreeing the use of specified clinical guidelines; by training initiatives.
- raising public awareness and participation – for example by planned use of the media; by increasing involvement of service users; by fostering ‘word of mouth’ spread of information about the purpose and availability of services.
- responding to the needs of specified target groups – for example by recognising and taking account of their specific needs; by modifications to service provision; by involving them in planning.
5.4 Key themes and processes identified from interviews and project visits, which reflect things that are working well, include:

- developing and nurturing partnership arrangements between service providers; between users and providers and between community groups
- investing in training and supervision
- improving all aspects of communication
- reviewing assessment and referral processes
- raising patient awareness and participation
- involving users and carers
- providing sensitive service environments
- focusing on the special needs of deprived communities.

5.5 Arising from these themes and processes have been both examples of 'good practice' and examples of particular difficulties. The former have been helped and supported by Steering Groups and the Managed Clinical Networks and the latter sometimes emerging from unexpected resource limitations, from difficulties to do with engaging deprived communities, from resource implications for data collection and the establishment of baseline positions. The problem of sustainability and identifying and exploring the principle barriers has not yet reached the top of the agenda for most projects, which to date have been largely engrossed in management and development issues.
6. NEXT STEPS

The evaluation has reached the end of Year 1. Indicative actions for the evaluation team in the future are listed below. These are subject to amendment if required, in consultation with the Evaluation Steering Group.

Year 2: 2006

- Second case study visits/interviews - Summer 2006: We envisage this element as focussing upon the following issues, but this is obviously subject to approval and debate from the Evaluation Steering Group:
  - the impact of personnel movement and resource limitations
  - the development of roles such as Project Leaders/Managers/Co-ordinators
  - equity of access to programmes and services
  - success or otherwise of innovations designed to reach target groups
  - maintaining achievement and quality standards
  - key inhibitors of progress
  - wider implementation and dissemination of ‘good practice’
  - practicalities of Project sustainability – including completion and mainstreaming.

- Tracking update – ongoing linked to BIG monitoring & exception reporting

- Steering Group Meeting – September 2006

- Year 2 Interim Evaluation Report – October 2006

Year 3: 2007

- Final case study visits/interviews - Spring 2007

- Tracking update – ongoing linked to BIG monitoring & exception reporting

- Steering Group Meeting – TBC
- Year 3 Final Evaluation Report – August 2007

- The timing of case study visits in 2007 will take account of projects coming to a close (or being mainstreamed) at different points in the year.