SOUTH MANCHESTER HEALTHY LIVING NETWORK

Learning for the Future

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- Photographs on the front cover are from chair based exercise classes run by the Discovery Team.

Evaluation can be uncomfortable at times and the co-operation of those being evaluated is especially appreciated. The findings are our responsibility. While at times these may be challenging, we hope they are helpful and enable SMHLN to maintain and develop its valuable contribution to community engagement and health in the new citywide HLN service in Manchester.

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Executive Summary

This report documents SMHLN's progress since its move to the PCT in 2006. It builds on the evaluation of Zest, the North Manchester HLN.

The evaluation focused on specific aspects of SMHLN's work:

- Linking health into the **locality agenda** via work with ward co-ordinators and a case study illustrating the work with Barlow Moor Community Association (BMCA) to develop work with **older people**
- The volunteering project, known as the **Discovery Team**
- Organisational issues including **location and management** arrangements and the second case study considering how SMHLN implemented a NHS initiative, a **computerised Cognitive Behavioural Therapy Project (cCBT)**
- Development of an **evaluation framework.**

These were chosen as they impinge upon the future HLN. It was hoped that learning from the evaluation would contribute to the proposed new service.

SMHLN is smaller than when funded by the Big Lottery but has successfully reconfigured itself and is highly valued by those it works with. It has provided activities that relate to current government objectives, such as exercise and diet, smoking cessation, mental health and support for older people. Its activities often combine health and social benefits and many are delivered by sessional workers who originally started as volunteers with the Discovery Team.

SMHLN has developed valuable partnerships and networks with different organisations, including community and voluntary groups, health workers and ward co-ordinators. The work has introduced a health focus into communities. It has also acted as a conduit between statutory services and the voluntary sector.

Stakeholders spoke highly of SMHLN, it has a reputation for delivering quality services. Many valued its good practice in engaging with local communities to combat health inequalities. It has a positive and effective approach in developing health related services.

The HLN is an important element in Manchester's capacity to engage people in health related activity; people who experience the worst effects of health inequity. While both nationally and locally the health and health care of the population continues to improve the equity gap remains unacceptably high. Hence the importance of building on the positive contribution of SMHLN.

Recommendations include

- Targeted initiatives should be developed which tackle health inequalities
- Strategies for sustainability need to be built into all provision.
- The HLN should continue to deliver NHS initiatives in community settings
- Work should be developed with community and voluntary groups who are in contact with those most in need.
- Work within ward co-ordination should be developed further with the increase in partnership workers
- The aims of the Discovery Team need reviewing to see how they fit with the new service
- Volunteers should link into the work of the proposed partnership posts in communities
- Strategies should be developed to meet the needs of the different types of volunteers
- Commissioners should be supported in understanding the potential for HLN's work with the 3rd sector.
- Key stakeholders should contribute to the vision and goal setting of the new service
- Governance arrangements should be understood, influenced and supported by all key stakeholders including commissioners
- The proposed development of health fora in the wards need clear terms of reference and better links to service development
- Evaluation material demonstrating the effectiveness of HLN's work needs to be developed as part of an evaluation framework.
- Indicators should be devised which help in service development and demonstrate the value of the work; this should be through participatory methods where appropriate
- There should be a clear relationship to the new PCT Engagement Team and LINKs
- The new manager of the HLN needs to be committed to tackle health inequalities; they need to champion the work so that relevant Boards, senior managers and commissioners understand its importance and potential
- The most appropriate financial arrangements for the HLN should be explored; these include being part of the PCT or a social enterprise model
- If the HLN's is part of the PCT options should be explored for a Health Improvement Section which brings together those services tackling health inequalities
- Regular events should be organized to showpiece the work, and develop and maintain HLN's profile.

Jargonbuster

AHWP	Adult Health and Wellbeing Partnership Board
BMCA	Barlow Moor Community Association
BtB	Beating the Blues, the name of a cCBT programme
cCBT	computerised Cognitive Behaviour Therapy
GP	General Practitioner
HAZ	Health Action Zone
HEA	Health Education Authority
HLN	Healthy Living Networks
LAA	Local Area Agreement , a 3yr agreement between MCC, its partners and the government which identifies priorities and targets for Manchester.
LSP	Local Strategic Partnerships
MCC	Manchester City Council
MCHIP	Manchester Community Health Information Profiler – statistics about health
NIACE	National Institute of Adult Continuing Education
NICE	National Institute for Clinical Excellence
NOF	New Opportunities Fund
National Health Inequalities targets	In 2001, the government set national targets to reduce health inequalities relating to infant mortality and life expectancy.
PALS	Patient Advice and Liaison Service
NHS	National Health Service
PCT	Primary Care Trust
PEC	Professional and Executive Committee, group of clinicians, who work closely with the PCT Board and senior managers
PBC	Practice Based Commissioning
PHW	Partnership Health Worker (a SMHLN post)
PPI	Patient and Public Involvement
POPP's	Partnership for Older People's Projects
PSB	Public Service Board
Quality of Life Survey	Survey based on 3,000+ Manchester residents
SHA	Strategic Health Authority - Since July 2006 there have been ten strategic health authorities for England to provide healthcare strategy. Manchester is in NHS North West
SMHLN	South Manchester Healthy Living Network
SMILE	South Manchester Improving Lifestyle through Exercise, an exercise referral scheme.
WCH	Withington Community Hospital
Zest	HLN in North Manchester

1. Introduction

This report documents SMHLN's progress since its move to the PCT in 2006. It follows and builds on:

- An in-depth evaluation[1] when SMHLN was funded through Big Lottery
- An evaluation of North Manchester's Healthy Living Network, Zest, completed in June 2008[2].

The evaluation addresses three main areas:

1. Looking back - which focuses on SMHLN's work. It includes an analysis of achievements in relation to specific projects and the lessons learned
2. Looking forward – which focuses on SMHLN's future and the development of a Manchester HLN which is currently being planned.
3. Communicating effectively – ensuring that the evaluation addresses the concerns of stakeholders.

1.1 Structure of the report

Section 1 introduces the report.

Section 2 sets out the methodology and purpose of the evaluation. It outlines the areas covered and the rationale behind this.

Section 3 refers to contextual factors and the remit of the Healthy Living Networks. It outlines how HLN help meets
Manchester's Community Strategy.

Section 4 briefly describes the background to SMHLN; its overall aims and discusses its approach to partnership working.

Section 5 reviews the work with ward co-ordinators and outlines SMHLN's partnership role in a community setting to develop health related activities with older people.

Section 6 outlines the work of the Discovery Team, the volunteers and sessional staff who contribute to SMHLN's work.

Section 7 considers the organisational aspects and includes the second case study, SMHLN's role in helping the PCT deliver with the 3rd sector.

Section 8 brings together the emerging themes to shed light on specific issues of policy and practice.

Section 9 discusses the importance of influencing strategy and outlines an evaluation framework.

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[1] South Manchester Healthy Living Network. Evaluation Report, 2004 – MMU.
[2] Colman C and Emanuel J (2008) The Best of Zest: Evaluation for Health and Sustainability. Commissioned by Zest, North Manchester Healthy Living Network

Section 10 discusses the issues emerging and how they could fit into the proposed city-wide HLN.

The final section (section 11) consists of recommendations.

2.1 Methodology

There are various audiences who are likely to be interested in different aspects of the programme and the lessons arising; these include:

- Commissioners of health and wellbeing initiatives
- Policy makers who develop and implement health and wellbeing interventions
- Practitioners developing provision to tackle health inequalities in statutory and third sectors
- Those responsible for developing the proposed city wide healthy living centre.

It was agreed that this evaluation would focus on specific aspects of SMHLN's work:

- Linking health into the **locality agenda** via work with ward co-ordinators and a case study illustrating the work with Barlow Moor Community Association (BMCA) in developing work with **older people**
- The volunteering project, known as the **Discovery Team**
- Organisational issues including **location and management**. This section includes a case study considering how SMHLN implemented a NHS initiative, a **computerised Cognitive Behavioural Therapy Project (cCBT)**
- Development of an **evaluation framework.**

2.2 Rationale

These initiatives were chosen as they impinge upon the future HLN. It was hoped that learning from the evaluation would contribute to the proposed new service[3] by:

- Focusing on locality work, an important aspect of SMHLN's work and a key area for a future HLN service
- Exploring how to gather data for monitoring, evaluation and reflective learning
- Developing baseline data and an evaluation framework for future work
- Discussing how HLN's can impact on LAA targets
- Considering the added value SMHLN contributes to the PCT, NHS and the voluntary sector
- Examining SMHLN's inputs into delivery and strategy
- Identifying supportive and enabling management arrangements
- Discussing the role of SMHLN in relation to community engagement
- Highlighting the role, value and effectiveness of the Discovery volunteer programme to community organisations, recipients and volunteers.

[3] Devereux G (2008) Executive Summary and key benefits – Business case template. Proposed service model for Manchester Healthy Living Network.

The evaluation considered two detailed case studies; **Beating the Blues (BtB) pilot** and SMHLN's involvement with **Barlow Moor Community Association (BMCA), developing work with older people**[4]. They provide a systematic way of looking at SMHLN's work in communities and with health services. They offer insights into practice and help develop expertise in tackling health inequalities.

The work with BMCA provided the opportunity to collect baseline data and develop an evaluation framework. We were interested in how working with the project would help them collect meaningful data as many community groups struggle with this.

Information about SMHLN's work was gathered using the following approaches:

- A review of existing evaluation material
- Attendance and observation of activities
- A Discovery Team meeting
- In-depth interviews with key stakeholders, individuals and groups
- Questionnaires to volunteers
- Questionnaires to participants
- Analysis of data
- Consultation with stakeholders
- Participatory methods.

2.3 Building on Zest evaluation

This study follows the evaluation of the North Manchester Healthy Living Network, Zest, and builds upon the lessons learnt. A key aspect of the Zest evaluation was the need to develop indicators in a number of specific areas; these were for:

- What a HLN does – which was identified as building involvement, partnership, confidence and community building
- How a HLN can contribute to meeting national and local health targets
- Indicators that measure people who engage in health related activity for the first time.

3.1 Healthy Living Centres

The Healthy Living Network programme was established in 1998, it was one of the first and largest set up by the New Opportunities Fund. Its purpose[5] was:

- To promote health in its broadest sense
- To target areas and groups that represent some of the most disadvantaged sectors of the community
- To reduce differences in the quality of health between individuals and improve the health of the worst off in society.

[4] The was jointly carried out with the SMHLN Partnership Health Worker (PHW).
[5] As indicated in the application instructions

The HLN initiative encouraged local 'ownership' of the actions taken, as they were seen as: *'Opportunities for local community action to improve health and for individuals to take responsibility for improving their own health*[6]*.*

3.2 Policy context

The NHS policy context has shifted since the HLN programme. There is now a growing emphasis on cost effectiveness and the economic value of different interventions. This and the concern about rising obesity levels moved attention towards diet and exercise[7] and individual life styles. There is a shift from tackling underlying risk factors, such as the economy and the environment towards more individual factors. However, wellbeing has become an important local authority priority which takes on board wider issues.

In 2001, health inequalities were identified as one of the key priorities for the NHS, alongside reducing waiting times, tackling hospital acquired infections and increasing patient choice. The causes of health inequalities are complex. Tackling these requires a whole system perspective, recognizing that there are no clear cut solutions for all situations. It means developing provision to reach those with the poorest health. However, changing health related behaviour and tackling health inequalities can not be 'done to' people, but requires their active participation if it is to improve their health.

Lord Darzy's[8] report earlier this year suggested that every health authority and council should jointly commission services to improve the wellbeing of the population and prevent ill health. He recommended tackling specific aspects viz: obesity, treating drug addiction, reducing harmful affects of alcohol, cutting smoking, reducing std, and improving mental health.

The growth in public service target setting also impacts upon HLN's work. It is difficult aligning targets to health inequalities, as health inequalities have to be addressed through collaborative practice, whereas targets can encourage 'silo' thinking. This can lead to easy-to-measure interventions, which focus on medical symptoms and cures, rather than tackling the systemic causes of health inequalities. Hence, the importance of agreeing HLN's purpose and developing indicators which test effectiveness based on a shared understanding of the causes of and solutions to health inequalities.

3.3 Health in Manchester

The most recent health profiles for local authorities in England were published in June 2008[9]. They used key health indicators to show local pictures of the nation's health. People in England live longer and have healthier lives, but the health gap between the most affluent and most deprived wards is unacceptably high.

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[6] Secretary of State for Health 1998: 4615
[7] Choosing Health White paper (2004) focused on diet, exercise and smoking.
[8] High Quality Care for All' , Lord Darzi, June 2008.
[9] Health Profile 2008 from Association of Public Health Observatories

While gaps in heart disease levels have been reducing, alcohol related problems are increasing especially in disadvantaged communities. It can be argued that overall the NHS has been successful at improving health outcomes with the noticeable exception of health inequalities.

The profiles showed that people's health in Manchester is[10] some of the worst in England; in particular life expectancy for men and early deaths from heart disease and stroke. Overall the population of Manchester has high levels of social and economic disadvantage which are reflected in the death rates. Life expectancy in Manchester is approximately 10 years less than the average in Kensington and Chelsea[11]. Furthermore men from the most deprived areas in Manchester live for four to five years less than men from the least deprived areas.

Manchester's statistics are particularly poor for teenage pregnancy and adults who smoke and binge drink. The Local Area Agreement (LAA) prioritises action to address high levels of binge drinking and alcohol-related hospital admissions.

Manchester City Council (MCC) has committed itself to developing indicators to measure how it is meeting its targets. These are set out in the Sustainable Community Strategy and Local Area Agreement (LAA). The LAA is Manchester's delivery plan for the next three years of the Community Strategy 2006-2015.

The following diagram[12] illustrates the delivery of the Community Strategy:

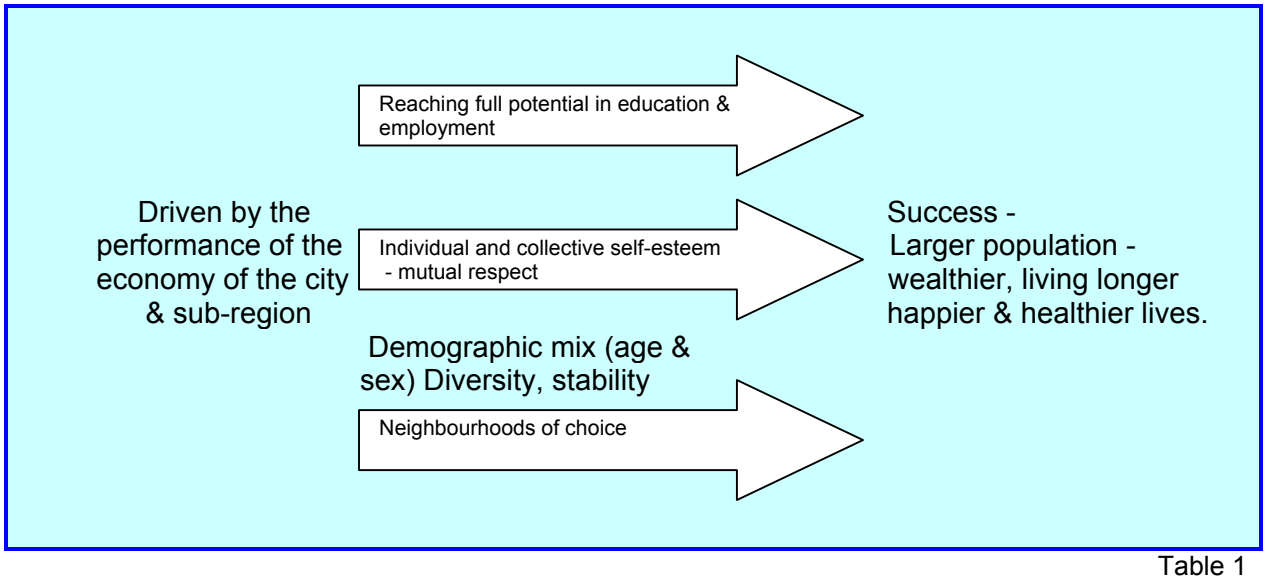

Table 1

[10] ibid
[11] ibid
[12] Manchester's Local Area Agreement – Delivering the Community Strategy, 2008

The three spines[13] are all driven by the economy. *'Reaching full potential in education and employment'* focuses on economic success and supports people achieve their full potential. As these people may then choose to leave the city, *'Neighbourhoods of choice'* builds sustainable communities where people want to live.

The middle spine, *'Individual and collective self-esteem - mutual respect'* connects and supports the other two, as public services on their own cannot achieve these targets.

Each of the spines has indicators at four levels[14]:

- Level 1 - which gives a high level overview linked to the Community Strategy
- Level 2 - which gives key indicators linked to the three spines of the Community Strategy
- Level 3 - which are thematic indicators, incorporating all Local Area Agreement and Local Public Service Agreement targets
- Level 4 - thematic early warning indicators.

These spines are sub-divided; those in bold have particular reference for HLN's:

Main priority	Sub-priorities
Reaching Full Potential in Education and Employment:	• Developing children's skills, aspirations and competencies • **Promoting health and wellbeing** • Supporting positive parenting • Raising resident wages and skills • Improving education with better attainment & attendance • Creating more routes into work • Encouraging cultural involvement to enable individual change
Individual and Collective Self-Esteem/Mutual Respect:	• **Promoting aspiration, wellbeing and happiness** • **Developing localised and personalised services in partnership with residents and organisations** • **Promoting and supporting community cohesion**
Neighbourhoods of Choice:	• Improving housing • Reducing crime and disorder • Improving the environment • **Developing locally focused services** • **Promoting stable communities** • Encouraging and supporting cultural activities to promote local ownership of neighbourhoods • **Developing a sense of place and community pride** • Promoting personal and business responsibility to make Manchester feel safer, cleaner and greener

Table 2

[13] As referred to in: Manchester's Local Area Agreement (ibid)
[14] These are in the process of development, especially at the lower levels.

These are discussed in relation to HLN's work in more detail later in the report.

MCC has established a citywide Public Service Board (PSB) to direct and monitor the delivery of the city's Community Strategy and regeneration agenda. It includes the major players in service delivery, viz: health, education, transport, the police and the voluntary sectors. It operates within the different ward plans, the Community Strategy and the Strategic Regeneration Frameworks

There are also a number of thematic partnerships including the Adult Health and Wellbeing Partnership Board The overall aim is to improve services and quality of life in Manchester.

4.1 SMHLN

SMHLN was established in 2001; it received £1,000,000 core funding for five years from the New Opportunities Fund. Further funding was obtained from the Health Action Zone and the Neighbourhood Renewal Fund (NOF). A proportion of the NOF budget was allocated for groups and projects in South Manchester. This enabled SMHLN to kickstart provision in some areas, focusing on those most in need.

The Director of Public Health from the old South Manchester Primary Care Trust chaired SMHLN's management committee. And Wythenshawe Regeneration Partnership, which is part of Manchester City Council, was the accountable body. The original team comprised a Co-ordinator, a Network Development Manager, a Physical Activities Co-ordinator, a Volunteer Team manager and administrative support.

In 2003/4, the priorities for SMHLN were derived from the National Health Inequalities targets. These were: helping people stop smoking, helping mothers to breast feed, supporting pregnant mothers to stop smoking, getting people more physically active, and getting support for young people with mental health problems.

The original aims were to:

- Bring together people and organisations who want to make a difference and improve health in their communities
- Make services better and more accessible for those who need them most
- Help enhance well being and develop new opportunities and initiatives in the most under-resourced local areas
- Enable local people to have more control over their health i.e. by enabling them to identify their needs through a team of local volunteers and researchers
- Help people and professionals work together and learn from each other.

SMHLN initially identified health needs by working with local agencies and their target communities. Events were held which solicited people's views. Additional information about local needs and issues was provided from other health workers.

In November 2006, with the demise of Big Lottery funding, SMHLN was mainstreamed within the new evolving Manchester PCT. The work was located within the old South Manchester Primary Care Trust area. The Volunteer Team manager for the Discovery Team continued, but as resources were limited a new Partnership Health Worker (PHW) post was created to facilitate local health improvements (Appendix 1 is a diagram of the current staffing structure and Appendix 2 shows its current position within the PCT).

4.2 SMHLN'S work

> *'SMHLN helps the PCT provide a community service; it helps people to stay out of hospital and to enable people to better manage their own health'* (PCT manager).

SMHLN has a positive reputation and is highly valued. They are seen as having: 'A *clear governance and management which is especially important as they are located within the health service*' (health service stakeholder).

Attracting people to health-related activities and encouraging them to remain involved, is central to its work. This means it can influence the health and wellbeing of its participants. One of SMHLN'S core values is the belief that maintaining a community engagement focus is key to lifestyle changes.

SMHLN supports the PCT to work in community settings. Recent examples include:

- Work with community venues about smoking in public with the 2007 changes in legislation
- Piloting Beating the Blues (BtB), a computerised Cognitive Behaviour Therapy (cCBT) Package for use with people with mild and moderate depression[15].

> *'I would approach SMHLN if I wanted to work on a specific programme, they are able to put me in touch with volunteers and tell me which groups to target'* (public health worker).

SMHLN's staff team[16] is smaller than in its Big Lottery days. However, the workers have a range of generic skills and a wealth of health and community knowledge and contacts. Their access to services and information within communities and health services gives credibility to the work and enhance their reputation.

Interviewees commended the SMHLN manager for her strong grasp of public health and health promotion which impacted on the work. The manager was also seen as being;*' … a good figurehead'…who had a clear understanding of evidence based practice'* (Board member). And compared to clinical health care SMHLN were seen as being more flexible and adaptable.

[15] http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11568 accessed on 21st May 2008
[16] Appendix 1

SMHLN have developed an extensive work programme which has included:

- The Discovery Team runs a number of weekly sessions targeted at gentle physical activity for older people, chair based exercise, in local centres
- Some Discovery Team volunteers have been trained as Stop Smoking Advisors and run weekly sessions at a local venue and WCH. They are paid for by the Stop Smoking service
- A weekly health information stall in Wythenshawe
- A weekly health radio show on Wythenshawe FM
- Developing older people's forums
- Network meetings for workers in the area
- A computerised Cognitive Behaviour Therapy (cCBT) programme
- SMILE (South Manchester Improving Lifestyle through Exercise)[17]
- Partnership working with different agencies
- Events; in the last year this has included four alcohol free bars held in Wythenshawe and a come-dancing event
- A daily information stall at Withington Community Hospital (WCH)

> *'SMHLN are willing to take risks and try out new initiatives'* (health stakeholder).

SMHLN have a different approach than most health professionals: *'SMHLN have people in the system who are not health professionals, they are about health promotion, empowerment; the NHS is very illness focussed. [SMHLN] have a grasp of nurturing, empowering patients rather than doing things to them'* (health stakeholder).

4.3 Partnership work

SMHLN was seen as having an enabling role in developing health related services. The qualities that helped included:

- Their roles and relationships with the local community sector
- Providing extra capacity, knowledge, information and experience
- Their experience and methods when working in partnership with the community sector
- Working so that the community sector feels involved and valued.

As SMHLN does not have the resources to provide workers in localities, a Partnership Health Worker (PHW) post supports the development of local health activities alongside the SMHLN team. The PHW's role is to:

- Identify gaps
- Create and maintain links with local health services
- Develop health activities
- Build capacity for health related provision.

[17] SMILE is an exercise referral scheme for those who have a medical condition. People are referred through their GP and then assessed (see Appendix 3).

'*If there had not been this regular contact [between the ward co-ordinator and SMHLN worker] then development of health related events in the communities, would be less likely to happen*' (statutory sector stakeholder).

This can be directly, by bringing services to projects such as Over 50s Sports Development, PCT Engagement Team, local community nurses; or indirectly, by working with the project to fundraise to increase health related activities.

Partnership working is at the heart of SMHLN and helps support coordination and cooperation between statutory sector agencies, voluntary organisations and community groups. Consequently, SMHLN has helped create a more 'joined up' response to local health needs often in areas with high levels of deprivation.

Some stakeholders saw this as the crux of SMHLN; '*They have a particular role in relation to partnership work with the voluntary sector and as strategic partners. They have better skills than other NHS services with community members and the third sector*' (Health stakeholder). This work is partly developed through partnerships with some of the ward co-ordinators.

'You're able to pick up the phone and problems get sorted. I find that reassuring and I feel valued. I know I don't have to go back time and time again, like with other agencies. I know HLN will get back to me' (voluntary sector stakeholder)

HLN's knowledge of different networks has helped save agencies' time; as one stakeholder commented: *'The SMHLN has made a difference (to our ability to develop health related services for older people). . . .The HLN know when it is being done elsewhere, . . . They helped us learn about agencies that can help, rather than doing it all from scratch'* (voluntary sector stakeholder).

This conduit is important for both statutory and community groups. Statutory bodies do not have time nor resources for as much regular contact with the community sector as they would like. Whereas community projects are not always able to get involved in wider strategic debates and meetings. The HLN and the partnership work can bridge this gap. The worker provides a link between agencies, and ward co-ordination and the engagement team in the PCT; *'I can't be on the ground or go to all the meetings. The HLN is already in the community working'* (PCT stakeholder).

Their commitment was valued because it was holistic. The community development approach were considered crucial in building effective relationships with community groups. This gave them confidence to get involved in developing health related initiatives.

'HLN had information . . about problems older people had accessing a local GP practice. This enables local older people to have a voice' (PCT stakeholder)

The introduction of the PHW was seen as an alternative resource offered to voluntary organisations when SMHLN's funding was no longer available.

Several voluntary organisations were unhappy with this change, although one found it beneficial: '*It has been a better relationship since the HLN stopped giving (us) money. The HLN feels an integral part of what we do, rather than just a funder. If (we) had to choose between the money and the worker, we would now choose the worker. There is now better communication'* (voluntary sector stakeholder).

While the partnership work was valued, concerns regarding sustainability exist: *'The problem for voluntary sector organisations is that we are never sure how long this is going to last. A big improvement would be to know that the partnership is going to last, to sustain the work'* (voluntary sector stakeholder).

4.4 Findings

As indicated this evaluation is focusing on specific areas of SMHLN's work: **locality working**, with ward co-ordinators and a case study of partnership work with a community project; the **Discovery Team**, the name for the volunteering project; organisational issues including **location and management**. The latter section includes a second case study of SMHLN implementing a 'top down' NHS initiative a **computerised Cognitive Behavioural Therapy Project (cCBT)**.

The remainder of the report discusses these in more detail.

5.1 Locality working

The partnership work operates at different levels – locally with workers and participants, and strategically with the PCT Engagement Team, the council's ward co-ordination, and other city-wide strategies e.g. Valuing Older People and South Manchester Regeneration Team.

Most stakeholders noted pros and cons in locality working as opposed to more specialist health work. Locality workers were seen as generalists, with expertise and knowledge of an area, but not expert in all health issues. *'In health promotion it would be difficult to expect someone working in a locality to be able to work on a range of health specialities'* (pubic health worker).

5.2 Ward co-ordination

Manchester wards have a ward co-ordination structure, staffed by a full time ward support officer with part time support of a more senior ward co-ordinator. Quarterly meetings co-ordinate service provision and contribute to local planning and identify gaps in services. They also enable local councillors to play a major role in service provision.

In some parts of the city, community and voluntary organisations with sufficient resources attend ward co-ordination meetings. However, in other areas community participation within ward co-ordination meetings is restricted. The ward meetings also develop three-year ward plans which reflect priorities.

Ward Co-ordination is thus at the heart of the neighbourhood and is a key aspect of the delivery mechanism for the LAA[18]. Ward co-ordination feeds issues to service managers and to executive members, these can then go to the Adult Health and Wellbeing Partnership Board (AHWP).

HLN's work also fits into regeneration work. A framework has recently been developed with targets and objectives that relate to the three spines within the LAA. An interviewee in regeneration commented: *'There is now the opportunity to develop a number of community based health activities which target specific communities. These should have linkages to other programmes and services such as leisure and sports development'* (regeneration stakeholder). This work fits into the emerging practice based commissioning and the HLN are well placed as; '*They are the community arm of the PCT'* (statutory stakeholder).

HLN's can help develop and mainstream successful initiatives, but it is important to ensure a coherent approach to the work as: *'There is a danger that a lot of [health] issues within the wards are similar. You could end up trying to develop a lot of local initiatives without necessarily building in sustainability'* (regeneration stakeholder).

'The PCT finds it difficult to engage with any other services apart from itself… if it wasn't for the work with SMHLN there would be no contact between [some of the] ward co-ordinators and the PCT' (statutory sector stakeholder).

This partnership working, at the core of SMHLN, has helped facilitate the relationship between the PCT and local services; *'SMHLN act as lynch-pins between the community and the PCT' (*statutory sector stakeholder). Ward co-ordinators use SMHLN for information about health services, health statistics, and as the first point of call within the PCT. In some areas, SMHLN are the key access into mainstream health services, either by providing referral pathways or bringing relevant health services directly to local communities.

There are five wards in Wythenshawe alone and each has four yearly meetings, so SMHLN cannot work with all co-ordinators nor attend all meetings. But frequent attendance is seen as important as: '*It is more difficult networking with someone you see every six months rather than every three; (*statutory sector stakeholder). Where SMHLN does work closely with ward co-ordinators, it helps ensure that health is on the agenda, in the ward plans and in local provision.

[18] From Manchester's Local Area Agreement – Delivering the Community Strategy

Within communities, some stakeholders felt that; *'Health is there within the ward plans, but it is work on the ground which is so important and difficult'* (statutory sector stakeholder). SMHLN has brought this health focus to neighbourhoods in its work with ward co-ordinators for example by participating in community events.

This work in communities reflects the responsiveness and flexibility built into SMHLN's programme; the cross sector working is integral to successful service development and delivery. Underlying its success is the trust SMHLN has gained; *'They are the only PCT workers I develop partnership work with'* (statutory sector stakeholder). Like Zest[19], North Manchester's HLN, SMHLN played a crucial role in maintaining partnership whilst the PCT was in disarray owing to its most recent re-organisation.

However, there are different levels of decision making within the city, ranging from local services, which may be taken at ward or even neighbourhood level, right through to strategic policy and framework documents that set out a more long term approach. An effective HLN needs to impact upon all levels.

Manchester has recently developed a Public Service Board (PSB) which monitors and evaluates targets to assess their appropriateness and progress. This will aid partnership working across agencies and it is hoped the new PSB will support ward co-ordination. Feedback and input from the ward co-ordination will be through officers from the PSB to resolve issues in wards which can not be resolved by services or partnerships[20].

SMHLN has demonstrated its influence and work within the ward co-ordination structure. This feeds into policy development and delivery of services. Health services are represented within the policy framework but HLN's have a specific role to play in ensuring local health issues are represented. Remaining on the fringes of strategic boards means that the HLN voice and perspective is less likely to be fed into the policy framework. Consequently, this process should be formalized with the new AHWP.

> *'Á lot of the work comes down to personal relationships and how well we get on together'* (statutory sector stakeholder).

5.3 Case study (BMCA) - a partnership with a community association to develop health related activities within a disadvantaged community.

This next section examines SMHLN's partnership work with BMCA developing services which tackle health inequalities. BMCA is a thriving community association based at a centre that opened seventeen years ago. Its activities include three sessions of exercise a week for older people, Tai Chi, Mature Movers[21] and Curling**.** Prior to the case study, the project collected users' names, postcode, gender and attendance from a signing-in book.

19 Colman and Emanuel (2008) The Best of Zest

20 From report June 2008 to Resources and Governance Overview and Scrutiny Committee

21 This is a chair based exercise session, like those described in other sections of the report.

'The Partnership Health Worker brought expertise about health statistics and health links, BMCA brought expertise with the community and the ability to attract funds not available to statutory bodies. The partnership brought in money for services that will impact on the lives of older people. The work will help meet health service and BMCA's aims' (voluntary sector stakeholder).

BMCA recently received funding to continue its work with older people to include:

- Recruiting volunteers
- Developing a domiciliary befriending service
- Offering domiciliary armchair exercise sessions
- Increasing the numbers attending the luncheon and social club
- Developing an older people's forum to improve access to information and inform decision makers at a strategic level.

Demographics

Although, the centre is in South Manchester near affluent areas, one of its super output areas has levels of income deprivation amongst older people that is within the highest 10% in the country. Thirty percent of people over 65 living in Barlow Moor reported that they did not have good health compared to 31% for Manchester and 23% for England and Wales. And 55% of them reported that they have a limiting long term illness[22]. Appendix 4 details the demographics of the area in detail.

Methodology

This case study was undertaken jointly with the PWH as she was interested in developing an evaluation framework. One of the evaluators, BMCA workers and the evaluator of their older people project were also equal partners.

As well as interviews with key stakeholders, users were asked to complete questionnaires in June 2008 (Appendix 5). Two BMCA workers, the SMHLN worker and one of the evaluators[23] administered these. Of the 21[24] people who completed the questionnaires, 20 were women.

Data[25]

The postcode data collected through the questionnaire was more comprehensive and accurate than information obtained from the signing-in book. Everyone who completed questionnaires, and all but one who attended over 50's activities between April and June 2008, lived near to the community centre. This indicates that nearly all the users live near to the centre and within the BMCA target area.

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[22] All these statistics are from MCHIP.

[23] Twenty six people were given information sheets and asked to complete questionnaires. 21 were completed;18 at the centre and 3 in people's homes; there were 5 refusals. The high refusal rate may be associated with the number of questionnaires people are currently asked to complete leading to some people feeling 'questionnaired out'

[24] Over this period, a total of 34 people attended the centre for over 50s activities.

[25] Appendix 6 has a detailed breakdown of the data.

Twenty respondents were white. Black and minority ethnic groups, and men were a minority of attendees and even these were underrepresented amongst questionnaire participants. Over 80% of respondents (17), said that they had long-standing illness, disability or infirmity. 16 of whom said this limited their activities. 43% (9) reported that their health had been fairly good over the previous 12 months whereas 33% (7) said it had not been good and 24% (5) that it had been good. This indicates that self-related levels of imperfect health are common.

Other data collected indicated that:

- Just over half (11) of respondents lived alone and 9 lived in 2 person households.
- The majority of respondents were between 60 and 90.
- Less than a quarter (5) of respondents owned or had regular use of a car.
- The three most popular activities at BMCA were attended by nearly half of the respondents (10 and 9 each); they were Mature Movers, lunch club/ bingo/ cards. The most popular activity was exercise.
- Most people attended either one or 3 activities every week.
- The majority who came to Mature Movers stayed for lunch whereas this was less so for people who attend Tai Chi.
- Nearly half had been coming for between two and five years and a quarter for up to a year.
- For nearly all respondents, the social side was important and for nearly half, the exercise.
- Nearly three-quarters were satisfied with the amount of contact with other people in a typical week. Coupled with other data this might suggest that coming to the centre is meeting their needs for social contact. Alternatively their expectations may be low or the question could have made people feel vulnerable so was answered positively.
- Nearly two-thirds of respondents (13) attended one session of exercise a week and four attended two or three sessions a week. Of the four who did not attend any, three reported having mobility impairments.
- Just over half the respondents (12) took some form of exercise more than 5 times a week.
- All said they did some activity at home such as gardening or housework.

Influencing local services

BMCA are planning to set up an Older People's Forum so people can have more influence on services and facilities in their area. The questionnaire set a bench mark of how satisfied people felt with their area as this is one of the LAA targets. Questions from Manchester Quality of Life Survey were included so data could be compared over time and between participants and people in different areas.

> *'There is a lot of work to be done to enable people to understand what they are being asked to influence.'* (voluntary sector stakeholder).

Analysing the data showed that the majority felt that they belong to the area and that it is a good place to grow old. This may reflect the length of time people had lived there and that they had chosen to grow old there, it could also demonstrate low levels of expectation. One respondent commented: *'I recently lost my husband so I have needed to come out and see people. I have good neighbours so it's a good area to be in – I wouldn't swap'* (user, BMCA). This quote indicates that it can be a very good place to live.

While the following quote points to concerns about the loss of shops and the implications: *'The retirement flats are a good place to live, but lack of nearby shops is a problem as it means you need a car. I am concerned about the post office closing and the charity shop closing which means losing a point of social contact' (*user, BMCA*).*

While nearly all respondents felt they know some health services in the area, less than a quarter felt they know all or most of them. Those who completed questionnaires were equally divided about whether they could or could not influence decisions in the area. Over 90% (19), thought that a forum for older people would help them be more involved in decisions. However not everyone was convinced that people would come or that groups make a difference:*' We are starting up a residents' association in the flats but I don't know if our opinion will influence anything'* (user, BMCA).

BMCA recognised that enabling people to be more influential requires resources, including time for:

- One to one communication,
- Raising awareness and levels of expectation
- Developing structures.

> *'[We need] more participation, . .. getting them accustomed to being proactive, to having more expectations. Ask them what they want to do. Let them know what the options are' (*voluntary sector stakeholder*).*

Staff know they need to create more opportunities for people to discuss things together; *'Some individuals do have influence in our organisation, but they are few and far between. BMCA endeavours to get people's views. It's about creating structured opportunities for people to be involved. I don't think people will do it by themselves. It needs facilitating and more resources, and ... a new word for forum. Make it something people want to join' (*voluntary sector stakeholder*).*

The PCT Engagement Team require more regular contact or communication with older people and want to find creative ways of doing this. They want people to have regular contact and local information available, including about Engagement and PALS, council ward booklets and signing people up to "Talking Health[26]".

This case study provided learning for all involved - HLN partnership projects and links into strategy.

[26] Talking Health is a PCT programme of engagement with stakeholders and the public to develop services.

Questionnaires

One reason for undertaking the case study was to obtain better data for evaluation. In addition, questionnaires can help develop a better understanding of how users see services and get a sense of their needs. Workers can then act on these. For example: BMCA thought it enabled people with mobility impairments to be included on trips; but in fact some assumed they could not go because of their impairments. And others would like to be more involved with the centre but sometimes are unable to get to activities.

> *'Older people were just coming along to lunches and outings. The worker brought different ways of working….brought a different perspective'* (voluntary sector stakeholder).

Workers found out more about specific needs and were able to respond accordingly eg. a worker put a woman concerned about losing her sight in touch with appropriate organisations. *'The lady was not going to come back again but has come today'* (worker).

The questionnaire, illustrated the difficulty of matching questions to the data required, some questions worked better than others (see Appendix 5).

Involving frontline workers

Not only did the questionnaire enable the collection of information but it also acted as a tool for engagement between the workers and users. It increased workers' knowledge which can be used for the development of the work. Involving frontline workers in the collection of data can help them understand how it can enhance their provision. Some readers may be concerned that this could lead to bias, however, we feel this is outweighed by opportunities for learning about the participants. It also helps develop trust possibly leading to greater involvement of users.

Data

The data can also be used for internal evaluation and service development especially if enhanced with regular opportunities to both review questions and share learning with key stakeholders. The second purpose of gathering accurate and useful information is more complex. Not all the information was captured and the importance of this was explored. This raised questions of exactly what the project is trying to do and what information is needed. For example, in terms of evaluation, what information can be usefully extracted from knowledge of where people live.

> '*The questionnaire acts as a tool to have a conversation. It brought the barriers down because it is 1:1.People are able to put their guard down, it opened doors'* (voluntary sector stakeholder)

Process

An important aspect of the learning was not to underestimate the time required for participatory evaluation and reflective practice. Timing and the process are crucial. BMCA were waiting to hear about funding to continue the project. This case study, although part of the evaluation of SMHLN, was also an opportunity to develop some tools and baseline information for the evaluation of the work.

A team including BMCA workers, the SMHLN Partnership Worker, a SMHLN evaluator and the evaluator undertaking the BMCA project evaluation actively participated in developing, administering, inputting and reflecting on the data. This process increased ownership and learning. By influencing the design of the project, members of the team could advise on how to make it user friendly, and potentially more workable and address their specific evaluation needs. By involvement in completing questionnaires they could learn about the potential strengths and weaknesses of the questionnaire hands on. The front line worker took action on the basis of what she learnt from each respondent, immediately.

The project is considering using a similar questionnaire as an assessment tool for new users. This can be followed up at regular intervals. It also sets up a formal process for worker to meet with users.

Reflection

Regular reflective meetings are valuable to:

- Share the learning with other key stakeholders
- Review the process for example questions may be interpreted differently both by respondents and interviewers, and this could be checked.

Attitudes were also important; the BMCA staff were open to evaluation and saw how it might benefit their work. At all stages the need for reciprocity was recognised and users were given the opportunity to participate in a raffle. The project was also reimbursed for the time and resources used.

Links with strategy

Once the information has been collected, the next stage is to relate it to wider strategy. The questionnaire provided an opportunity for conversations on a one to one level. It is hoped the proposed Forum will allow people to meet as a group to discuss issues. This could capture information about their experiences of the area. Both types of information could then be used to influence strategy. The information collected was also deemed to be useful for funding bids.

6.1 The Discovery Team

The Discovery Team comprises over 50 volunteers and a small number of sessional workers, Bank staff, who are paid to deliver SMHLN's activities[27]. The Discovery Team was part of the Big Lottery bid. Its overall aim was to get a group of local people who would 'work within their own communities to identify their health needs and come up with ideas to meet them[28].

[27] The Smoking Cessation workers are paid for by Public Health Development Service.
[28] From SMHLN Annual Report and Financial Statement, year 2.

This incorporates a community development perspective that: *'Local problems need local solutions'* (statutory stakeholder). It was also hoped that local people would develop their skills leading to their employment within the health sector. The NHS is probably the biggest employer in the area.

At the beginning of SMHLN, when funded through Big Lottery, a Discovery Team sub-group was set up. It devised the following aims for the work:

- To undertake research and community-led needs assessment and produce a report for the Network as a baseline for future priorities and activities.
- To provide a framework for identifying needs and shaping solutions. The team will use creative and participative methods for surveys, interviews, presentations and group work.
- To involve and develop expertises within local communities by recruiting volunteers and sessional workers.
- To organise training for volunteers to develop new skills via in-house and external courses, learning by doing, shadowing or coaching leading to employment opportunities.
- To identify potential contributions different agencies and partners can make to the work of the Discovery Team.

Although the sub-group finished when the Discovery Team moved to the PCT, the aims remained the same.

SMHLN has developed a comprehensive volunteers policy, including health and safety procedures, recruitment and selection processes, a job description, and outlining what SMHLN is able to offer team members.

The Discovery Team has encouraged local community organisations to incorporate health issues, or an understanding of health inequalities, into their work. Many stakeholders felt the manager had helped shape the development of health provision. She was praised for ensuring appropriate provision for diverse groups. As one stakeholder commented: *'She has helped challenge [our] programme. She helped us provide a more flexible and accessible service'* (health worker stakeholder). In essence, the Discovery Team manager brought a community development perspective to some mainstream health provision, enabling it to provide a more open approach to engaging with different communities.

> *'[The Discovery Team] has been useful in promoting healthy living lifestyles going in local venues such as church halls and community centres'* (statutory stakeholder).

6.2 Discovery Team's work

All stakeholders interviewed were very positive about the Discovery Team; the volunteers and Bank staff were seen as: *'Ground level workers who can interact directly with the public'* (public health stakeholder); a layer often missing within the NHS. They had also: ' … *gone from strength to strength'* (public health stakeholder).

The Discovery Team are involved in different areas of work including:

'It would be good to organize seminars in work places' (Discovery Team stakeholder).

- Weekly chair based activities for older people at five community venues
- Daily staffing of an information stand, at WCH, and a weekly stand at Wythenshawe Forum
- A weekly radio health show on Wythenshawe FM.

Although, some Discovery Team members are paid as smoking cessation workers by the Smoking Cessation service, their work is supported by the Discovery Team manager. In addition the Discovery Team members help out in activities and events throughout the year.

When first established the Discovery Team identified venues for their health activities. They chose areas with most need and little provision. For example, they set up sessions in locations where high number of people with strokes lived. Initially, they incorporated health talks into many of the sessions.

When funded through the Big Lottery, SMHLN was able to subsidise the Discovery Team's work, but it no longer has resources to do this. So any activity that SMHLN sets up in the future will include a formal agreement with the stakeholder, including looking at sustainability.

When SMHLN moved to the PCT, the Bank staff's work was evaluated as part of Agenda for Change, they were given job descriptions and the posts were banded on NHS grades. This led to substantial reductions in pay.

Participants at chair based activities in 2008, said they benefited by:

- *Improved health*
- *Developing more confidence*
- *Improved mobility*
- *Feeling less isolated*

The Discovery Team manager informs Bank staff about relevant events and they share these with members of the public when appropriate. And Discovery Team members share their experiences with people: *'I talk about my experiences, how I managed [to change my behaviour] and what I had to do to get through it. People listen to me as I put my heart in it'.* However, the members' knowledge is limited as one commented: *'I feel it would be better if I had more information; then I could help people better. So if I knew about different groups I could signpost people to them. I was able once to tell someone about the [ ] centre, but that was only because I had worked there so I knew about it' (*Bank staff stakeholder).

Participants at chair based activities are very positive about the activities they attend. All receive an exercise information sheet and SMHLN undertakes a yearly survey of attenders. Many reported improved health since attending the activities. The Bank staff feel that their relationships with the participants were crucial and; *'Being a regular person with a group is important, people get to know you; that continuity is needed'* (Discovery Team stakeholder).

Activities provided through the Discovery Team have a strong 'social' element alongside their health benefits that was re-iterated by many participants. This helps combat social isolation which can be linked to poor health, particularly in older people. The Discovery Team's informal approach was also appreciated, as one participant noted: '*If I go to my GP I sometimes get talked at, and lectured to, but {the Discovery Team worker} is more understanding; they spend time and talk to me'* (chair based exercise participant). Often it was the social benefits that provided participants with the motivation to attend. For many, meeting others is important for their wellbeing.

Participants at chair based activities in 2008, said they attended because:

- *My doctor sent me*
- *For company*
- *To stop my health deteriorating*
- *To help my arthritis*
- *To help my mobility*

As the activities take place in community venues, they are non-stigmatizing. Small community centres are often more informal and less intimidating; *'I prefer attending exercise classes here, rather than at the leisure centre; I know where I am here, it's smaller and not so noisy' (*chair based exercise participant).

6.3 Information stand

The Discovery Team staff the information stand at WCH during week days; there is at least one Discovery Team member at the stand ninety-five percent of the core time that the hospital is open. Each clinical service retains specialised information within their departments. General health leaflets are displayed at the stand, which links into the hospital's services for the local community; *' …as the hospital is not just about treatment but about keeping people healthier'* (health service stakeholder).

*'People sometimes ask about diet in relation to their condition such as breast cancer or diabetes and I don't feel very good as I don't have the information to help them' (*Bank staff stakeholder).

The hospital has feedback points and they often receive positive comments about the stand. Although, the hospital does not specifically audit or monitor the work, the Discovery Team complete monitoring forms under the following headings: name; date; address; age; gender; ethnicity; health issue; action and G.P.

Data was analysed for 4 weeks[29] to give an overview of the work, although this was incomplete. In total there were 172 recordings of contacts; of which 9 were 'couples'.

[29] 24-27 February 2007; 24-27 July 2007; 22-26 October 2007; and 26th-28th February 2008.

The following table shows contacts within the weeks analysed:

Information stand (total 172)

Month	Feb (07)	July (07)	Oct (07)	Feb (08)
Numbers	60	30	48	34

Table 3

In terms of analysis of the data, geographical area (address); age, gender, ethnicity, health issue and action were considered. However, the data is fairly scant. In only 48 instances were all of these completed for the contact (less than a third of the total).

Information stand – geographical area (38 not recorded)

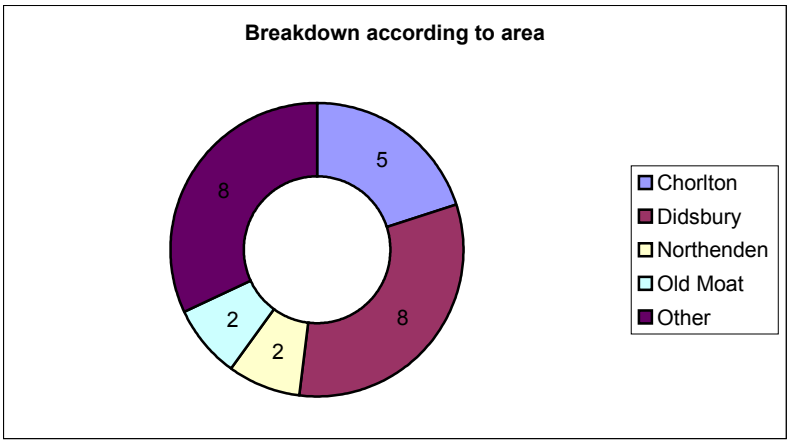

Table 4

Other: Old Moat, Baguley, Burnage, Moss Side, Rusholme, Sharston, Withington

The table shows where people who use the stand live, as expected this breakdown reflects the hospital's location. Residents from Didsbury and Chorlton visited the information stand more than people from other locations, not SMHLN's target areas.

In terms of gender, more women were represented, 140 to 49 men:

Information stand - gender

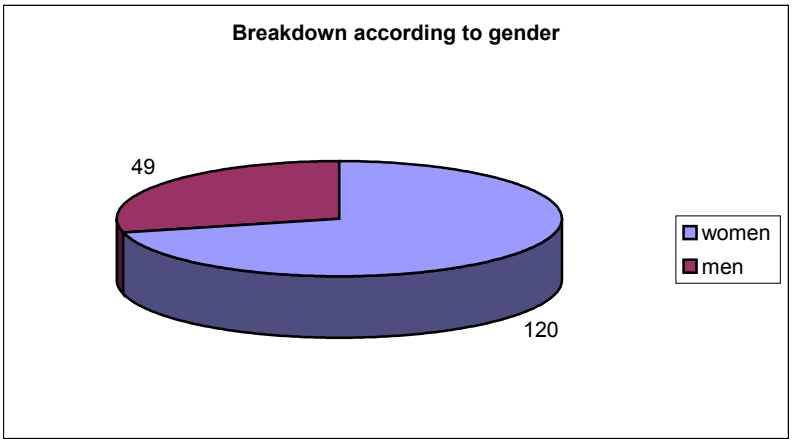

Table 5

In terms of race the majority were white, 124, but there were 45 of Asian, Black and mixed race, which may be because of the Asian, Black and mixed race Bank staffing.

Information stand- race (4 unrecorded)

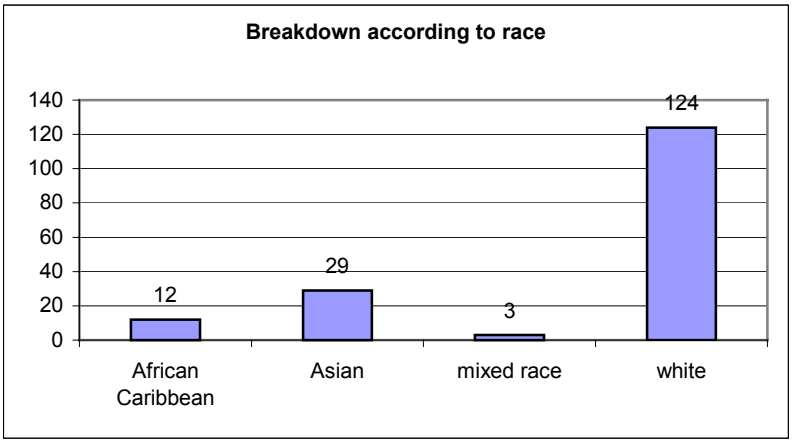

Table 6

*'Lots of people come to pick up leaflets as well as asking for directions for the hospital. If they are looking at the leaflets for a while I ask them if I can help. But most of the time people just pick up a leaflet and then go' (*Bank staff stakeholder).

The Discovery Team members interviewed said that most people came up to the stand and took the leaflet/s they were interested in and then left. Sometimes they would ask about a particular topic and the Discovery Team representative would give them the relevant leaflet. It was hoped that the Discovery Team would help people access interactive information about health topics at the stand. But as there are problems with the server this is not happening at present.

The next two tables look at the information given from the stand. It is very difficult to assess the effectiveness of the initiative as the data recorded is poor. Most people took or were given a leaflet, but we do not know whether they needed someone at the stand before they took the information they required.

Information stand- health issues

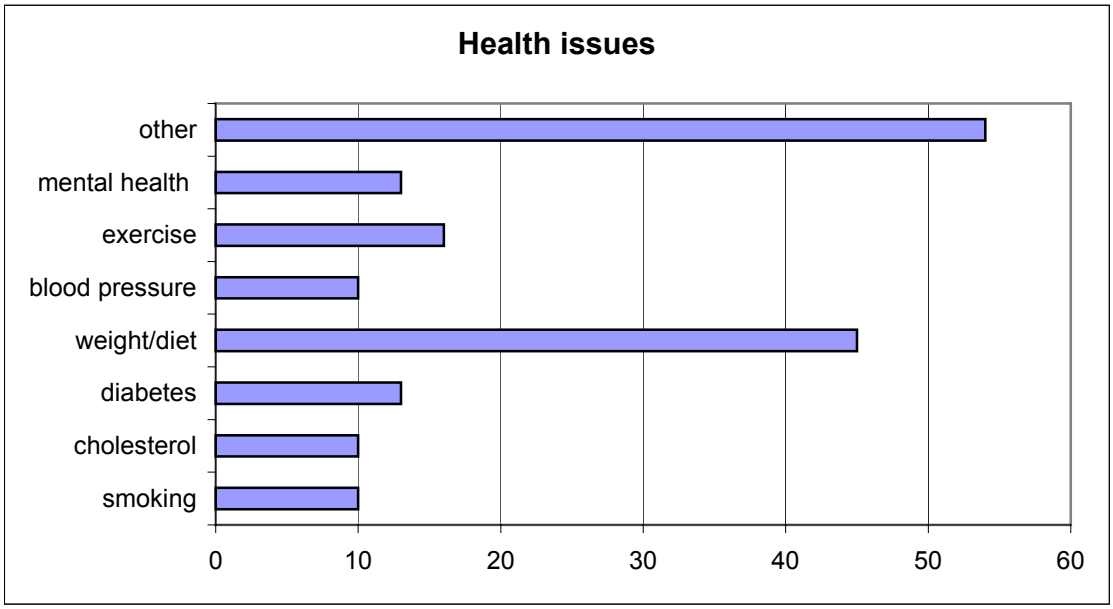

Table 7

Other was broken down as follows:

Topic	No	Topic	No	Topic	No	Topic	No
Angina	1	Asthma	1	Bereavement	1	Bypass surgery	1
Hearing	3	Sleep	2	Blood tests	3	Knee/hip replacement	3
Physio	2	Babies	1	Pregnancy	2	Osteorposis	1
Bladder	2	Arthritis	4	Stroke	1	Teenagers	1
Chest pains	1	Backache	2	Older people	2	Cancer	4ancer
Alcohol	2	Menopause	2	Migraine	1	Carers	1
Heart	1	Brain haemorrhage	1	HLN	2		

Table 8

As can be seen people took a wide variety of leaflets. Many were interested in food, weight and diet.

The following table shows action taken from the stand,

Information stand- action

Table 9

As can be seen, most people take leaflets. 'Exercise' refers those who were given information about specific exercise classes, and 'smoking' to those who received their second prescription for giving up smoking.

Effectiveness

To successfully analyse the effectiveness of this work, we would need to assess whether people:

- Would have taken that information irrespective of a Discovery Team member being present at the stand
- Whether people 'acted' on the information obtained within their leaflet
- Whether those who asked for information about exercise classes attended.

Leaflets are used to give information but how they are used and the quality of the material is important. It is also worth bearing in mind that five and a half million people in Britain have reading difficulties and considerably more (22% of the working population) have a low level of literacy[30]. Research[31] has also considered the accuracy of information within leaflets and found some to be misleading.

A number of studies have tried to test the effectiveness of leaflets; one[32] evaluated a nutritional health leaflet and measured people's knowledge about, and attitudes towards, healthy eating by means of a postal survey. This showed that the leaflet made no significant difference. However, groups chosen were random whereas those who take leaflets from the stand have a specific interest in the information.

Consequently, it is difficult to assess how this initiative contributes to the overall aims of SMHLN. This view is held by many who staff the stand; *'Sometimes I feel as though I don't need to be [at the Information Stand); but on the whole I feel it is better to be there, in case people want to ask a question (*Bank staff stakeholder). And*; 'Sometimes I feel we only touch on things as all we can really do is give people a leaflet and help them if they don't understand it'* (Discovery Team stakeholder).

Information stands do have a role to play, and SMHLN did have a more creative vision for the work, for example by having different themes each month and involving artists, whose work could then have been displayed in the building. But there were no resources for this development.

The following table shows those who used the information stand at Wythenshawe Forum, which serves an area where more people experience poor health as a result of social and economic factors than the area serviced by WCH.

[30] Rudd, R. E., Zobel, E. K., Fanta, C. H., Surkan, P., Rodriguez-Louis, J., Valderrama, Y., Daltroy, L. H. (2004). Asthma: In Plain Language. Health Promot Pract 5: 334-340

[31] BMJ 1998;317:264-265 (25 July) Information in practice; Evaluation of readability and accuracy of information leaflets in general practice for patients with asthma.

[32] Knowledge and attitudes about eating and health; Sally Nichols, W. E. Waters, M. Woolaway § Margaret B. Hamilton-Smith, In Journal of Human Nutrition and Dietetics.

Information stand Wythenshawe

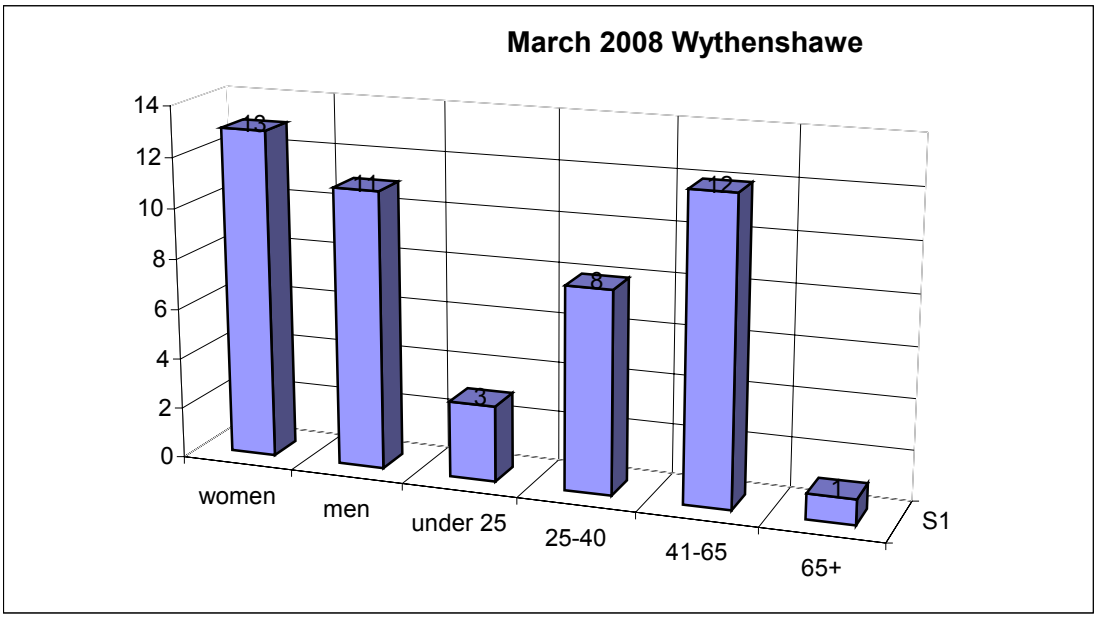

Table 10

Here within a community setting, there is a more equal spread of gender and age. However, as this is a busy venue it is often difficult to record information as people are less likely to browse than at WCH.

Comprehensive information is kept for the smoking cessation work as can be seen by the following table:

Stop smoking data 07/08

WCH:	**Wythenshawe Forum**
82 - quit dates set	59 - quit dates set
26 - still quitting @ 4 weeks	30 – still quitting @ 4 weeks
Quit rate: 32%	*Quit rate: 51%*

The overall quit rate for 07/08 was 43%

Table 11

The Discovery Team is more effective within the community setting than the hospital. Again, it is difficult to analyse the reason for this. People attending the hospital could have different characteristics than those who go to the community venue.

6.4 The Discovery Team membership

The team has diverse membership in terms of ethnicity, age and gender. The following three tables show the gender, ethnicity and age of the Discovery Team. These show that the majority of members are women and over 40 years of age, which reflects volunteering in general[33].

Discovery Team membership - gender

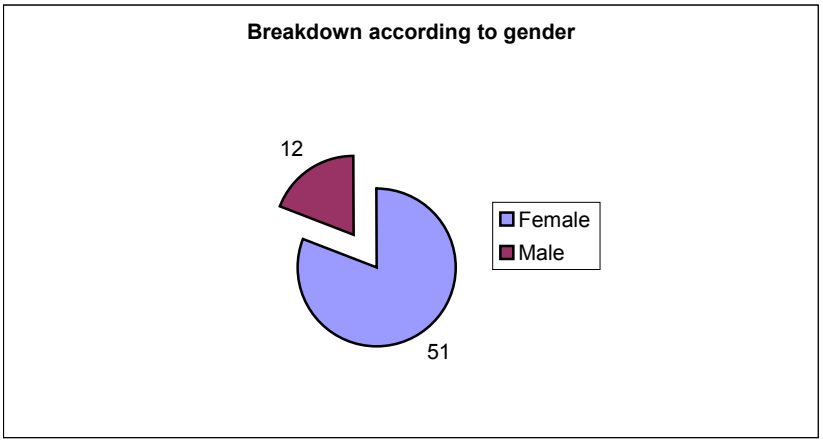

Table 12

There are a large number of people of Asian and Black origin, twenty seven out of a total of sixty three. The biggest group of Asian background are of Indian origin (7 out of 15).

'I think we need more meetings to get a bigger picture of what is going on [in SMHLN]' (Discovery Team stakeholder).

Discovery Team membership – ethnicity (total 63)

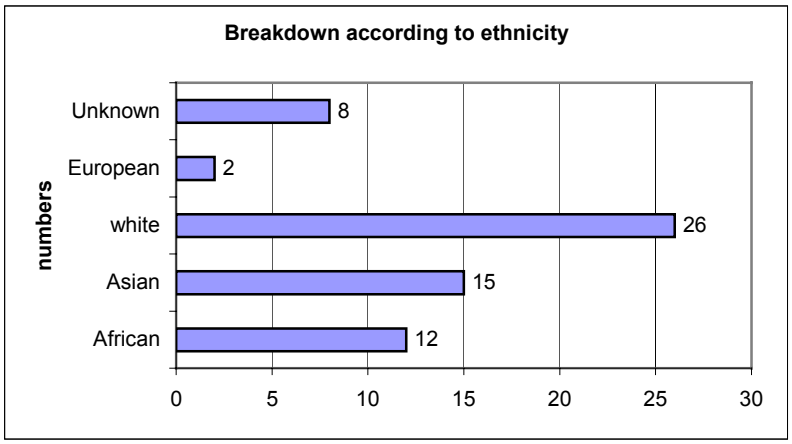

Table 13

Many members find out about the Discovery Team from the Information Stand at WCH..

[33] The breakdown, according to SMHLN's categories is: Asian others – 3; Asian – 3; African Caribbean – 3; Chinese - 1,and Indian – 7..

Discovery Team membership - age (total 62,1 not recorded)

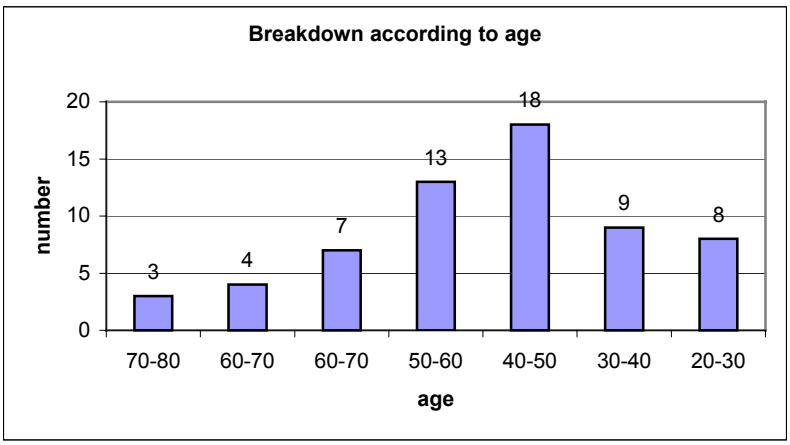

Table 14

The make up of the team has not changed much since an evaluation in 2005[34]. Neither have reasons volunteers join the Discovery Team changed since 2005[35]. At this time, the aspects of volunteering members liked best were 'learning and experience' and 'meeting people' (10 each) followed by 'delivering the work' (7 respondents)[36].

Some members involved in the evaluation did not always feel fully informed about what they could do, conditions of the volunteering and how volunteers became Bank staff. This does not necessarily mean they have not received information about these aspects, but they may need this reinforcing on a number of occasions.

Analysis of the information collected from some Discovery Team members (25) shows that they are specifically interested in:

- Induction for new volunteers
- More support and advice about how they can develop their skills
- Participative meetings with staff - these were held when SMHLN was funded through the Big Lottery.

There are a diversity of motives that drive people to **volunteer**; one commented that: *'It is nice to socialize with other people. Otherwise we would be stuck in the house. I've made friends within the network'* (Discovery Team stakeholder).

[34] op-cit- Discovery Team Audit Views from volunteers (2005), when out of 44 volunteers 13 were Asian, 9 – Black and 22 white, with a disproportionate number from Indian origin (10 of 44). Of 24 whose age was known, 20 were over 50 and 17 of 24 female.
[35] SMHLN Evaluation 2004/5 MMU.
[36] Discovery Team Audit Views from volunteers (2005)

Within SMHLN it is possible to identify two different 'types' of volunteers:

- Retirees who want to get involved. They might wish to 'give' something back into the community, or see it as a way of socializing and meeting new people
- Those who see volunteering as a springboard into health related employment or a means of furthering their career through learning new skills.

'I would like more opportunities to develop my skills' (Discovery Team stakeholder).

It can be argued that the two groups have very different needs. For older people, volunteering can help them stay physically and mentally active. Those who no longer work may feel the loss of structure, social contact, purpose, social identity or status. Volunteering can also help combat social exclusion.

Research[37] has shown that older people are much more likely to volunteer where they can use their previous work skills. There is therefore a vast potential of people who could link into a health volunteering project. And one of the Discovery Team's member, a retired nurse, has attended activities and taken participants' blood pressure. If this was too high, she advised them to see their G.P..

Members who want to use volunteering as a route to work have a specific set of needs. Volunteering[38] is an excellent way for people to develop their skills. However, this means either directly providing, or ensuring volunteers can access a wide range of services including:

- Opportunities for volunteers to develop their skills, including training and placements
- In-depth advice and support for completing cv's and interviews
- Links with an accredited volunteering award
- Information and support about recognised pathways of career progression within the health service.

These don't necessarily have to be provided within the 'volunteering' project, but need to be integrated into the work, possibly through links with relevant agencies.

The Discovery Team recognizes the role and aspirations of volunteers and the manager supports members with application forms and appropriate health service jobs. And in 2006 they organized a conference outlining volunteering opportunities.

SMHLN has also attempted to set up health service placements but is difficult within the health service culture. Volunteering opportunities within community settings are more possible but this needs a formal structure, including support. However, SMHLN's budget is limited and development of members' skills can only be a small part of their role owing to the breadth of the work.

[37] Rowntree
[38] For example the recent Morgan Inquiry into young adults and volunteering, 2008

This is not to detract from the Discovery Team's achievements, most members were very positive; *'The work has really helped my confidence in this field' (*Discovery Team stakeholder). Many commended the manager and indicated a close link between her support, the opportunities to volunteer and their growing level of confidence; *'You can contact [the manager] at any time; you know she will be there to ensure everything is running smoothly'* (Discovery Team stakeholder). For some their involvement has led to part-time employment in the project as Bank staff.

> *'I have had the opportunity to do some things which I haven't done before. I have met people and it might help me get employment''* (Discovery Team stakeholder).

Unsurprisingly, the majority of volunteers who responded to the consultation would like to get more involved, for some this includes: *'To be given the opportunity of taking part in the planning and organising of activities'* (Discovery Team stakeholder) and *'I would like to take part in targeted promotions'* (Discovery Team stakeholder).

Training

All Bank staff undertake relevant induction training within the PCT, including communicating with the public; *' I have learnt that I need to be careful what I say as I am a representative of the NHS'* (Discovery Team stakeholder). However, as Discovery Team members usually attend only PCT training courses, they are limited in what activities they can offer. The PCT training is rarely tailored made to the specific needs of the Discovery Team. Currently, SMHLN are setting up chair based training, whilst the PCT are waiting to recruit a member of staff.

> *'[Training] is a two way-thing; as volunteers you get more confidence and this gives the [exercise] group more confidence'* (Discovery Team stakeholder).

There was a mixed response from Discovery Team members, who took part in the consultation, to the training they had attended. Some courses are very beneficial as they cover broad aspects of health promotion: *'It was just what I needed; I learnt about how to get the client to help themselves, to help them decide where they want to focus'* (Discovery Team stakeholder). However, others were not so positive: *'Often a course might be advertised for a whole day, but only lasts a few hours. And others are cancelled at the last minute'* (Discovery Team stakeholder). Some volunteers found it difficult to use the knowledge; *'It is not always clear how we can put learning from the courses into practice'* (Discovery Team stakeholder).

Moving on

Volunteers were often overwhelmed or confused by the employment options available to them; *'I don't know how to find out about job opportunities, or whether there is any training that I could do… I don't know where to start [to find this out]. It is frustrating at times'* (Discovery Team stakeholder). Although, some were interested in becoming health trainers, as this is one of few posts in the health service for which they are eligible.

The following illustrates the pathway of some Discovery Team members.

Pathway journey of some of the volunteers

- A 62 yrs old female attended cCBT sessions and after completion started volunteering. She is now a Bank staff member.
- A 76 yrs retired male started volunteering in October, 2003. He did chair based exercises sessions and went on to deliver it at four centres. In 2007 he became a self-employed trainer.
- A 60 yrs old female came to a diabetes awareness event and joined the team. She now works as a resource officer.
- A 43 yrs old man joined in 2006, and trained as a stop smoking advisor and a chair based exercise instructor. He is now employed as Bank staff and also as a freelance instructor. He is currently involved with at least 10 groups delivering the sessions.
- A 48 yr female joined in October 2002 and went on training courses, she presented the radio 'Lead our good life' show. She became interested in nursing and now works as a qualified nurse at Wythenshawe hospital.
- A volunteer got a job as a Support Worker at the Royal Infirmary supporting people who have had chronic heart disease.
- The youngest volunteer was 18 years old and now works in a local solicitors office in the city centre.

Currently SMHLN do not collect monitoring information on all vounteers who move on; but this would be a good illustration of how the HLN contributes to economic regeneration, and a Local Area Agreement priority. However, there are resource implications for collection and collation of all data.

6.5 Effectiveness

The Discovery Team's work has changed since its Big Lottery days, mainly due to limited funding. It is no longer able to offer the breadth of health related activities within communities. Previously, as well as organising health events, the Discovery Team ran stress management courses including one for young mothers. Currently, it mainly offers chair based exercise.

The Discovery Team manager has created a feeling of goodwill and trust, and built up a sense of teamwork. Although, some Discovery Team members would welcome more of a financial incentive, for many being valued and formal recognition of their work is most important. Although they felt supported and appreciated by SMHLN, many felt their worth was not recognized within mainstream health services: *'There should be greater recognition by the NHS of the work we offer and do; it is equally as important as any other parts of the health service'* (Discovery Team stakeholder).

Training often needs to be tailor made rather than 'fit in' with courses from established organisations. And although, word of mouth may be the most effective method of engaging volunteers, other more proactive approaches will be required if a broader range of people are to be involved.

There is little doubt that The Discovery Team is valued for its good work: '*It has engaged a lot of people who otherwise would not have got involved '* (statutory stakeholder). But it was not clear how the work fits into its own aims of identifying needs and shaping solutions. Nor is it clear how the volunteers transfer their knowledge about health needs within communities, or whether the PCT would act on this. In addition, it is difficult to collect appropriate data from those who use the information stands, but indicators are needed to evaluate its effectiveness.

7.1 Organisation

> *'As long as its position [within the PCT structure] does not hinder its work, it does not matter where it sits'* (health service stakeholder).

In 2006 when SMHLN moved to the PCT, there was some confusion over where it would sit as it coincided with the merger of the three PCT's in Manchester. Although, it was placed in Adult Services, Scheduled Care, few felt this was the best place but it didn't fit into any of the existing silos. Views ranged from; *'It was more by default than design where it ended up; it ought to be part of Public Health'* (health service stakeholder) to *'Although it doesn't fit comfortably within Scheduled Care, it is most probably the best place for it as it straddles this service and public health'* (health service stakeholder).

The next section explores location and management arrangements and outlines organisational issues prior to tendering.

SMHLN's work was well understood by those they worked with, especially Public Health, the Engagement Team, regeneration, ward co-ordination and the voluntary and community sector. However, some key PCT provider services and the commissioners were less clear about their role.

> *HLN needs to be with the right manager, in the right unit, with the right targets and indicators* (PCT stakeholder).

One stakeholder felt that some PCT workers did not know about HLN's; *' Not everyone knows what it does. There needs to be informing within [the PCT] and awareness raising, especially when the HLN is contributing to health promotion targets'* (health sector stakeholder). High profile themed meetings for stakeholders have in the past helped promote SMHLN's work.

Equally as important as its location are the qualities of the HLN manager: *'It is imperative that the manager must have a feel for what the HLN is about. It is about community based health, health promotion, community empowerment and engagement. They must be open to being challenged by the community- some see these as fringe issues…Not every manager has these qualities'* (PCT provider stakeholder).

It was generally agreed that within Scheduled Care, SMHLN had been left to develop its own working practice. Some felt it had *'…been led by its funding so it has been hard to formulate any strategic direction for the work'* (health service stakeholder). However some felt its current location had left it isolated within the PCT, leading to a sense of disempowerment within the larger organisation.

Most statutory stakeholders interviewed felt that Public Health Development and HLN complemented each other's work. Although, this did not happen as well as it could: *'Many of the services are not joined up, all those working together on health improvements need to be brought together under a formal management structure'* (health service stakeholder).

Currently, there are a number of PCT reviews that impinge upon SMHLN's work and the new HLN. There is a management review of services within Adult Division to help break down barriers between services and there is also a review of services with Public Health Development. These should help the PCT identify where the most appropriate place for a HLN service would be if located within its structure.

7.2 Management Board

When funded through Big Lottery the independent SMHLN had a management committee with community and voluntary sector representation. Once mainstreamed, the management committee stopped meeting as: *'The PCT was bound to call the shots'* (Board member). Consequently an advisory stakeholders board was set up which meets several times a year. There were varied opinions about involvement; *'The Board is useful as it means you can keep tabs on what SMHLN is doing'* (Board member) whereas another '… s*truggled to see how their own organisation might benefit from involvement' (*voluntary sector stakeholder).

HLN's

As part of this evaluation discussions were held with a number of HLN's in the North West. This identified factors that impacted upon their future arrangements with the demise of Big Lottery funding. It was hoped this could feed into the development of the future HLN.

> *'[Our future after Big Lottery] had a lot to do with who you know and the reputation of the work'* (healthy living network stakeholder).

The following were identified as relevant:

- The focus for the HLN's work – whether this was on one or two aspects such as mental health, or food and diet or whether the HLN provided a broad community health focus
- The relationship with the statutory sectors - the extent to which the HLN was tied in with the PCT (and/or local authorities) or was independent
- Funding - whether the HLN was mainstreamed through the PCT with additional funding from other organisations, or whether it acted as social enterprise agency receiving contracts.

The next section examines these.

Funding

A number of HLN's planned their design and strategy with sustainability in mind. Early on they developed a strategy to ensure continuation once Big Lottery funding disappeared; *'We always had an eye on what would happen when funding ceased'* (healthy living network stakeholder). This included effective links with officers who could champion their cause in the key organisations. They developed and nurtured relationships so that these people had confidence in the HLN's work. Although, this was not the case with all HLN's as one noted; *'We just potted away under the radar'* (healthy living network stakeholder).

> *[Our HLN] has always been ahead of the game; we looked at what central government was saying and anticipated the trend. And we are still doing that now'* (healthy living network stakeholder).

Some HLN's were 'entrepreneurial' and identified different funding sources tied in with grant opportunities. Consequently, having a manager with experience and skill in the fund raising process was crucial, although they ended up spending most of their time seeking new sources of funding towards the end of their lottery grant. A few HLN's felt that being too closely aligned to a statutory sector agency limited their ability to raise funds. Consequently, they ensured they were seen as being different to mainstream health providers, although they might be doing similar work.

All HLN's developed close working relationships with the PCT. In one, PCT staff were seconded into and managed through the HLN. Once Big Lottery funding finished the PCT continued to pay for their staff and the HLN's work.

The PCT and the local authority are without doubt important players for funding. Whilst funded through Big lottery, **SMHLN** worked closely with and had the support of the then Director of Public Health. He wanted the work to continue and helped get it mainstreamed within the PCT. However, SMHLN was at a disadvantage when it was being mainstreamed as it coincided with the PCT's reorganisation. It can be argued that this impacted upon its location within the PCT, its management structure and ultimately the work it developed.

7.3 Focus for the work

Some HLN's grew from projects which addressed gaps in health provision. They developed work targeted at specific groups, such as structured intervention for adults with mental health problems in secondary services and young people in the NEET (not in education, training or employment) category. Other HLN's aligned themselves to the developing priorities of their PCT's.

They ensured their work was integral to the PCT's ability to meet its targets; *'The work fitted into the PCT's agenda as they moved to a more preventative focus'* (healthy living network stakeholder). Another HLN took advantage of national policy developments and matched identified local need with current government policy objectives.

Once Big Lottery money finished, those with a strong health focus received PCT funding although this often took time to arrange. Those taking a broader approach looked for funding from other sources, such as grants from their local authority, the sports council, and new programmes with a wide health and wellbeing remit. They chose to continue working with partners to obtain further grants, from a position of relative strength and independence. And the size and breadth of their work gave them influence to win contracts.

In one, the old HLN became a new community health development team fully integrated into the PCT. The PCT recognized that a more focused approach was necessary to address health inequalities, targeting those in need, rather than trying to work with all communities. This was because: *'The health inequalities have not changed in the last eleven years so we have moved to a more neighbourhood approach focusing on those areas with the highest levels of deprivation'* (healthy living network stakeholder).

Stakeholders within the PCT who knew **SMHLN**'s work, felt their roles, responsibilities and operations had been worked through in relation to other health services; *'It is clear what SMHLN do and how they fit in with the [PCT} work;*(health service stakeholder). In terms of the focus for their work, they were seen as; *'…foot soldiers, working with people at the community level'* (health service stakeholder) whereas public health were one step away. There were some stakeholders who felt that the NHS was very illness focused whereas: *'SMHLN had a grasp of nurturing and empowering patients, rather than doing things to them'* (health service stakeholder).

> *'SMHLN are a focus for PCT work in the community'* (health service stakeholder).

Other service providers were concerned that the PCT saw SMHLN as; *'… its community health arm; for [the PCT] it ticks their community engagement box; so they feel they do not have to do much more in community health work''* (statutory stakeholder).

7.4 Relationship with the statutory sector

All the HLN's were originally independently funded through the Big Lottery; and most of the key players were represented on their steering groups. Although, the HLN's struggled to develop evaluation criteria, they ensured key stakeholders were fully aware of their work. Those HLN's which effectively met gaps in provision were able to demonstrate their value.

Consequently, when the Big Lottery grants came to an end there was a definite commitment to ensure their work continued; *'Almost from the beginning the manager saw it as his role to get the work mainstreamed. He worked hard letting key commissioners know about the work'* (healthy living network stakeholder).

Some of the HLN became charities, with a service level agreement with their main funder, the PCT and are; *'At the forefront of the social enterprise model'* (healthy living network stakeholder). They chose this model as being too closely aligned to a statutory sector agency limited their ability to raise funds and could affect their independence; *'We wanted to become independent as it would mean we could do a lot more and get commissions from agencies who wouldn't commission a statutory agency'* (healthy living network stakeholder). With the change in status their work has grown exponentially. Independence meant there was much less bureaucracy and; *'We do not have to appease local councillors, to get decisions approved all we need to do is approach Board Members'* (healthy living network stakeholder).

'We made sure we always had one foot in both camps [the council and the PCT]' (healthy living network stakeholder).

One project's steering group had considered becoming independent, but decided that on balance, being part of the statutory services had advantages. It meant it was easier to access a wide range of steering groups and partnerships, so they could keep abreast of policy developments. They could then see how these impinged upon their work. But even those HLN's that have gone for independence still have strong relationships with the PCT, where key managers are on their management board.

There were fears that with **SMHLN**'s move to the PCT, it might; '*…get swallowed up and never be seen again; but this doesn't seem to have happened'* (Board member). SMHLN is located at a hospital, WCH. One stakeholders felt that this was advantageous as: *'Services in hospitals carry more weight, especially with the PCT, compared to those in community venue such as libraries'* (health service stakeholder). It was also felt that SMHLN's hospital location gave them credibility with other agencies. It would be interesting to know if this view was shared within the voluntary and community sector.

7.5 Implications for the future

The PCT is widely seen as responsible for funding the HLN, and it has taken this on board. However, where the HLN is based will be subject of a tendering process

The NHS was perceived as having a better understanding of health needs than the local authority: *'The NHS is more open to working in different ways, It is not autocratic and better at taking risks than the LA'* (PCT stakeholder. However, being part of a large organisation means the work can get lost, and it could become embedded within a bureaucratic structure. It can also be threatened by any future PCT financial concerns. In addition local people and community groups may not have as much impact upon the direction of the work.

Consequently, it is important to clarify the relationship of the new HLN with the PCT, in other words what best fits the HLN's aims. Issues to consider are whether a new service can keep its integrity and independence if it is part of the statutory sector. If mainstreamed it affects the organisation's ability to comment upon health services. There is an obligation to keep quiet about ineffective services and try to use the insider role to influence provision.

Those HLN's that became independent of the PCT were able to negotiate contracts for the work as they had developed very specific health services for targeted groups. HLN's with a broader community focus were part of the PCT.

It was felt **SMHLN** worked well with Public Health Development Service as demonstrated by the new Food Co-ordinator posts, where Public Health were employing the workers, but they were managed through the HLN. Although some health service stakeholders felt the working partnership between HLN and public health needed to be developed further especially in a city wide HLN. The option of bringing together all services tackling health inequalities into a Health Improvement arm of the PCT should be explored.

HLN's need to ensure that key people in the PCT are familiar with and value the work. Other HLN's achieved this through representation on their management boards, frequent reports and meetings with key players. A new HLN service, irrespective of its location, needs to develop structures which demonstrate its effectiveness to key players, so they are both familiar with and value its work. This links into the evaluation framework.

The next section evaluates the effectiveness of the SMHLN piloting a top-down community based provision for the statutory health services.

7.6 Case study: Beating the Blues

This case study looks at the role of SMHLN in the delivery of a new service recommended by the National Institute of Clinical Effectiveness (NICE) in South Manchester.

Background

In 2006, the PCT invested in locally enhanced services for depression using BtB, a computerised cognitive behavioural therapy (cCBT) programme for depression and anxiety. This case study complements an internal evaluation of the programme[39]. It focuses on organisational issues, the role of SMHLN in the development and planning of a top down initiative. It involved Interviews with stakeholders from commissioning, mental health, general practice, Manchester and other PCT officers, SMHLN, voluntary organisations and the Strategic Health Authority.

[39] Little V (2008) Beating the Blues: a model developed in South Manchester for including the community and voluntary sector in delivery. draft internal evaluation South Manchester Health Living Network, Manchester PCT

Findings

The evolution and development of BtB is complex especially owing to Manchester PCTs amalgamating and the introduction of Practice Based Commissioning (PBC). An analysis of the project highlights qualities of the HLN in the light of the current health service agenda and implications for future practice.

Beating the Blues was attractive because:

- It had been recommended by the National Institute for Health and Clinical Excellence (NICE) as effective for mild and moderate depression[40]
- Mild and moderate depression are high areas of unmet need for services
- It was deemed to be accessible because users can work on it on their own with minimal supervision
- It is attractive for those who like using computers
- It provides skills for life.

Development and operation

Initially it was to be placed within the Primary Mental Health Care Team but the local mental health leads did not feel it needed such a high skill level. They asked SMHLN to take over its delivery as they had the 'appropriate' approach for the work unlike many other health professionals.

A planning group was established which included PCT managers, a GP, the Primary Mental Health Care Team and voluntary organisations. This set up the programme, led by the manager of SMHLN. They agreed that delivery should be community based with voluntary sector involvement. NHS stakeholders identified a number of SMHLN's qualities which had been valuable in project development. These included:

> *'SMHLN developed a structure for rolling it out. They are a broker for groups in the voluntary sector like us. I am going to see the Joint Mental Health Commissioner about funding, I wouldn't have got there without SMHLN. . . .The PCT don't talk to little people like me even though they recognise we are reaching the unreachable'* (voluntary sector stakeholder).

- Networks and contacts – SMHLN had a wide network which saved time. These included Self Help Service, a voluntary organisation already offering cCBT in Central Manchester, from whom they were able to get advice.
- Credibility in the local community, which enabled SMHLN to identify voluntary groups that could promote the scheme successfully.
- Partnership working skills, for example their work with the Primary Care Mental Health Team to ensure that deliverers accessed training and support.
- Leadership in how they got the organisations working together.

[40] Department of Health (2007) Improving access to psychological therapies (IAPT) programme: Computerised cognitive behavioural therapy (cCBT) implementation guidance http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073470

The voluntary sector also valued these qualities. In addition, SMHLN were seen as a intermediary or bridge, an invaluable quality with the new commissioning arrangements.

'Voluntary sector providers are essential to delivery in the future. They will be and already are key partners. They are the way forward for the NHS. We need intermediaries to make it happen. We tend to deliver through our networks' (SHA stakeholder.)

Community settings were attractive because they can increase access and have little stigma as well as being value for money. One stakeholder with a clinical perspective, recognised that services needed to go to where people are comfortable: '*People won't come to the health service especially concerning mental health. We need to go to where they want to go. If the services are joined up they can access medical services from there if they need them' (*GP stakeholder*).*

Those administering the programme were trained by the Primary Mental Health Care Team[41].and had a buddying role, including helping with the equipment. There were also risk guidelines, so if programme scores were over a certain level they were to give emergency contact details to the user and refer to their supervisor. The training and support was valued, as one administering it commented: '*It was a good training. We have also got support from the Mental Health Team. We know they are there if we need them or anyone is unsure, either in relation to technical issues with the equipment or if we are concerned about someone's mental health. We have needed them, and it has worked well*' (voluntary sector stakeholder).

The following table shows sites of the programme:

Programme sites

Site	Delivered by
Withington Community Hospital	HLN workers & volunteers
Tree of Life	Workers & volunteers
Woodhouse Park Family Centre	HLN workers & volunteers
Forum Library/ Withington Library	Primary Mental Health Care Team Graduate Mental Health Workers
Barlow Moor Medical centre	Health Care Assistants

Table 15

'This package offered opportunities to increase access. I am aware that for everyone that comes through the NHS with a mental health problem there is one person in the community does not. This is because of the stigma of mental health issues; people do not want it on their health records' (stakeholder).

[41] Training included the programme, mental health, CBT, support available, exclusion criteria and risk assessment. There was a screening form which needed competing which outlined suitable criteria for participants for the programme.

The pilot involved one voluntary organisation, Tree of Life[42]. Neither they nor SMHLN were given any additional resources for this work; they shared access to the laptops and programme licenses.

Outcomes

83 people participated of which 59% completed the 8 session programme, between September 2007 and February 2008. The limited literature on implementation of BtB, suggests that other PCTs find lack of recruitment and completion of the programme common. The rates achieved were better than other areas, for example, 31% in Berkshire[43]. In the voluntary sector the completion rates were 68%, 16% greater than the average on all the Manchester sites.

The voluntary sector site, only had resources to offer if for 2 hours a week and had to stop recruiting people as demand outstretched capacity; '*One user had come via the carers group and had found ways to cope. Before going through the programmes he had thoughts of suicide but afterwards thought that suicide was a permanent solution to a temporary problem'* (voluntary worker).

SMHLN won an award of £10,000 from Mike Farrer's self help challenge[44] for Beating the Blues work. SMHLN hoped to use the award to facilitate the continuation of BtB from the Tree of Life project.

Sustainability

The programme is no longer delivered in South Manchester. At the time of its development the Manchester PCTs were amalgamating. Self Help Services were given a new contract to continue providing BtB. Although this was for citywide provision, they operate from Hulme which it not accessible to many parts of the city. Mental health commissioning are currently undertaking a review to include consideration of whether BtB will be funded in future and if so arrangements for commissioning.

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[42] This offers a holistic range of services from low cost furniture to support groups and complementary therapies in Wythenshawe, an area of high social and economic deprivation see: http://www.treeoflifecentre.org.uk/

[43] See for example, Bennett M, Harris N and Learmouth D (2006) Beating the Blues in Primary Care-Experiences of users and practice staff. Berkshire Healthcare NHS Trust http://www.cwmt.org/pdf%20files/BtBfinal.pdf and Ridge M & Dom G (2008) Beating the Blues, Draft audit, Lambeth PCT.
There is a limited amount of information available on the implementation of Beating the Blues. Similar outcomes have been identified in other areas, for example the majority of users being white, female and in the 36 to 45 age group. Completion rates for the programme may be higher in South Manchester than other areas, a 3 year study in Berkshire involving 243 users in 2 GP practices had a completion rate of 31%. In Lambeth PCT where there are 10 licences (6 in GP practices) an audit anecdotal underuse; they identified 80 people who had started the programme 25 of whom had completed it. The Berkshire study also found that people who completed over half the sessions demonstrated improvement.

[44] Mike Farrar is the Chief Executive of NHS North West, the Strategic Health Authority for the North West of England.

This case study is not about the value of BtB in itself. The lack of sustainability may in part be attributed to re-organisation and lack of involvement of commissioners, however, there are a number of lessons.

SMHLN and a local voluntary organisation were encouraged to invest time and energy into developing a service. Expectations within communities were raised. Opportunities have been missed in terms of a number of policy requirements. These include:

- To fund and resource treatments recommended by NICE Technology Appraisal reviews
- For commissioners to build a positive working relationship with a voluntary organisation which may be a valuable potential provider
- To provide more CBT.

Although, the steering group understood SMHLN's role as an intermediary between the voluntary sector, this appears not to have been recognised nor understood more widely within the PCT. Commissioners may benefit from having a better understanding of role the HLN can play in relation to involving voluntary sector organisations in delivery of services.

The attraction of BtB was access; addressing health inequalities was not mentioned by stakeholders. A self-referral scheme often attracts people who are healthy and privileged[45]; cCBT may be particularly attractive to people good at accessing services because of its wide application to life skills whether or not they are depressed. Locating the programme in Wythenshawe and especially the Tree of Life and offering buddying support targets people experiencing poor economic and social circumstances and their health consequences. However BtB users need to be reasonably comfortable with a computer and literate in the English language; this makes it inaccessible to some groups when targeting for health equity.

[45]Tudor Hart Inverse Care Law, The Lancet accessed from http://www.sochealth.co.uk/history/inversecare.htm

8.1 Themes

In order to aid readability and avoid unnecessary repetition, the findings from the different strands have been brought together thematically to shed light on specific issues of policy and practice.

8.2 Health inequalities

Stakeholders appreciated SMHLN's role in tackling health inequalities it has: *'… done a good job in positioning itself vis-à-vis the communities, in building positive relationships with them, but this needs extending to more areas'* (statutory stakeholder). Many stakeholders felt that although, the model was good, the coverage was weak; *'For smoking cessation to be effective in Wythenshawe you need more than just two sessions a week'* (statutory stakeholder).

There is a difference between improving access and addressing health inequalities. Only those using health services will take information from the stand at WCH, leaflets they may access irrespective of whether the stand is staffed. And both written information and cCBT need good levels of (English) literacy so can exclude people and thereby increase health inequalities.

8.3 Work with specialist health providers

The CBT case study showed a positive model of working between specialist staff and locality workers. The following example demonstrates this process in action.

Model of work

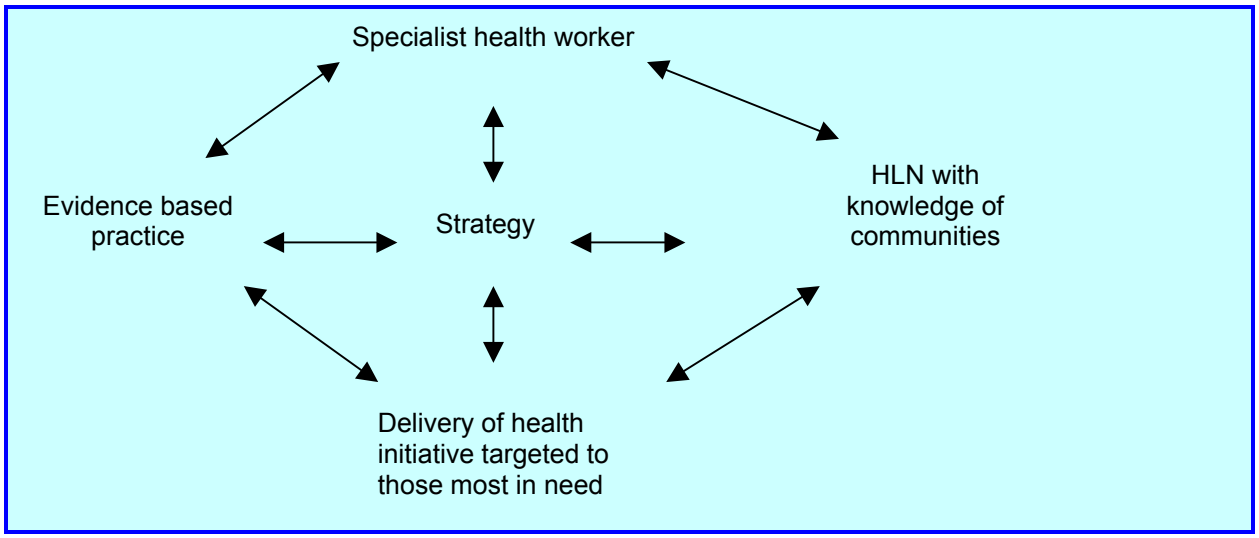

Table 16

Provision needs to focus on what works (evidence based practice) in relation to health inequalities for those most disadvantaged. Evaluation of the national healthy living networks[46] demonstrated that targeted community provision can reach disadvantaged groups who otherwise may not access health related programmes.

HLN's partnerships with community and voluntary groups can help the most disadvantaged access services. The HLN has a leading role in bringing interested players together, co-ordinating the planning and helping with governance. This is part of an evolving, reciprocal process, each organisation is giving and receiving from the work: 'W*ithout HLN input the work . . . would not have got off the ground*' (voluntary sector stakeholder).

> *'You don't feel that there is a hidden agenda [with SMHLN]'* (community stakeholder).

SMHLN were seen as being an equal partner who listen to community groups' ideas. It was also acknowledged that; *'Time is a factor, some community programmes take a long time to effect; you cannot just put money in and expect things to happen'* (health stakeholder).

Links with PCT Engagement Team

Currently, there is a close working relationship between the PCT, Engagement Team and SMHLN. The Engagement Team ensure PCT commissioners know about community health concerns raised by SMHLN. A recent example was the communities concerns about Wythenshawe breast screening mobile unit's move. The Engagement Team organised a survey for women about the issues, currently this information is being collated and will be shared in a report in November 2008.

SMHLN have networks and contacts, which other organisations, such as the Engagement Team are able to us; *'As SMHLN have already done the groundwork and … their work is respected it makes it easier for us to go and talk to people';* PCT stakeholder.

9.1 Influencing strategy

A robust evaluation framework, well embedded into HLN and partnership work could capture information about users to help influence strategy. Strengthening and ensuring the Partnership Health Workers role to ensure they link into strategy development is crucial. This would mean that 'bottom up' information is captured and fed into city-wide strategy.

> *'There is a danger that a lot of issues within the wards and areas are similar. And you could end up trying to develop a lot of local initiatives without necessarily building in sustainability and coherence, but there needs to be continuity and mainstreaming of effective initiatives'* (PCT stakeholder).

[46] Evaluation of the Big Lottery Fund, Healthy Living Centres Programme 2007.

The Zest evaluation (Colman & Emanuel 2008) indicated the potential for the HLN to have a stronger impact on service development by:

- Better reporting arrangements from the forums to ward co-ordination and the Public Service Board
- Working with and through the new LINKs.

The BMCA case study illustrated that locality projects can capture individual concerns. BMCA will engage users in discussion fora to influence strategies and services.

The following diagram indicates routes for influencing strategy:

Routes for influencing strategy

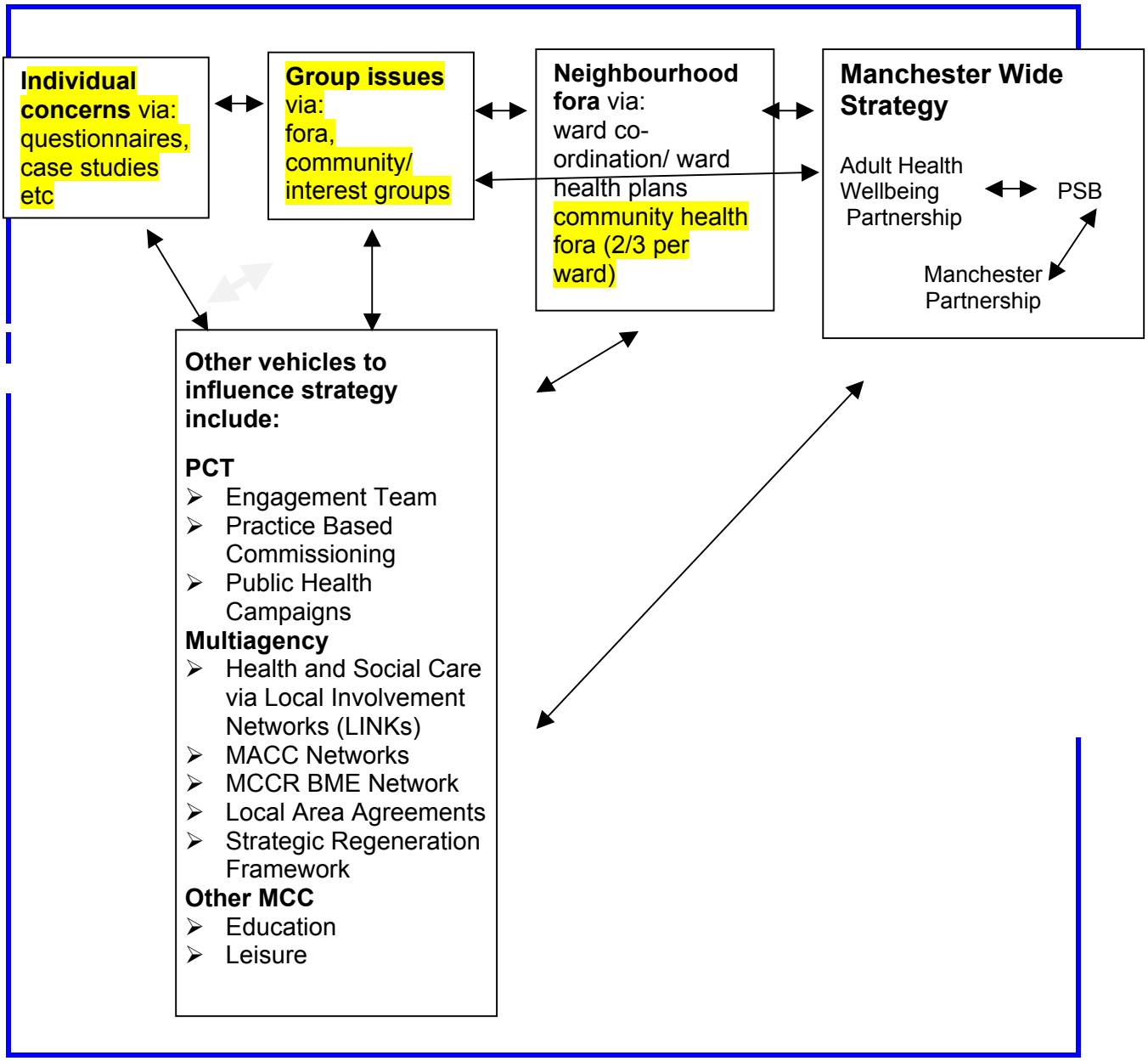

Table 17

The highlighted areas illustrate where HLN partnership projects can contribute to strategy. Needs identified by HLN's work which relate to the local and regeneration agenda should feed into ward co-ordination structures and/or community health forums; whereas issues which have citywide relevance should be fed into the Area Health and Wellbeing Partnership (AHWP).

It is proposed that community health forums will cover 2-3 wards and be co-ordinated by HLN Partnership Workers. Consequently, different levels of engagement can feed into neighbourhood ward co-ordination, which produce ward health plans, and into citywide strategy via the AHWP, Public Service Board and Manchester Partnership. The arrows go in both directions because it is possible for neighbourhood fora and citywide groups to collect information via agencies like BMCA at individual and group levels.

The lower box shows that there are several routes to influence strategy eg via the PCT Engagement Team, LINKs and umbrella voluntary sector networks representing communities of interest. The new HLN should build on existing practice, working in reciprocal partnerships, to ensure groups complement rather than duplicate each other. It is important that SMHLN's and Zest's contributions to PPI work are recognised so there needs to be a formal structure to the new Engagement Team and LINKs.

The contribution to NHS strategy can be strengthened by stronger links with health service commissioning, especially Practice Based Commissioning and through public health campaigns. The wider determinants of health should also be addressed through influencing strategies such as the Strategic Regeneration Framework and other MCC services such as Leisure and Environment. Again by developing a good evaluation framework appropriate information may be captured which influences these bodies.

9.2 Indicators

The new HLN will need to ensure that the *'Money is spent wisely';* (PCT manager). There needs to be an appropriate fit between services and their effectiveness in reducing health inequalities. Measures should be developed which demonstrate this: *'SMHLN need to ensure they are cost effective, and can demonstrate how they deliver to the PCT priorities. And they also need to show they are delivering a coherent programme'* (health service stakeholder).

Community interventions operate at multiple levels, there are few 'standardised' interventions so provision needs to be embedded and adapted to the local situation. Interventions are usually short term, whilst the health issues they address are entrenched and long term. This makes it difficult to demonstrate health related outcomes. But as one stakeholder noted; *'There needs to be a clear purpose, [HLN's work] needs to be based on evidence of effectiveness. Measurements might be proxy but this doesn't mean they should not be used'* (PCT manager).

SMHLN is located within Scheduled Care and is very different from other services there, such as district nurses. Consequently, there are few indicators which measure its effectiveness. For example, the hospital does not monitor nor audit the information stand; it feels that as long as it is well resourced and staffed it is performing a valuable service; *' It opens it up to being more than a just a hospital service,* (health service stakeholder).

And many agree it is problematic trying to measure the impact of HLN's work, *'It is hard to measure how people feel'* (health stakeholder). Another stakeholder felt that ' *If some services are liked by local commissioners such as G.P's then measurement is not so important'* (PCT manager). Although other PCT managers disagreed; *'Services are provided in response to commissioners' requests; they should be delivered against measurable standards and indicators'* (PCT manager).

This search for meaningful measurements was shared by the HLN's interviewed as one commented: *'We spent a lot of time at first asking what evidence people wanted. But no-one came up with an answer'* (HLN stakeholder). Although, one HLN measured their effectiveness by the number of health related qualifications obtained, such as first aid, exercise, cook and taste and walk leaders. Yet the case study at BMCA showed it is possible to collect meaningful data. And that indicators not only help with evaluation but the process can be used in the development of the work.

> *'As there is no HLN in Central Manchester what is the evidence that having one in the south has made a difference?'* (PCT manager).

In thinking about indicators, it is essential to think who needs to be influenced and how.

9.3 Contribution to the LAA

This section looks at the development of an evaluation framework for HLN's work which contribute to the LAA's **Individual and Collective self esteem/mutual respect.**

The main spines are considered in turn with the final columns indicating two areas of work, BMCA and the Discovery Team, with examples of how they could be measured.These should provide a structure for evaluating the work in relation to the LAA. The framework could be adapted for all HLN work.

Individual and Collective self esteem/mutual respect –what should be measured and how

Level 1Aspiration, Wellbeing & Happiness

LEVEL 2	LEVEL 3 HLN contributes to:	LEVEL 4	BMCA	Discovery Team
Satisfaction with Life	Health & Wellbeing	Contribute to health inequality targets through workforce development Reaching the hard to reach: Opportunities & aspirations of older people for inclusion; especially those with physical, sensory impairments/ mental health problems Provide access to and encourage appropriate use & uptake of HS and other local services	Work on health related issues including events, development of activities, presentations. Partnership development with community groups Information distribution	Courses Qualifications gained Progression incl. areas, activities, employment Activities Areas Numbers & characteristics of participants incl. gender, disadvantage Perceived health benefits Opportunities opened up Community groups worked with and outcomes Information given: - characteristics of recipients and action
	Belonging in Neighbourhood	Satisfaction of people over 65 with both home and neighbourhood	Questionnaires to users involved in appropriate partnership activities	People who want to move in next 2 years Log reasons
		Involvement with local organisation	Activities for older people Forums for older people Impact on sense of belonging Questionnaires to participants Issues fed into strategies/ other services	Activities Partnerships Development of activities

Table 18

Level 1 Social capital

LEVEL 2	LEVEL 3 HLN contributes to:	LEVEL 4	BMCA	Discovery Team
	Volunteering	Number and capacity development	Activities volunteers involved in	Nos. Qualifications Courses Activities – incl area
	Influence decision making/ civic participation	Contribution of HLN to development of fora for influencing decisions How HLN supports / enables BMCA to ensure information from their users influences decisions	Fora Participation in strategy groups Questionnaires, minutes of fora Participation in structures linking into strategy	Links into strategic groups Mainstreaming of activities Nos involved in volunteeringl
	A thriving third sector	Contribution of HLN Partnership work to maintenance and development of BMCA	PHW/HL List Outcomes Resources Areas N activities	Volunteering opportunities Activities/ participation

Table 19

Level 1 Supporting vulnerable residents

LEVEL 2	LEVEL 3 HLN contributes to:	LEVEL 4	BMCA	Discovery Team
Independent living	Experience of social care?	No. ff vulnerable people supported to maintain living independently.	Activities Maintaining and increasing involvement of older people with BMCA activities Nos. Barriers Involvement	Activities for targeted group Nos participating Areas Feedback from participants Other activities participants involved with

Table 20

Level 1 Community cohesion

LEVEL 2	LEVEL 3 HLN contributes to:	LEVEL 4	BMCA	Discovery Team
People get on well from different backgrounds	Diversity Respect	Involvement of people from different backgrounds Contribution to Race for Health programme	Activities. Routinely review profile in relation to local population Inclusion of health related activities targeted at specific needs of older people from minority ethnic groups living in the area	Ethnic monitoring, users and staff List targeted provision

Table 21

Level 1 Localised/personalised services in partnership with resident and organisations

LEVEL 2	LEVEL 3 HLN contributes to:	LEVEL 4	BMCA	Discovery Team
		Tackling the major killers	Activities contributing eg physical activity, healthy eating, smoking cessation, mental health, safe drinking and cancer prevention List Nos Profile Etc	Targeted activities Participants Link to evidence based practice Promotional work Participant feedback

Table 22

All this work contributes to building contributes to building involvement, partnership, confidence and community building

10.1 Discussion

The evaluation has shown that SMHLN's work has been effective in reaching out to and working with communities around a broad 'health' focus. It has built links with local organisations and adapted the work to fit changing local needs. It has nurtured partnerships across a wide range of communities and in particular, the Discovery Team is seen as a valuable resource within WCH.

SMHLN enabled the development of health related activities in disadvantaged communities through their support to projects, regular contact with ward co-ordinators and input from the Discovery Team. Their hard work, reliability, knowledge of communities, network skills, support and hands on help were valued. The spirit of reciprocity that underlies their work was particularly welcomed, whereby community groups get support and resources to develop their capacity for health related work.

Workers and volunteers are appreciated as they offer a 'ground level' non-medical approach enabling people to take control over their health. HLN's have a key role in voluntary public health and the future service will be responsible for health trainer volunteers.

However, the HLN needs a clear focus on addressing health inequalities which is not necessarily about increasing access to services[47]. It is as true today as 35 years ago that the healthiest and wealthiest access services most, so provision needs to be targeted and appropriate for disadvantaged communities. For example, locating the cCBT programme in more deprived areas, such as Wythenshawe and with groups like Tree of Life can target people experiencing poor economic and social circumstances. However, any initiative dependent upon computer skills and English literacy will mean it is inaccessible to some groups.

10.2 Volunteers

The Discovery Team have the potential to skill a large number of volunteers so they are better informed about health issues, this can be integrated into SMHLN's partnership work. The value of volunteers to the PCT, especially their contribution of time and local knowledge, may not be fully realised. Like health trainers they can be ambassadors for the health service.

There are two distinct groups of volunteers; retired and those who want to develop their experience and skills for employment. These groups have different needs and contributions and it may be useful to explore how this is integrated in one programme.

[47] Tudor Hart J op cit

The volunteers value their support and would like:

- To participate more in the planning and organisation of activities
- More meetings to discuss the work and share practice
- A greater link between training and practice
- More information about pathways to careers.

Currently, the Discovery Team is limited by resources but their aims will need reviewing in light of the new HLN's priorities. This should consider:

- The information stands at WCH which is popular with the hospital. However, it is unclear how this promotes health equity nor the evidence base for giving health information through leaflets especially to disadvantaged groups.
- The strengths and weaknesses of the HLN volunteer programme as a route to employment. And whether the introduction of health trainers changes this.
- The communities represented by volunteers and the activities they engage in. The Discovery Team has been successful in recruiting volunteers from Black and minority ethnic communities but it is not evident how they are developing the expertise of these communities. Strengthening this may ensure the programme has a greater role concerning health equity.

10.3 Work with the 3rd sector

SMHLN can help PCT reach communities and commission through the 3rd sector. It is valued by Public Health Development and the Engagement Team for their ability to reach local communities and the voluntary sector. Staff use the HLN for advice about community groups and volunteers. The Engagement Team are able to access more people especially in disadvantaged communities by working with the SMHLN. Examples include work with community venues about the legislation banning smoking and the cCBT work.

Offering cCBT through voluntary organisations working with disadvantaged groups was positive as was using buddying to help people to use the programme. This may have contributed to the higher rates of completion of the programme compared to GP settings in other PCTs.

However, SMHLN's role in accessing the voluntary and community sector was not fully understood by all senior managers and especially by commissioners. There is untapped potential for commissioners to access 3rd sector organisations through SMHLN's skills and expertise. This was identified as important with the increase commissioning of services from the third sector.

10.4 Partnerships and conduit between agencies

The SMHLN has an excellent record of partnership work. Like Zest, the North Manchester HLN, this filled a gap whilst the PCT was re-organising and organisations found it difficult to develop partnership work with the health service. SMHLN acts as a conduit ensuring that projects with few resources to attend key meetings are not left out of the loop. It can also improve the work of staff in statutory organisations by providing contacts and information within communities.

The cCBT case study illustrates the ability of the HLN to bring together an interagency team and lead the development and delivery of a service in an innovative way. The pilot was impressive enough to win an award but was not embedded sufficiently within the PCT to ensure sustainability. The project may have been a casualty of re-organisation but highlights the need for involvement and ownership by commissioners from the initial planning stages.

The case studies illustrate how SMHLN develops a platform for health. The added value includes:

- Engaging and involving people from an area of need in health related activities
- Involvement in partnership work based on reciprocity with organisations and wider fora including Neighbourhood Ward Co-ordination and the PCT Engagement Team
- Developing the confidence and capacity of community organisations in health related activities and ensuring that the needs of the user groups are fed into citywide engagement structures.

10.5 Evaluation framework

The BMCA case study showed that it is possible to collect data without detracting from the work of the project or putting off users. There are some factors which help this process for those involved – workers, users, stakeholders:

> *'I was asked how the evaluation could contribute to my work at the beginning of the evaluation and I got what I wanted! I have never experienced that from evaluation before'*, (SMHLN stakeholder).

- Enabling all to understand what information is being collected and how it will be used.
- Opportunities to influence the content of the evaluation, especially so the data collected will be useful to the project
- Ensuring key players have time and resources for involvement
- Opportunities for reflection on the process and on how information can inform strategies.

The case study with BMCA was very successful. However, BMCA were unusually open to participation in the evaluation. As well as providing information for their evaluation it had the potential to contribute to their needs.

The timing and participatory nature of the evaluation enabled shared understanding, influence and ownership of the process. This spirit of reciprocity underpinned decisions at all levels. The result was collection of good data, shared interest in the results and enthusiasm for using the tools in the future.

The questionnaire proved useful for one to one conversations providing immediate learning for project staff. The evaluation team felt that although the questions needed reviewing they provide a basis for development. Two potential roles for the questionnaire were identified; to promote action learning and to obtain data.

Links into strategy

HLN are key players in capturing 'bottom up' information. There needs to be effective channels so HLN can feed this into policy development. The Zest evaluation[48] showed the potential for HLN's to have a strong impact on service development by better reporting arrangements from the fora to ward co-ordination and AHWP as well as working with and through the new LINKs and PCT Engagement Team.

10.6 Sustainability

The Discovery Team now build in sustainability into provision. However, sustainability was not embedded into the cCBT project, consequently, opportunities for policy requirements were missed. These included:

- To fund and resource treatments recommended by NICE Technology Appraisal reviews
- For commissioners to build a positive working relationship with a voluntary organisation which may be a valuable potential provider
- To provide more CBT.

Again this indicates the need for commissioners' involvement and ownership from the outset.

10.7 Organisational issues

HLN needs to be with the right manager, in the right unit, with the right targets and indicators. Its location will be subject to tendering. However the review of other HLNs indicates the advantages and disadvantages of different locations and management structures.

The options for location in the PCT include Public Health Development and provider services, the latter may add to their ability to work with other community health services. There are a number of service reviews being undertaken and this evaluation should be integrated with them. One option might be to bring the new Healthy Living Network together with the Community Nutrition Team and Public Health Development into a new Health Improvement Team.

[48] Colman and Emanuel op cit.

This could co-ordinate services for a greater impact in tackling health inequalities. However, whereever HLN are placed opportunities should be taken to maximise the ownership and involvement of key stakeholders.

The option of developing the HLN as a social enterprise in the medium to long term should also be further explored.

Equally important are the qualities needed to manage the service. The managers need to understand community based health, health promotion, community empowerment and user engagement. In addition it is essential they have skills to feed into strategy and ensure senior managers within health and regeneration services understand HLN's value.

10.8 SMHLN's profile

In the current climate the HLN needs to have a high profile with the following groups; GPs, Commissioners, Public Health, Non-Executive PCT Directors/ local councillors, regeneration, ward co-ordinators, the community and voluntary sectors.

While some key stakeholders may be aware of HLN's in Manchester, there should be better understanding of how they enable the PCT and other agencies to meet their targets. This links into the evaluation framework, as better data will enable the HLN to demonstrate how it is contributing to HP targets and LAA indicators.

There also needs to be more engagement and awareness raising within the Trust and the Board including clarity about who takes things to the Board to show the effectiveness of the work.

11.1 Recommendations

The proposed city-wide Manchester Healthy Living Network has the potential to promote health improvement with communities and individuals from disadvantaged groups. It can do this by building:

- Partnerships
- Confidence
- Engagement and involvement
- Local support.

The learning from this evaluation has demonstrated SMHLN's strengths. These can form the bedrock of the new service, alongside the learning from Zest's evaluation.

SMHLN's partnership work and volunteer programme identified qualities which need maintaining; these include:

- Work in specific areas of need
- Partnership work with voluntary and community groups
- Acting as a conduit for the PCT and other services
- Raising the health agenda within ward co-ordination and in communities
- A broad approach to tackling health inequalities
- An in-road into community and voluntary organisations
- A broad range of willing volunteers.

In addition this evaluation has pointed to areas for development. The final section outlines these.

Health inequalities

- The aims and purpose of the work need to be considered in light of the broad objectives of the HLN.
- Targeted initiatives should be developed which tackle health inequalities. The Information Stand at WCH should be considered in light of this.
- Access should not be confused with addressing health equity. If the role of the HLN is primarily to engage and build the capacity of the least privileged, the work must be clearly targeted to reach those most disadvantaged.
- Strategies for sustainability need to be built into all provision.

Work with the 3rd sector

- The HLN should continue to deliver NHS initiatives in community settings. Work should be developed with community and voluntary groups who are in contact with those most in need.
- Commissioners should be supported in understanding the potential for HLN's work with the 3rd sector.

Volunteers

- The aims of the Discovery Team need reviewing to see how they fit with the new service.
- Work in communities with the increased partnership workers posts should be explored.
- Strategies should be developed to meet the needs of the different types of volunteers.
- The role of the Volunteer Manager should be reviewed in light of the extensive needs of the programme.

Raising and maintaining the profile

- Key stakeholders should contribute to the vision and goal setting of the new service. This will ensure a shared understanding, mutual influence and support for the work.
- Regular events should be organized to showpiece the work, develop and maintain HLN's profile. The HLN might wish to look at how Healthy Schools ensures a strong visible presence.
- Key players including the commissioners and PCT Board should be informed about HLN's role and potential.
- Governance arrangements should be understood, influenced and supported by all key stakeholders including commissioners.

Influencing strategy

- The proposed development of health fora in the wards should help ensure local people and communities can be involved in the decisions about local health services. Specific recommendations from the Zest evaluation of forums should be considered. These included clear terms of reference and better links to service development.
- Developing formal structures into the strategic partnerships and boards will help to incorporate learning from HLN into service provision.
- Evaluation material demonstrating the effectiveness of HLN's work will help give it credibility to influence strategy and policy. Remaining on the fringes of strategic boards means that the HLN voice and perspective is less likely to be fed into the policy framework.
- Work within ward co-ordination should be developed further with the increase in partnership workers.
- There should be a clear relationship to the new PCT Engagement Team and LINKs.

Evaluation

- An evaluation framework should be developed with key stakeholders and users.
- Indicators should be devised which help in service development and demonstrate the value of the work; this should be through participatory methods where appropriate.
- There needs to be sufficient resources including time to evaluate the work.

Management arrangements/ location

- The new manager of the HLN needs to be committed to tackles health inequalities; they need to champion the work so that relevant Boards, senior managers and commissioners understand its importance and potential.
- The best financial arrangements for the HLN should be explored; these include being part of the PCT or a social enterprise model in the future.
- If the HLN's is part of the PCT options should be explored for a Health Improvement Section which brings together those services tackling health inequalities.

12.1 Appendices

12.2 Tables