South West Well-being Programme
Final Evaluation Report
March 2011
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Acknowledgements

We would like to thank all participants who have taken part in this study. We are particularly appreciative towards the staff involved in managing and delivering the South West Well-being programme for their time and assistance. We also acknowledge the major contribution made by people from across the South West of England who gave their time to tell us about their experiences of taking part in project activities. We are grateful to Chris Rawles and Barbara Caddick for their administrative support during the course of the research.

We gratefully acknowledge the new economics foundation for their work in developing core elements of the SWWBQ and the assistance of Saamah Abdallah, from nef, in data analysis. The SWWBQ includes the Warwick-Edinburgh Mental Well-being Scale. This was funded by the Scottish Executive National Programme for improving mental health and well-being, commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh.

Core elements of the project profiles template have been designed to reflect the Green Book case study approach adopted by CLES Consulting as part of their national evaluation of the BIG Well-being programme.

The evaluation was funded as part of the BIG Lottery’s SWWB programme and contracted by Westbank Healthy Living Centre.

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Executive Summary

Well-being and the role of the South West Well-being Programme

There is increasing evidence that positive well-being leads to a more flourishing and fulfilling life at home, school, work and in the community we live. It is central to our ability to function well, be productive, healthy and cope with adversity and change. As The Government Office for Science’s Foresight highlights, well-being is a driver for a wide range of positive outcomes:

Well-being is “a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their economy. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.”

Holistic interventions aimed at improving well-being have begun to attract considerable interest in recent years. Such work not only offers long-term benefits to individuals, action to improve positive well-being could have very high economic and social returns. Research to inform our understanding effective action plays a vital role in supporting a shift to invest in prevention and health improvement. The intelligence provided on the wider determinants of well-being and individuals’ lives is also of value in developing insight into the complex interrelationships between the factors that impact on well-being.

This report focuses on South West Well-being, a BIG Lottery funded programme aiming to promote local action on the promotion of health and well-being across the region. It brings together a consortium of community-based organisations that have a track record in third sector health promotion in areas of social disadvantage or with groups of people at risk of ill-health.

Overview of the South West Well-being Programme evaluation

South West Well-being (SWWB) is a Big Lottery funded programme delivered by a consortium of fifteen community-based voluntary sector organisations1 from across the region. The initiative runs from February 2008 to April 2011 and is led by Westbank Healthy Living Centre.

During the course of the evaluation we have compiled two reports in addition to this final report. The first report on the SWWB programme (South West Well-being programme: First year evaluation, 1 All fifteen projects focused on community and voluntary sector delivery. For three projects, coordination was provided through the primary care trust or local authority.
2009) presented a formative evaluation of the SWWB programme in its first year of delivery. It explored the organisational context to project delivery, beneficiary perceptions of SWWB services, early achievements and challenges, and common underlying themes in delivery.

The second report (South West Well-being programme: Adding Value, 2010) focused on the nature and extent to which SWWB projects add value to local service provision. Added value can be defined as the additional benefits gained as a by-product of a service or project, which would not have occurred, had the service or project not gone ahead.

UWE’s SWWB evaluation has adopted a mixed methods approach that includes an account of both processes and outcomes through qualitative and quantitative research. The programme outcomes are at both the level of the individual beneficiaries or the programme and at a wider organisational level. There are 6 key elements to the evaluation:

1. The South West Well-being Questionnaire (SWWBQ), a set of measures that cover general health, healthy eating, physical activity, mental health, and personal and social well-being. The core elements of SWWBQ have been adopted from a national well-being questionnaire developed by the new economics foundation.
2. Good practice case studies, chosen to reflect an innovative or exemplary aspect of project development and delivery;
3. Project profiles, drawing upon a standardised case study format;
4. A survey of the perspectives of practitioners working in outside agencies on the performance of the programme;
5. A economic evaluation of the contribution of volunteering and the unit costs of different types of SWWB services;
6. An exploration of the consortium working process, based on written and group activities involving representatives from each of the projects.

**Participation, partnership and organisation outcomes**

Over 30 months SWWB projects has worked with over 25,000 people, of whom 43% are on low incomes, 18% have low level mental ill health and 19% are obese, overweight and/or have weight related medical conditions.

Participants have taken part in over 105 types of SWWB project activities that include gentle exercise groups, befriending groups, grow and cook groups, art and craft groups, individual counselling and one-to-one personal health goal setting. Qualitative and monitoring feedback suggests that the projects offered a very high level of individually tailored support to beneficiaries.
Projects embraced different levels of intervention including a structural orientation towards community, environmental and local economic development whilst also focusing on individual health-related behaviours.

Of the three programme strands, the promotion of mental health is often the underlying, if not central, objective for many activities. All projects report they are addressing health inequalities to some degree with variation across the programme with those projects operating in areas of relatively low health poverty aiming to address ‘fine grain’ health inequalities.

All projects employ an understanding of promoting social capital through diverse activities including social networking, community capacity building, and the promotion of neighbourhood trust and reciprocity. Many emphasise the benefits of group-based social engagement.

 Volunteers are central for many of the projects. Over a three year period, 903 volunteers contributed an estimated 165,677 hours to support the delivery of project activities. This is a per annum equivalent of 55,225 hours or 28 full time staff. Based upon an hourly rate of £7.11 (£5.93 hourly national minimum wage plus 20% employment overheads), the total volunteer hours equate to an economic contribution of over £1.17 million towards the programme.

The service costs for SWWB were found to be relatively low. Using the national PSSRU formula, the unit costs for group based activities range from £3.20 to £9.40 per session One-to-one services have unit costs ranging from £15.30 to £30.90 and are targeted at individuals with higher levels of ill health or social needs. This compares with national figures of £11.25 unit cost for voluntary day care service session of similar duration for older people and a £64.00 unit cost for a one-to-one cognitive behavioural therapy session.

The SWWB programme works as a close ally to GPs, social care services and a range of partner organisations. A survey of 171 practitioners in partner agencies finds that 71% recommend or signpost SWWB services with 59% confirming they formally refer people to a SWWB project. Practitioners indicate effective links between SWWB and their own organization: 64% said SWWB activities provided a good fit alongside other local services. This shows the potential for linking clinical services with community services with a demonstrated impact on health and wellbeing.

The evaluation has also identified organisational learning based upon the experiences of SWWB programme’s consortium members. Best practice case studies illustrate how projects have both innovated and matured in their service delivery over the course of the programme. These highlight how an alliance of healthy living organisations has worked with the Big Lottery’s portfolio model, while also reflecting the learning derived from wider research on partnership working.

SWWB programme is a consortium model that holds a number of attractions for commissioners of civil society and health improvement initiatives. The format streamlines the supply chain, has kept overheads low, promoted prompt front-line delivery, directed efforts and managed quality assurance.
Well-being Outcomes for Project Participants

The evaluation team analysed the health and well-being outcomes of beneficiaries who completed a before and after questionnaire containing a combination of validated and original measures. These participants had taken part in structured activities that combined group and one-to-one support. Typically the activities took place over the course of six sessions. All had a holistic approach to well-being and general health improvement, although the majority of activities focused the work around healthy eating, physical activity or mental health. Respondents completed the questionnaire after taking part in the activity - or at a review point. 1178 baseline questionnaires have been completed and, to date, 737 matched follow ups have been returned.

The findings of the study showed a range of positive changes at follow up.

**General health**
Sixty five per cent of SWWB respondents reported their general health to be ‘good’ to ‘excellent’ at baseline. This rose to 82% at follow up. These data show improvements in comparison to recent large scale surveys, although there are small differences in the measures adopted. For example, the NWPHO study (2009) found that 72% of respondents reported that they were in ‘good’ or ‘very good’ health.

**Mental Health**
Taking part in the programme is associated with considerable improvements in mental health. Overall, 63.6% of participants report improved mental health. The percentage of participants reporting significant depressive symptoms fell from 35.6% to 18.5% during the course of project activities. This compares to 20.8% of the adult population in England.

**Physical activity**
Beneficiaries taking part in SWWB activities are likely to be more active and to take part in more frequent and intensive exercise. Using the GP Physical Activity Questionnaire, the percentage of respondents classified as being ‘active’ increased from 13.8% at baseline to 32.4% at follow up. 45% of participants recorded an improvement their physical activity using the 28 day 5x30 minutes exercise measure.

**Diet and healthy eating**
The proportion of individuals taking part in activities with a focus on healthy eating who were meeting public health ‘5 a day’ guidelines on fruit and vegetables rose from 25.5% to 39.5%. This compares to 29% for a comparable age profile in the England population. Overall 31.7% reported eating more fruit and vegetables.

**Personal well-being**
Overall satisfaction with life as a whole, a recognised measure of well-being, showed significant positive change: 47.4% reporting improved overall life satisfaction at follow up. Form a score out of 10 the average rose from 6.1 at baseline to 7.0 at follow up. Bearing in mind the relatively high levels of mental ill health amongst SWWB participants, these are results that are approaching the UK average score of 7.2 for a general population.

At the same time, the proportion of participants producing ratings of ‘moderate’ or ‘high’ on the Short Warwick Edinburgh Mental Well-being scale rose from 57% at baseline to 73.7% at follow up. This compares to 83.2% of the England population. This represents 60% of participants reporting an improvement in their personal well-being.

**Social well-being**

The evaluation also found statistically significant positive changes in terms of wider aspects of social well-being, including perceptions of belonging to a community, attending local activities, regularly meeting socially with friends and relatives, and perceptions that people in the local area help one another.

Analysis shows that mental and social well-being is strongly linked to the programme goals to improve healthy eating, physical activity and mental ill health. For example, at follow up people reporting higher mental well-being are more likely to:

- Enjoy eating healthy food
- Enjoy putting care and effort into preparing food
- Regularly prepare meals from basic ingredients
- Believe that physical activity is enjoyable and important for health

These findings support the SWWB holistic service model because it suggests that work in one area can deliver wider health benefits for participants. Overall the findings from the study indicate a very positive set of associations between participation in SWWB activities and the well-being of respondents. However the limitations of the findings need to be recognised: for example, further study would be needed to determine evidence of longer term and sustained behavioural changes.

The South West Well-being (SWWB) programme has sought to deliver a community focus on promoting capacity for personal and social well-being; as opposed to the management of ill health and disease. To do this, SWWB put volunteering, mentoring, peer support and social networks at the heart of its services.
1. Overview

1.1 Introduction

South West Well-being (SWWB) is a Big Lottery funded programme delivered by a consortium of community-based voluntary sector organisations from across the region. The initiative runs from February 2008 to April 2011.

For the South West of England the programme represents a new approach to collaborative working between independent Healthy Living Alliance organisations that specialise in local community engagement to promote health and well-being.

This is the third evaluation report on the South West Well-being programme. The first report analysed the delivery of the first eleven funded projects and identified common links across the programme. The second report focused on the nature and extent to which SWWB projects add value to local service provision.

1.2 Aims of this Report

This report is works toward the final summative evaluation of the SWWB programme over the course of its delivery. It seeks to:
- Analyse evidence of well-being outcomes for project beneficiaries,
- Bring together learning from the process of working as part of a consortium for health and well-being,
- Present case studies of good practice from all fifteen projects,
- Present profiles of all fifteen projects.

1.3 Audience for this Report

This report is intended for practitioners and decision makers from the statutory, private and third sectors with an interest in community based promotion of health and well-being. The report is of interest to those working in the local project areas and in regional development in the South West of England. This report will also be of interest to individuals associated with the Big Lottery funded national and regional well-being programmes. The report is divided into separate sections to meet the interests of a range of different audiences.
2. The South West Well-being Programme

2.1 BIG Lottery Well-being Fund

The Big Lottery Well-being Fund is a £165 million initiative that supports programmes across England, working on the three themes of:

- healthy eating
- physical activity
- mental health

Between 2006 and 2008 the Fund issued grants to 17 Portfolios, seven of which are thematic portfolios managed mostly by charities or coalitions of charities, and ten which are regional portfolios mostly managed by statutory organisations. South West Well-being differs in this respect as a regional portfolio managed by a voluntary sector organisation.

The regional ‘portfolio’ funding model reflects an approach developed by the Big Lottery Fund to issue larger scale grants to a single managing body, which in turn devolves funding to a number of local project providing organisations.

2.2 South West Well-being Portfolio

“South West Well-being: a healthier way to live” runs from February 2008 to January 2011, with an extension through to April 2011 for some projects. The Big Lottery Fund grant is £3.96 million for this period and local partners contribute varying amounts of match-funding or in-kind support for the programme.

Westbank Healthy Living Centre is the lead management organisation for the portfolio. In the first year of delivery eleven projects across the region were funded under the scheme. Ten of these eleven projects are hosted by voluntary sector organisations. Subsequently a further four ‘seedcorn’ projects were developed in new areas of the South West.

2.3 Policy Context

Recent government strategy has stressed the need to rethink how community-focused action promotes health, well-being and social care in a changing society.

Much evidence shows that the prevalence of depression and anxiety, overweight and obesity and reduced levels of physical activity is increasing in the UK population. These are linked to a major burden of ill health in the form of cancer, heart disease, type 2 diabetes and mental ill health. They
adversely affect people’s life chances and quality of life, have a disproportionate impact on lower income and marginalised groups, and significantly contribute to the widening gap in health and other inequalities (Marmot, 2010).

At the local level, health and social care services - working with civil society - clearly need to find imaginative and pragmatic solutions to these issues (Cabinet Office, 2010; Cabinet Office and Institute for Government, 2010). The recent White Paper for public health ‘Healthy Lives, Healthy People’ (DoH, 2010a) has placed renewed emphasis on local strategic partnerships working through Health and Well-being Boards to engage all stakeholders in developing evidence-based prevention and wellness activities in the communities they serve. Recent policy has also highlighted role of local social care services and primary care services in contributing towards sustainable action on well-being (HM Govt 2011; DoH 2010b; DoH 2010c). The continued focus on wellbeing as part of a local Health and Well-being Strategy for each Local Authority means that research and evaluation evidence in this area will have a central role in driving making.

In recent years the voluntary and social enterprise sector has sought to rise to this challenge (Cabinet Office, 2010). Increasingly these agencies have refined their focus on service quality, cost effectiveness and outcomes. Organisations such as those South West Well-being (SWWB) projects have sought to deliver a community focus on promoting capacity for personal and social well-being – as opposed to the management ill health and disease. To do this, SWWB has put volunteering, mentoring, peer support and social networks at the heart of its services.

2.3 South West Healthy Living Alliance’s strategy

The initial proposal for the programme developed from work conducted by the South West Healthy Living Alliance (SWHLA). This is a group of organisations that have, largely, emerged from the healthy living centre movement. Healthy living centres are local community-based organisations that focus on promoting well-being and promoting health, rather than providing healthcare or medical solutions to illness. Some operate from physical multi-purpose community centres whereas others are virtual centres that deliver outreach services across a network of venues.

Figure 2.1: South West region and SWWB projects
In 2006 SWHLA produced a strategy document, “Well-being in the South West: a healthier way to live”, that defined its vision for community-based service development in the South West:

“The Vision is to improve the health and well being of the most deprived communities within the South West over three years with projects that will provide an holistic service, aiming to reduce health poverty by targeting those with low level mental ill health, those approaching older age and families by improving mental well being, increasing physical activity and encouraging a healthy diet.

The portfolio aims to achieve this through engaging with the target beneficiaries with fun, non threatening activities and then supporting them to make positive lifestyle changes, depending on their needs and wishes. Focusing on reducing stress and anxiety and increasing physical activity and healthy eating, all activities will include confidence building and encouraging the development of friends and social networks all contributing to improve mental well being. [...]  

In all, this approach might be described as:

Supporting the healthy living and well-being of individuals and communities by providing locally accessible, people-focused and holistic approaches to tackling health inequalities particularly for those people most in need.

The strategy also sets out the objectives of the healthy living projects to be:

- **Engaging Individuals and Communities**
  To improve the opportunities for mobilising community and individual activity towards improving health and tackling inequalities;

- **People and Lifestyles**
  To support people in meeting their full potential, helping them better access mainstream and alternative health services and particularly to develop lifestyle approaches that prevent future illness;

- **Local Health Collaboration**
  To provide a local focus for bringing together health promotion in the broadest sense, across a wide range of interests which do not necessarily have a tradition of working together.
3. Evaluation Methodology

3.1 Evaluation overview

South West Well-being is a community-based health promotion programme that operates through a consortium of independent organisations. This type of programme represents challenges for evaluation that are well documented in social and health programme evaluation theory literature, see for example Connell & Kubisch 1998; Nutbeam 1998; Judge 2004, Springett 2001, Pawson and Tilley 1997; Tones and Green 2004; Platt et al 2005.

Some evaluation challenges include the extent to which the formal business plan can be interpreted as the intervention blueprint; the boundaries between the programme and other partnership initiatives; the emergent and changing character of the programme goals over time; the coherence and integration of a consortium of bottom-up initiatives; and the appropriateness of standard outcome measures for a complex and holistic programme.

According to Green and South (2006:84), an overarching question is one of how to successfully apply evaluation principles in a way that is consistent with the nature of the activities and the values that underpin programme delivery. This evaluation has adopted a mixed methods approach that has sought to include an account of both processes and outcomes through qualitative and quantitative research. The programme outcomes are at both the level of the individual beneficiaries or the programme and at a wider organisational level.

3.2 SWWB Beneficiary Well-being Outcome Evaluation

Background & Rationale

BIG has explicitly identified itself as an outcomes-driven funder and is keen to reflect this through its evaluation activity. The SWWB evaluation has included a focus on the outcomes for beneficiaries based upon a self reported health and well-being both before and after engagement with programme activities. This section provides a background to the development and use of the South West Well-being Questionnaire (SWWBQ): the primary tool for this part of the evaluation.

The SWWBQ consists of a set of measures that cover general health, healthy eating, physical activity, mental health, personal well-being and social well-being. The core elements of SWWBQ have been adopted from the national Well-being tool. This was developed in 2007-08 by the new economics foundation (nef) specifically for the BIG’s Well-being Programme. Nef conducted a scoping review of all 17 national and regional Well-being portfolios and consulted portfolio evaluation teams on the development of appropriate tools. UWE, in consultation with SWWB projects, advocated for a tool that made use of recently developed and validated measures of positive well-being. This was also to ensure that the SWWB portfolio tools should fit with the national evaluation framework for BIG’s Well-being Programme. SWWBQ, therefore, adheres very closely nef’s core well-being tool along
with the additional Social Well-being Module also developed by nef. The following rationale offers a background to the SWWBQ tool. This draws upon nef’s report on the development of the national Well-being Programme tools (Abdallah et al, 2008).

Nef’s conceptual framework for evaluating well-being outcomes for the BIG Well-being programme has sought to emphasise the linkages between the three programme strands - and personal and social well-being assets. This ‘assets model’ brings together the three main strands of the BIG Well-being Programme. Personal well-being assets underpin these strands and emphasise the central role of psychological resources such as confidence, self esteem and autonomy. Similarly in this model, social well-being assets - such as community engagement, belonging, trust and social support – act as mediators for the promotion of physical activity, healthy eating and mental health. Nef’s framework is summarised in figure 3.1.

**Figure 3.1: New economics foundation Well-being Assets Framework**

In the nef framework, mental well-being is taken to be a positive concept and is seen as a mid- to long-term state that provides individuals with the resources required to flourish. Research indicates that mental well-being is not simply an opposite state to mental ill health. For example whilst Cox & Ajetunmobi (2007 cit: Abdallah 2008) found a negative correlation between personal well-being and depression, there was also a significant group of individuals who had low personal well-being but no symptoms for depression.

The distinction between mental well-being and mental ill health meant that the questionnaire sought to measure both independently using the CESD depression scale for mental ill and the WEMWBS scale for mental well-being:

> “What differentiates WEMWBS from all existing measures of mental health is that it has been developed specifically to measure positive mental health - all the items represent positive thoughts or feelings. Its positive focus offers a vision of future population mental health and enables others to see where mental health promotion programmes might be headed.” (Parkinson, 2006)

’Social well-being’ in the tool is measured in terms of activities that involve social engagement and participation and feelings of social support and sense of community belonging.
**Physical activity & healthy eating**
Healthy eating is measured in terms of nutritional intake of healthier food (fruit and vegetables) and food habits. Preferences and attitudes towards healthy food are an important predictor of intake and therefore the tool has sought to capture aspects such as enjoyment of preparing and eating healthy food.

The measures for physical activity capture changes in behaviour in relation to amount, frequency, and intensity. This enables an assessment of physical activity at three levels of ‘low’, ‘moderate’ and ‘high’. The tool also includes feelings and experiences in relation to the enjoyment of physical activity. Two projects specialising in weight loss collected and reported on weight and Body Mass Index.

**Well-being Linkages**
Considered as a whole set of measures, the nef tool has enabled us to examine whether SWWB’s project activities have well-being benefits that extend beyond their intended outcomes.

Nef’s framework proposes that personal and social well-being can be thought of as ‘assets’ – or resources – that closely link to physical activity, mental health and healthy eating. Emerging research indicates that positive outcomes in one area may underpin, sustain or mutually reinforce outcomes elsewhere. These linkages can take a variety of forms, Abdallah et al (2008) point to research that shows that, for example,:
- Moderate physical activity may help alleviate symptoms of depression
- Participation in gardening based activities has been found to be associated with improved life satisfaction and sense of purpose
- Participation in civic society, social support and networks has been found to reduce risks of mental ill health.

**Measures**
In summary, the questionnaire measures cover the following areas:

- **Overall health**
  - Smoking & alcohol intake

- **Healthy eating**
  - 5 a day fruit and veg’ intake
  - Enjoyment

- **Physical activity**
  - GPPAQ activity level
  - Enjoyment, sedentary behaviour

- **Mental health**
  - CES Depression scale

- **Well-being assets**
  - Life satisfaction
Further details on the measures and their derivation are summarised in Appendix 1. The full registration form questionnaire is in Appendix 2 & 3.

**Administration**

The SWWBQ has been designed to be used in a before-and-after methodology with direct beneficiaries. The baseline administration (T₀) of the questionnaire took place as the beneficiary began substantive engagement with the project. The follow up administration of the questionnaire (T₁) took place either at the end of their engagement or at the completion of an activity period, for example the end of a six week course. The SWWBQ is also designed to be used at a later point (T₂) of about 3 months after engagement has finished. In practice most projects chose to administer the questionnaire at T₁ in this study.

The questionnaire is intended to be self completed, although it can also be completed with the assistance of an activity worker. Following training and advice from the evaluation team, project workers administered the questionnaires directly. An initial version of the nef tool was piloted with one SWWB project in 2008 with adults aged between 25-60. This was found to take about 10-15 minutes to complete. Participants reported that the questions were acceptable and straightforward to understand. Further piloting with other national projects found a similar reception to the questionnaire.

**Data entry and analysis**

SWWB projects entered registration and questionnaire data onto a specially designed Microsoft Access database. The data was then exported to UWE in Excel and this was, in turn, analysed using SPSS. Data checks against hard copy questionnaires were run to ensure the reliability of the data entry.

### 3.3 Consortium Working Process Evaluation

As part of the review all SWWB Steering Group members were invited to provide written feedback in response to the questions:

Thinking about your organisation’s experience of working as part of the SWWB regional portfolio...

- What have been the achievements and successes?
- What have been the challenges?

These were returned, anonymised and loosely grouped by the research team. At a subsequent Steering Group meeting participants began to identify some key themes. Although the initial plan was to develop a consensus on key themes using the Nominal Group Technique (Delbeq et al. 1975), participants elected to first identify learning with regard to specific aspects of the programme -
rather than to generate a potentially generic list of consensus statements. The evaluation team have
firstly selected main themes arising from the feedback to date and, secondly, incorporated evidence
from the first year fieldwork to generate the account that is provided in the next section of this
report. At this stage of the process, all participants are invited to add further comments. The
Steering Group members were then invited to feedback on the key themes.

3.4 Good Practice Case Studies

All project leads were invited to identify an area of ‘good practice’ that reflected an innovative or
exemplary aspect of project development and delivery. A number of key themes were generated
based upon training, operations and knowledge exchange meetings that have been held by SWWB
practitioners over the course of the programme.

Project teams researched and produced an initial draft themselves, or we produced a draft based
upon interviews. These were subsequently edited for consistency and agreed by project teams.

3.5 Project Profiles

Each project profile draws from a common template based upon the national ‘Centre Case Study’
format developed by CLES for the BIG Lottery. The data have been checked to reflect a consensus
between the UWE researchers, project leads and the SWWB programme manager.

Project aim

This statement is drawn from the Big Lottery funding application document. In many cases this has
been revised to give a more accurate reflection of the project.

Rationale

This section seeks to explain the development the project, an outline of the project operation and,
where available, the theoretical basis of the intervention.

Host organisation and Project Area

These sections explain how the project is located within the host organisation and the setting within
which the project operates.

Project Structure Diagram

The structure diagram seeks to graphically summarise the organisation of the project’s activities,
their relationship to the core staff team, the organisation’s governance and, where appropriate, the
partnership delivery links.
Participant Perspectives

Drawing upon qualitative interview data with selected participants, these sections seek to give an account of activities from the perspective of service users. Where necessary, quotations have been put into context. Personal names have been changed unless individuals have given consent to use their real name.

3.6 Ethical issues

Participants for both interviews and questionnaires were provided with written and verbal information on the study. In most cases it was possible to collect written consent. In cases where this was not possible researchers verbally asked for consent and made clear the right to not participate or to withdraw at any point. Project leads have been asked to convey draft material to participants to invite comment and offer an opportunity to withdraw direct quotations. Questionnaire and registration data sent from projects to UWE were all anonymised before exporting using a unique ID reference code.

The study has been given ethical approval by the Faculty of Health and Life Sciences Research Ethics Committee of University of the West of England, Bristol.
4. The South West Well-Being Programme: Beneficiaries & Volunteers

4.1 Introduction

This section presents findings from the evaluation to date of the outcomes for SWWB beneficiaries. It draws upon monitoring data reported to Westbank, the portfolio lead, by all project delivery organisations. It also draws upon a more detailed set of data collected through registration forms and the completion of the SWWB Well-being questionnaires. The role of volunteers is also explored through drawing upon project monitoring records.

4.2 Volunteers

The SWWB programme has placed considerable emphasis on working with volunteers to develop and deliver project activities - and to encourage local engagement and ownership. All project teams maintained records of activities in which volunteers were involved, the number of individuals involved and the hours contributed. Volunteers were involved in a whole range of capacities that included administration, activity delivery, recruitment, outreach, peer support, befriending, transport and publicity. These included both ad hoc and regular volunteers. Table 4.1 summarises the number and the hours that volunteers contributed.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Part Time Volunteers</th>
<th>Number of Volunteers are active in any one week</th>
<th>Number of hours completed in any ONE week</th>
<th>Total hours per week</th>
<th>Total weeks of operation</th>
<th>Total hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowle West</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>141</td>
<td>564</td>
</tr>
<tr>
<td>Living Well - West Somerset</td>
<td>70</td>
<td>15</td>
<td>3</td>
<td>45</td>
<td>94</td>
<td>4230</td>
</tr>
<tr>
<td>Step by Step-N Cornwall</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>20</td>
<td>141</td>
<td>2820</td>
</tr>
<tr>
<td>Healthy Living Wessex</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>141</td>
<td>0</td>
</tr>
<tr>
<td>Penwith-W Cornwall</td>
<td>40</td>
<td>10</td>
<td>4</td>
<td>40</td>
<td>141</td>
<td>5640</td>
</tr>
</tbody>
</table>
Table 4.1 shows that over a three year period, 903 volunteers contributed an estimated 165,677 hours to supporting the delivery of project activities. This is the equivalent of 55,225 hours per annum, or 28 full time staff per annum using the Institute for Volunteering Research formula (IVR, 2007).

There are a wide variety of methods for calculating the economic value of volunteering. Using a simple wage value equivalent formula (IVR, 2007) and using the hourly rate of £7.11 (£5.93 hourly national minimum wage plus 20% employment overheads), the 165,677 volunteer hours equate to an economic contribution of over £1.17 million towards the programme.
Based upon a £12.17 hourly rate - the 2007 national median hourly wage plus employment overheads – this economic contribution rises to over £2 million towards the programme.

SWWB participating organisations expect to have achieved a high degree of volunteer sustainability during the course of delivering the programme. After the end of the programme funding period, organisations anticipate continuing to work with over one third the number of volunteers (363/903). However maintaining this level of voluntary support will be contingent of organisations having the core resources to support such activities.

Clearly volunteering is much more than an issue of monetary value. Other sections in this report such as the Practice Case Studies and the Westbank Project Profile illustrate the range of personal and social benefits of volunteering.

4.3 Beneficiaries and well-being outputs: project monitoring data

In terms of its scale and breadth, the South West Well-being programme is a considerable initiative for the promotion of health and well-being in the south west of England. Table 4.2 shows that SWWB projects are, overall, exceeding their planned targets for beneficiary outputs. By the end of programme, SWWB projects are very likely to have exceeded their target outputs twofold in terms of the numbers of people completing activities categorised by one of the three well-being themes. Physical activities comprise almost half of the recorded outputs to date. The table also illustrates the different scales and types of intervention. Projects recording larger numbers tend to be delivering short term group based activities. Those with fewer recorded numbers tend to be engaged in more intensive one-to-one work.

Projects monitor the take up of services by specific groups of beneficiaries. These are groups defined in their original business plan. Whilst many projects have categories that only apply at the local level, key categories in relation to general health status, low income and social isolation were used by the majority of the projects. Table 4.3 summarise these key categories. It shows that SWWB projects work with significant percentages of people with poor health or low incomes. The figure approaching 20% for depressive symptoms reflects that found in national studies of the UK population (Defra Lifestyle Surveys). Beneficiaries with low physical activity are likely to be under-recorded (see section of SWWBQ outcomes).
Table 4.2: Total beneficiary numbers, well-being outputs and targets. To Project Quarter 11/13

<table>
<thead>
<tr>
<th>Project</th>
<th>Cumulative Total Number of Beneficiaries</th>
<th>Well-being Outputs*</th>
<th>Beneficiary Outputs</th>
<th>Total Number of Beneficiary Outputs</th>
<th>Target Number of Beneficiary Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Healthy Eating</td>
<td>Mental Health</td>
<td>Physical Activity</td>
<td></td>
</tr>
<tr>
<td>Mental Health For All: Weston-super-Mare</td>
<td>803</td>
<td>271</td>
<td>350</td>
<td>436</td>
<td>1057</td>
</tr>
<tr>
<td>Pathways to Health: Penwith</td>
<td>2432</td>
<td>687</td>
<td>1740</td>
<td>480</td>
<td>2907</td>
</tr>
<tr>
<td>Step by Step: North Cornwall</td>
<td>683</td>
<td>110</td>
<td>549</td>
<td>343</td>
<td>1103</td>
</tr>
<tr>
<td>Healthy Living Wessex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activate your Life Lighter</td>
<td>951</td>
<td>947</td>
<td>943</td>
<td>947</td>
<td>2837</td>
</tr>
<tr>
<td>Weigh to Live</td>
<td>912</td>
<td>405</td>
<td>148</td>
<td>392</td>
<td>945</td>
</tr>
<tr>
<td>Lawrence Weston Health Steps</td>
<td>341</td>
<td>576</td>
<td>366</td>
<td>125</td>
<td>1067</td>
</tr>
<tr>
<td>Well-bean Project</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plymouth Well-being</td>
<td>2164</td>
<td>802</td>
<td>954</td>
<td>916</td>
<td>2672</td>
</tr>
<tr>
<td>Upstream Health Maps</td>
<td>919</td>
<td>1272</td>
<td>2679</td>
<td>1908</td>
<td>5859</td>
</tr>
<tr>
<td>Pathways to Health: Knowle West</td>
<td>2049</td>
<td>556</td>
<td>1186</td>
<td>1637</td>
<td>3379</td>
</tr>
<tr>
<td>Wellspring Community Kitchen</td>
<td>433</td>
<td>582</td>
<td>9</td>
<td>0</td>
<td>591</td>
</tr>
<tr>
<td>Westbank New Steps</td>
<td>1414</td>
<td>484</td>
<td>985</td>
<td>960</td>
<td>2429</td>
</tr>
<tr>
<td>CASP</td>
<td>1404</td>
<td>1414</td>
<td>1120</td>
<td>1120</td>
<td>3654</td>
</tr>
<tr>
<td>5x30 Devonwide (NW)</td>
<td>6848</td>
<td>0</td>
<td>0</td>
<td>6848</td>
<td>6848</td>
</tr>
<tr>
<td>Somerset: Living Well</td>
<td>603</td>
<td>129</td>
<td>161</td>
<td>516</td>
<td>806</td>
</tr>
<tr>
<td>Be Happy Be Healthy</td>
<td>3092</td>
<td>403</td>
<td>531</td>
<td>4276</td>
<td>5210</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>25048</strong></td>
<td><strong>8638</strong></td>
<td><strong>11721</strong></td>
<td><strong>20904</strong></td>
<td><strong>41364</strong></td>
</tr>
</tbody>
</table>
* Well-being outputs’ are the number of beneficiaries recorded as participating in project activity categorised by theme. Individuals can take part in more than one themed activity therefore totals sum higher than cumulative beneficiary total for many projects.

### Table 4.3: Health status and social economic circumstances of beneficiaries (N=25,048)

<table>
<thead>
<tr>
<th>Beneficiary Group Description</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with low level mental ill health (depression, anxiety)</td>
<td>4,588</td>
<td>18.3%</td>
</tr>
<tr>
<td>Adults &amp; children who are overweight, obese and/or have weight related medical conditions</td>
<td>4,670</td>
<td>18.6%</td>
</tr>
<tr>
<td>Older people who are socially isolated or at risk of social isolation</td>
<td>4,039</td>
<td>16.2%</td>
</tr>
<tr>
<td>Adults with low levels of physical activity (&lt;5x30 minutes moderate PA per week)</td>
<td>10,746</td>
<td>42.9%</td>
</tr>
<tr>
<td>Adults &amp; children in low income families. Unemployed people</td>
<td>7,371</td>
<td>29.4%</td>
</tr>
</tbody>
</table>

Projects worked with a wide range of other social groups. These include: people living in areas of high social deprivation (14.8%); BME groups (<3%); people with learning difficulties (<1%); hard to reach or homeless teenagers and teenage parents (<2%); people with low confidence or self esteem (<2%); single parents (<1%).

#### 4.4 SWWB beneficiary database records

In addition to the monitoring records outlined above, the majority of organisations recorded core beneficiaries on the SWWB Database – or a similar type of database (see Methodology report section). Some organisations used the database as a system for recording only those beneficiaries who were also completing the SWWB Questionnaire. They therefore represent a sub-sample of adult beneficiaries for whom supplementary information was collected.

To date the database records registration details from 4,089 direct beneficiaries. Eighty six per cent (n=2,665) were still actively taking part SWWB programme activities, 10% (n=305) had completed
their activities, less than 0.4% (n=18) were early leavers and the remainder (4% n=126) were described as previous clients or potential clients.

The modal age range of the beneficiaries was 31-35 years of age but the median age range was 41-45 years of age. The SWWB programme attracted a broad range of people with 96 beneficiaries aged 0-5 years of age and 7 aged 90-95 years of age. The majority of beneficiaries were female (70.2%, n=2693) and 95.9% (n=2894) defined their ethnicity as white. 1.6% (n=47) described themselves as mixed, 1.1% (n=33) as Black or Black British and 0.7% (n=22) as Asian or Asian British. 98.6% spoke English as their first language but there were 20 other first languages spoken across the portfolio including Somali, Polish, Punjabi, Arabic and Ukrainian.

The most popular way of hearing about the project was Word of Mouth (35.8%, n=1042). But it is clear that the beneficiaries have discovered SWWB activities from a variety of sources from the community: health and social care professional (21.9%, n=637), from newspapers, newsletters, poster or leaflets (15.7%, n=457), a project worker (15.4%, n=449) and other sources included one off events, a website, other organizations etc. (3.8%, n=111). In terms of referrals onto a SWWB project the majority 55.6% (n=1383) refer themselves. But there has been (23.4%, n=665) referrals from a health and social care professional and other referrals have included from the project worker and other voluntary and community sector organizations.

From the database 10.3% (n=287) defined themselves as disabled, 8.8% (n=189) as receiving disabled benefit and 5.4% (n=110) were carers. In terms of the family (31.5%, n=642) of beneficiaries live alone, 23.5% (n=480) live with a partner and a child, 10% (n=204) with a relative and 6.3% (n=129) were single parents living with children.

The majority of beneficiaries are home owners (45.4%, n=787), 33% (n=571) were in council or housing association accommodation, 13% (n=226) in private accommodation, 4.4% (n=77) are in a nursing or residential home and the rest are in other accommodation like a caravan, canal boat, friend’s floors and even homeless.

4.5 South West Well-being questionnaire findings: overview

As of February 2011 the SWWB portfolio had delivered 737 baseline and follow up questionnaires from 13 projects in the portfolio. This represents 16% of direct beneficiaries registered on the SWWB database. Our initial analysis has explored impact on:

- general health
- healthy eating
- physical activity
- mental ill health
- mental well-being
- social well-being.
4.6 General health, smoking and alcohol consumption

Overall 47% (n=715, missing data 22) of people reported improved general health at follow up. Direct beneficiaries were asked to rate their health on a five point scale at baseline and follow up. We found that there is a statistically significant improvement in self reported health from baseline (M=3.1, SD 1.03) to follow up (M=2.63, SD 9.78; t(714)=11.77). The mean decrease in health scores was 0.47 with a 95% confidence level of 0.395 to 0.5536. The eta squared statistic (0.16) indicated a large effect size. The modal description for overall health at follow up was *good* compared to only *fair* at baseline.

| Table 4.4: Self Reported General Health in the Last Week (n=671) |
|-----------------|-----------------|-----------------|-----------------|-----------------|
|         | Excellent | Very Good | Good | Fair | Poor |
| Baseline | 5%        | 23%        | 38%  | 25%  | 9%   |
| Follow-up | 11%       | 36%        | 37%  | 13%  | 4%   |

Whilst the measures are somewhat different, these data show improvements in comparison to large scale surveys. 65% of SWWB respondents reported their general health to be ‘good’ to ‘excellent’ at baseline. This rose to 82% at follow up. The NWPHO study (2009) found that 72% of respondents reported that they were in ‘good’ or ‘very good’ health.

Self reported smoking was slightly higher than the England average. However alcohol consumption was slightly lower than the England averages. This may reflect the difference in age profiles. The national HSE figures have not been age adjusted to correspond to the SWWB sample.

| Table 4.5: Self report smoking and alcohol consumption (n=715) |
|-----------------|-----------------|-----------------|-----------------|-----------------|
|               | Male | Female | Male | Female |
| Smoking       | 24%  | 25.8% | 20%  | 24.3% |
| Alcohol (last week) | 71%  | 68.8% | 57%  | 54.6% |

* Source: HSE, 2008
4.7 Healthy eating

At the start of the programme, SWWB beneficiaries reported eating a similar number of portions of fruit and vegetables to the UK average. Self reported fruit and vegetable consumption fell overall at follow up (N=601; from 3.9 at baseline to 3.5 at follow up; mean difference -0.38 portions; SEM 0.115; t3.273; p=0.001).

However these overall findings mask a marked increase in fruit and vegetable intake amongst participants taking part in activities with a focus on healthy eating. In fact 45% of beneficiaries taking part in healthy eating activities report eating more fruit and vegetables at follow up (n=262, missing data=3), for all activities this figure is 32.3% (n=601, missing data 136). Table 4.6 shows that for participants taking part in healthy eating activities, the percentage of people meeting public health guidelines rose from 25.5% to 39.5% at follow up.

Figure 4.1: Percentage of respondents reporting eating 5+ fruit or vegetable portions a day. All n=737. HE interventions only n=321. Missing data: baseline all 68; follow up all 97. England average adjusted to match SWWB age profile. Data source: Health Survey for England, 2008.

Participants also reported more positive attitudes towards healthier eating. Across the whole programme respondents were significantly more likely to agree that they enjoyed putting effort and care into the food they eat rather than neither agree or disagree. Baseline (M =3.75, SD 0.972) to
follow up (M=4.19, SD 1.008) t (642) =-9.87. The mean increase in putting effort and care into the food they eat is 0.44 with a 95% confidence level of -0.52 to -0.34. The eta squared statistic (0.12) indicated a moderate effect size. Overall this represented a significant increase in the number of people who reported that they enjoyed making an effort with food (69% to 81%).

4.8 Physical activity

Two measures were used to examine changes in levels of self-reported physical activity. Firstly the General Practice Physical Activity Questionnaire (GPPAQ) generates a classification from ‘inactive’ to ‘active’.

Secondly a Sport England general physical activity question asks respondents how many days in the past four weeks they have done 30 minutes of physical activity sufficient to cause deep breathing. Respondents are given six options ranging from ‘0 days’ to ‘20+days’. 20 days a month equates to 5 days a week.

Using the GPPAQ, there was a highly significant improvement in self reported physical activity (N=702; SEM=0.051; t=-2.646; p<0.001) in the study sample. Overall 57.6% of participants improved their level of physical activity using the GPPAQ scale. This figure rises to a 73.6% showing improvement for the 148 respondents who took part in focused physical activity projects. The percentage of respondents classified as being ‘active’ increased from 13.8% at baseline to 32.4% at follow up.

The Sport England general physical activity question produced results with a similar trend to the GPPAQ results. Using this measure, 45.2% reported increased physical exercise at follow up (N=737; missing data=149). This represented a statistically significant increase (N=512; SEM=0.074;t=+23.811;p<0.001). According to this measure, at baseline 13.9% of participants were following public health guidelines on exercise. At follow up this figure rose to 14.3%. This is in the context of national research that suggests 31% of adults meet current guidelines (NWPHO, 2009). Figure 4.2 shows that the major positive shift was for individuals reporting between 4 to 19 days of 30 minutes exercise.
Figure 4.2: Number of days engaged in the past four weeks in 30 minutes physical activity sufficient to cause deep breathing (for example: brisk walking, cycling, sport, active recreation. Not including job-based physical activity) Baseline n=612; Follow up n=609. Percentages

Attitude towards physical activity
Respondents’ attitudes to physical activity also improved. 38.1% of respondents were more likely to state that: “As well as being important for my physical health, physical activity is something I enjoy” at follow up. This represented a statistically significant increase (N=273; SEM=0.088; t+/--3.459; p=0.001).

4.9 Mental ill health

Using the seven item version of the Centre for Epidemiological Studies Depression Scale (CES-D7), we found that there is a significant improvement in self reported mental health. There was a statistically significant decrease in reported depression scores from baseline (M=10.23, SD 0.223) to follow up (M =12.42, SD 0.191) t (382)-10.376. The mean decrease in depression scale scores was 2.21 with a 95% confidence level of -2.602 to 1.773. The eta squared statistic (0.17) indicated a large effect size. Cronbach alpha reliability scores were strong with 0.895 at baseline and 0.795 at follow up. On the shorter CES-D we selected a cut off score of 8 or less out of 21 as indicative of significant or mild depressive symptoms. The baseline and follow up mean scores here indicate that at

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2 For the national evaluation of the BIG Well-being programme, CLES have adopted a somewhat different methodology for the analysis of CES-D. This has a lower threshold for significant depressive symptoms. Nevertheless the UWE and CLES analyses consistently find significant reduction in depressive symptoms for the SWWB data. http://www.biglotteryfund.org.uk/er_eval_well_being_yr2_report.pdf
baseline beneficiaries reported mild depressive symptoms on the scale but not on follow up. Overall 63.6% reported improved mental health in terms of reduced depressive symptoms.

Figure 4.3: Change in depressive symptoms using seven indicators (CES-D7 scale)  
Percentages [SWWB, Sept 2010 n=671; BIG Well-being Sept2010, n=617]

These data can be put in the context of wider research. The percentages of people reported substantial depressive symptoms are:

- 20.8% of the UK population (NWPHO, 2007)
- 36% of respondents in the other BIG Well-being portfolios to date (Sept 2010)
- 35.6% of SWWB respondents at baseline
- 18.5% of SWWB respondents at follow up

4.10 Mental well-being: life satisfaction

48.4% of beneficiaries reported improved overall life satisfaction. Beneficiaries were asked how satisfied or dissatisfied they were with their life on a scale from 0-10 where 0 was extremely dissatisfied and 10 extremely satisfied. There was a statistically significant increase in reported satisfaction from a baseline (M =6.17, SD 2.39) to follow up (M=6.98, SD 2.17) t (693)=7.939. The mean increase in satisfaction scores was 0.81 with a 95% confidence level of -1.00 to -0.606. The eta squared statistic (0.8) indicated a moderate effect size. This improvement is supported by evidence that beneficiaries provide higher scores on the item: I feel good about myself. There was a
statistically significant increase in reported scores on feeling good about themselves from a baseline (M =3.12, SD 1.03) to follow up (M=3.45, SD 1.06) t (670)=-6.77. The mean increase in feeling good about themselves was 0.33 with a 95% confidence level of -.420 to -0.231. The eta squared statistic (0.6) indicated a moderate effect size.

This measure is a good predictor of wider aspects of psycho-social well-being that can be compared to other survey data. At baseline SWWB respondents scored an average of 6.1. UK adult population surveys (NWPHO) provide an average score of 7.2 and the average score for other BIG Well-being portfolio respondents (n=617) is 6.6. Comparisons with the SWWB at follow up indicate that respondents are more likely to self report overall life satisfaction in line with the UK average (7.0, 7.2).

At baseline 25.5% SWWB respondents reported a score less than 5. At follow up this fell to 13.6%. This compares to 34% of the BIG Well-being portfolio respondents reporting a score of less than five.

**Figure 4.4: Overall Life Satisfaction.**
[SWWB, n=671; BIG Well-being Sept2010, n=617; UK Average Defra Lifestyle 2007]

### 4.11 Mental well-being: positive functioning and feeling

Overall 49.9% (n=585, missing data 152) report improved personal well-being; participants are more likely to feel optimistic, useful, relaxed, good about themselves, able to make up their mind, close to other people, and able to deal with problems. The Short Warwick Edinburgh Mental Well-being Scale (Short WEMWBS) puts these areas of experience together to develop a seven point scale. Using this scale found a significant improvement in self reported personal well-being. Figure 4.5 shows the distribution of scores across three domains – ‘low’, ‘moderate’ and ‘high’ mental well-being – as defined in the NWPHO study (2009). There was a statistically significant increase in reported scores from baseline (M =23.21, SD 5.2) to follow up (M=25.42 SD 4.5) t (585) =-10.495. The mean increase in mental health scores was 2.26 with a 95% confidence level of -2.61 to -1.792. The eta squared
statistic (0.16) indicated a large effect size. Cronbach alpha reliability scores were 0.847 at baseline and 0.887 at follow up suggesting strong reliability for the scale items.

**Figure 4.5: Distribution of mental well-being scores (Short WEMWBS), N=671**

![Bar chart showing distribution of mental well-being scores](image)

**Table 4.6: Mental Well-being scores (Short WEMWBS): comparison between SWWB and national data.**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Low well-being</th>
<th>Moderate well-being</th>
<th>High well-being</th>
<th>Bases</th>
</tr>
</thead>
<tbody>
<tr>
<td>England population*</td>
<td>27.7%</td>
<td>16.8%</td>
<td>62.8%</td>
<td>20.4%</td>
<td>18,500</td>
</tr>
<tr>
<td>SWWB baseline</td>
<td>23.3%</td>
<td>43.0%</td>
<td>53.8%</td>
<td>3.2%</td>
<td>737</td>
</tr>
<tr>
<td>SWWB follow up</td>
<td>25.5%</td>
<td>27.3%</td>
<td>66.7%</td>
<td>6.0%</td>
<td>737</td>
</tr>
</tbody>
</table>

* North West Mental Wellbeing Survey 2009

Responses to specific personal well-being questions can be compared to other research. The percentages of people reporting never or rarely feeling relaxed are:

- 10.9% of the UK population (NWPHO, 2007)
- 20% of respondents in the other BIG Well-being portfolios to date (Sept 2010)
- 28.3% SWWB respondents at baseline
- 13.6% SWWB respondents at follow up
4.12 Social well-being

There were eight items that explored beneficiaries’ sense of social well-being. There were no changes in the sense to which people were satisfied about the area they lived in, whether they belonged to a local community or the extent to which they thought people cared about them.

There were significant increases on the other items but the size of the increases and effect scores are lower than on other items of well being. 35.2% of respondents reported that they were more likely to attend activities organised in their local community (SEM0.072; T=5.643; p<0.001).

The extent to which beneficiaries felt they belonged to a community at baseline (M =2.98, SD 1.16) increased at follow up (M=3.29, SD 1.12) t (669)-6.79. The mean increase in feeling they belong to a community was 0.31 with a 95% confidence level of -0.400 to -0.220. The eta squared statistic (0.06) indicated a moderate effect size.

The extent to which participants declare that they regularly meet with friends and relatives increased from a baseline (M =3.71, SD 1.09) to follow up (M=3.89, SD 1.01) t (678)-4.165. The mean increase in meeting friends and relatives socially was 0.18 with a 95% confidence level of -0.266 to -0.96. The eta squared statistic (0.03) indicated a small effect size.

The extent to which people in the local area help one another increased from a baseline (M =3.30, SD 0.991) to follow up (M=3.49, SD 0.989) t (619)-4.93. The mean increase in people believing that local people help each other was 0.19 with a 95% confidence level of -2.74 to -1.18. The eta squared statistic (0.005) indicated a small effect size.

4.13 Associations between well-being, healthy eating, mental health and physical activity

Our analysis shows that there are statistically significant associations between different behaviours reported by beneficiaries: aspects of well-being are strongly linked to the programme themes of healthy eating, physical activity and mental health. At follow up people reporting higher mental well-being (WEMWBS score) are more likely to:

- Enjoy eating healthy food (p<0.001)
- Enjoy putting care and effort into preparing food (p<0.001)
- Regularly prepare meals from basic ingredients (p<0.01)
- Believe that physical activity is enjoyable and important for health (p<0.041)

These findings support the SWWB holistic service model because it indicates that work in one area can deliver wider benefits for participants. Overall the findings from the study indicate a very positive set of associations between participation in SWWB activities and the well-being of respondents.
5. The South West Well-being Consortium Approach

“Working as member of a regional consortium has created a great deal of interest with other organisations. I have seen it change the impression and level of respect the other organisation gives to our company. We have gone from ‘small third sector organisation’ to ‘professional player’.” Project G

5.1 Introduction
Consortia for promoting health and well-being are not new. However, a great deal of valuable learning arising from their delivery often goes unreported. This learning often remains the ‘tacit knowledge’ of those with experience.

This section of the report aims to give an account of how SWWB programme worked as part of a consortium. Drawing upon the learning from participants, the study presents some key themes that can act as a basis for action by others.

5.2 Context: Consortium for health and well-being
As a format for service delivery, a consortium offers major attractions for both contractor and consortium members themselves. It reduces the number of contracts and streamlines the supply chain for the contractor. For the consortium itself, it brings larger contracts to front-line deliverers. Consortium members can better advocate for their shared goals; improve or innovate standards; create efficiencies and economies of scale; and share risks or opportunities for development.

Consortia can take a variety of organisational forms and structures as legal entities. Rather like the concept of partnership, there is no universally accepted definition of a consortium (Wildridge et al 2004). However, most consortia share some common features. In general, consortia are associations of organisations (or other entities) with the objective of participating in a common activity or pooling of resources to achieve a common goal. They can usually be considered as one form of partnership: a form that entails contractual commitments and legal obligations to deliver against agreed goals and outcomes.

Whilst consortia may seek to obtain benefits not achievable by other routes, consortium working -as with partnership working- can present challenges (Rummery 2002). Participating organisations can be exposed to new risks, incur additional costs or encounter fundamental ideological differences.
Under-resourcing, unrealistic goals, power imbalances and perverse incentives – such as inappropriate performance targets – can all afflict consortium members.

Despite these and other recognised difficulties, consortium working for health and well-being is gaining momentum amongst community and voluntary sector organisations that operate at local levels. This reflects the potential benefits of developing shared approaches to complex health issues, the scope for innovative practice or the pooling of risks for funding bodies. The SWWB programme represents a unique consortium development in the south west of England. It brings together a group of independent organisations with experience of working within locally defined areas. Whilst each organisation has a very individual history, all share some common origins in connection with the healthy living and community health movements that have flourished since the late 1990s in the UK. The diagram overleaf sets out a brief overview of the ‘life cycle’ of the SWWB Consortium.

5.3 BIG Lottery Fund’s Portfolio Model

The portfolio approach was designed for programmes where BIG wanted to make grants for strategic projects consisting of a portfolio of more than one project. In this way, the funding could be used most effectively to tackle needs strategically. It is intended to allow grant holders to use their expertise, contacts and local knowledge to compile a portfolio of projects that complement one another and take into account existing provision and overall needs. Portfolios always contain more than one individual project. Individual projects may be delivered on a number of different sites. Lead organisations are expected to identify local needs and develop the most appropriate strategy to meet them, compile a portfolio of individual projects that complement each other, be the accountable body for the grant and delivery of the portfolio of projects for the duration of the grant contract, manage the delivery, monitoring and evaluation of the individual projects within the portfolio, sub-contracting individual projects to other organisations. Apart from the Well-being programme other portfolio programme examples include Changing Spaces, Children’s Play and International Strategic.

The portfolio model encourages applicants to work together with other organisations to develop and deliver the portfolio and the individual projects. Under the Well-being programme BIG accepted applications which were developed jointly with one or more voluntary, public or private sector organisations with the relevant knowledge and expertise. BIG’s programme therefore has a range of portfolios with differing approaches to delivery – however in all cases, irrespective of partnership or delivery arrangement one lead organisation applied for funding and this organisation has the legal and financial responsibility for the BIG grant.
‘Life Cycle’ of the South West Well-being Consortium

**Origins**
- **1990s** Separate community health organisations across the SW England in receipt of funding: Big Lottery Healthy Living Centres, Neighbourhood Renewal, Single Regeneration Budget, Dep. Health & PCT grants etc.
- **2003** National and SW Healthy Living Alliance (SWHLA) founded

**Start up**
- **2006** SWHLA “Well-being in the South West” Strategy
- **2006** Big Lottery Well-being Fund Opens
- **2007** SWHLA: Application and selection process for consortium members
- **2007** Westbank HLC as SWWB Portfolio lead agency

**Delivery**
- **2008, Feb** First wave of SWWB; 11 projects start delivery across south west
- **2008, Feb** Reporting, monitoring and evaluation systems developed
- **2008, May** Projects start reporting on beneficiaries

**Development**
- **2009, Feb** Four second wave SWWB projects start delivery across south west
- **2009, March** First Year SWWB Evaluation Report
- **2009, May** SWWB thematic training programme starts
- **2009, July** SWWB Celebration Event

**Future**
- **2009** SWWB organisations submit new funding applications to sustain services
- **2009** New consortia proposals: Well UK developed
- **2010** Consultations with local commissioners, Big Lottery & other funding bodies
- **2010** Evaluation reports on adding value to local services and project outcomes
- **2011, Feb** SWWB programme completion
5.4 Experiences of participating in the SWWB consortium: challenges and achievements

Our analysis identifies six key themes from the feedback. These are presented below and illustrated by examples.

**Building a Common Vision**

“Without a consortium there would be no well being programme in the south west - and many people would be worse off within our communities.” Project G

“Our sense of common purpose was essential at the beginning” Project F

“We achieved a sense of common purpose with very disparate projects” Project J

Project leads felt that the creation of the South West Well-being consortium has been a major achievement in itself. Not only has it led to the development of a new programme for the region, it brought together a new group of independent organisations and raised the profile of their own organization in being associated with the consortium.

This has been a challenge, not least in the initial stage of developing a shared vision for the programme. The process started with a small number of leads in the South West Regional Healthy Living Alliance (SWRHLA) who had been developing common approaches since 2003. These individuals championed the idea of creating a vision and a regional strategy that marked out the perspective of healthy living organisations. This strategy formed the backdrop to the programme bid to Big Lottery and was informed by the values and philosophy of the healthy living centre movement. In response to the call for outline proposals from Big Lottery, the SWRHLA was therefore able to respond rapidly and offer an assurance of front-line public health delivery.

For some project leads part of the success of the consortium has been to achieve a balance between this shared deeper vision for the programme and the local aims that were tailored for each individual project. Inevitably this has involved compromises. However, a fortunate aspect of this process appears to have been the broad funding brief of the Big Lottery’s Well-being fund that has helped support this flexible approach at the local level.

**Creating a Framework for Working Together**

“I feel the issue about membership criteria - i.e. knowing that organisations are legitimate...and clarity on who is best able (legally and financially) and best qualified to be the lead agency...was our single biggest challenge.” Project C

During the process of developing the bid and the early delivery of the programme the consortium had to develop a new framework for governance: a framework that could address the key issues such as membership and legal responsibility. Leads reported that the initial selection process for consortium projects involved some difficult decisions. With the advice of external consultants,
seventeen applications from organisations were shortlisted down to eleven that met criteria for project quality and programme fit. Whilst this process introduced rigour into the programme development, some leads regretted the loss of potential consortium partners:

“We lost alliance members when ‘sifted out’. It would have been good to have been able to keep them on board.” Project C

Nevertheless, this selection and development process reflected a clear effort to achieve good standards of project delivery. In hindsight, project leads reported that the selection process could have been even more rigorous. This could have included a pre-selection membership application process for organisations:

“There are things that need to be put in place prior to accepting partners into consortiums rather than taking organisations on trust.” Project D

Final selection of the lead organisation for the consortium was a late decision in the process of developing the programme. A success of the consortium has been the opportunity for the initial group members to have a role in this selection.

“One challenge has been to keep a working relationship with the decision makers to support the management of the consortium - rather than the well being programme.” Project O

Some project leads wanted to emphasise the more pragmatic aspects of working as part of a consortium:

“I feel that a consortium can be a fairly loose arrangement (not in the rigour of being accountable and doing what it is that you are responsible for) but in the sense that the common ground may only be a desire to achieve certain outcomes and a desire to deliver services to the best practice standards of delivery. Ultimately I am not sure the consortium really needs to do anything else.” Project P

The responsibilities of the lead organisation in this type of consortium are considerable. From the perspective of the lead agency, the significance of this level of accountability has made the SWWB programme very different from other types of partnership initiative:

“Our main learning has been around the role and responsibility that a lead organisation assumes. In essence BIG contract with the lead agency that then hold the legal responsibility for the delivery of the entire portfolio and the performance of the partners.” Project S

**Managing the Consortium**

“As lead we have worked hard to provide the interface between BIG and the partners. Monitoring and reporting systems were established immediately and all partners ....have commented that the monitoring process has worked smoothly and without causing delivery organisations extra workload.” Project S
Whilst the management of this particular type of programme was new to the lead organisation, project leads reported being highly impressed with how Westbank had taken on the brief. In part this reflected the early use of clear and simple contractual, finance and reporting systems by the manager. It also appeared to reflect the value of having an ‘insider’ organisation adopt the managerial role. Project leads felt that Westbank had a good understanding of the community health organisations that are either in or closely connected to the voluntary sector. The lead organisation was also reported to have acted effectively in bridging the requirements of Big Lottery with delivery organisations. Some aspects that worked well have been:

“Knowing that Westbank has been willing and capable of managing the contract on our behalf and in our best interest with minimal input.” Project J

“Systems put in place to support us in monitoring the project in terms of beneficiary numbers and finance. Support and understanding from the central team advising us on positive changes. Mock compliance visits.” Project F

This support was particularly appreciated with respect to the management of adversity and conflict, features that are likely to be inevitable in programmes on this scale.

“During various difficulties and low points, the consortium has been managed professionally and has maintained its cohesion.” Project B

“The consortium has supported the management of a complex working framework to manage organisations and people who were found to have misused and abused their membership of the consortium, to the point where the consortium is being looked at as an exemplar and is in a position to look forward. However, difficult we have found parts of the process we should never forget what we have achieved as a group.” G

Common standards for reporting, monitoring and evaluation presented challenges for some consortium members. The majority felt that standardisation helped drive quality, build coherence and reduced some of the complexities of managing local systems. However, some leads felt that these standard approaches did not fit well with existing systems or that they were implemented differently for some projects:

“The shared learning … helped to increase understanding of databases, evaluation and engaging with people.” Project G

“Using a shared approach to M&E and reporting has helped us all stay focused on the well-being [programme] outcomes”

“Trying to fit our project into a broad monitoring and evaluation system which tries to provide a ‘one size fits all’ approach, was not always appropriate for our way of working.”
Building Trust and Commitment

Effective communication has had an important part in maintaining the commitment of project organisations to the consortium. A challenge for the SWWB programme has been the geographical separation of organisations across the region:

“Geographically partners are a long way away from us in terms of time constraints and pressures of work.” Project C

“Being at distance from other partners [has been a challenge], we are used to working in close physical proximity to our partners.” Project F

The central team routinely circulate programme updates and news on funding or development opportunities. This has clearly played a role in developing the identity of the consortium. However, project leads were more likely to highlight the role of shared training and informal networking. Subsequent to the recommendations of the baseline report, thematic training events that involve frontline staff were very positively rated as opportunities to exchange good practice in healthier eating, mental well-being, physical activity and volunteering initiatives:

“Sharing success and best practice has been an important part of maintaining the consortium.” Project G

“The thematic sessions have worked really well when the relevant workers from across the consortium were able to come together.” Project H

“The consortium partners have found out more about each other’s work, seen examples of other good practice and cemented their relationship.” Project B

This sharing - as opposed to hoarding – of knowledge and expertise has been a clear dividend of the consortium. If anything on reflection, some project leads regret that there had not been further opportunities for deeper, more intensive and tailored knowledge exchange between organisations.

Project leads also identified the role of fun, enjoyable celebration events in keeping up a sense of momentum for the consortium. In the background, the less visible actions of project ‘linkers’ and ‘networkers’ have also helped build the sense of common purpose for the programme.

Developing and Expanding the Consortium

With the addition of four new projects to the consortium after the first year of delivery and the re-development of another, the SWWB programme has changed considerably since its inception. The new project organisations – known within SWWB as ‘seedcorns’ - report similar benefits to the first wave, although they have had to work hard to engage with some aspects of the consortium:

“Starting later than other projects, has meant playing ‘catch up’ sometimes.” Project F
Membership changes were recognised as a challenge:

“The importance and difficulty of sustaining partnership, for example, when the membership is changing.” Project I

Participation in the consortium helped affirm and develop the professionalism for some project leads. In part this is a reflection of the opportunity for organisations to extend their role beyond the local level:

“We feel that being part of this consortium has raised our profile locally, regionally and nationally” Project H

“Working as part of the consortium has also opened up opportunities for working with other regional organisations” Project G

“We have learnt much more about strategic developments in funding the third sector” Project C

“We have had more access to information on regional and national priorities for wellbeing, external funding and third sector roles.” Project A

Some consortium members feel they have been able to ‘raise their game’ as advocates of new approaches for promoting health and well-being – both across the region and in their local area:

This consortium works differently to the normal ‘subcontracting down to, local organisations’ frameworks and the fact that each member has a role and opportunity to influence the whole is looked at with envy by others. I think it supports especially the public sector to see TSO’s as professional, who are able to see the big picture and appreciate it, and not parochial localised ‘nimbies’. Project G

**Sustaining the Consortium**

The longer term development of the SWWB consortium is clearly a matter of concern for all members. Project leads point out the relatively short duration of the programme as a period within which to consolidate the future. At the project level this also creates pressures:

“The insecurity of projects having a finite life span [presents an issue]. Just as the efforts of the team had started to become establish the brand.”J

Whilst the programme cycle is tight, the consortium has actively started to explore future options as a support base for individual organisation projects and a basis for some members to develop new consortium funded work. One development has been the development of Well UK. Upstream had won Department of Health Social Enterprise ‘Pathfinder’ funding to form an independent consortium to tackle health and care contracts. Westbank and Devon CVS joined Upstream to form Well UK. The Big Lottery then funded Leaside Regeneration to work with a small number of Healthy
Living Centres, all members of the National Healthy Living Alliance, to explore further opportunities for social enterprise.

This work was undertaken in recognition that consortium working can be an effective way of delivering national or regional pieces of work that-at the same time-retain an essence of local identity and ownership. Well UK’s rationale has been to enable smaller deliverers a chance to deliver on bigger contracts and vice versa for the contractors. Through effective consortium management Well UK believes that there are significant additional benefits. These include a focus on national quality standards, professionalism, cost effectiveness and key health and social improvement priorities. Development of standards and sharing of good practice is Well UKs strength and ensures continual support and up-skilling of local delivery partners.

5.5 Learning from Consortium Working: central themes

This section sets out some central themes based upon the experiences of SWWB programme’s consortium members. Some themes mirror the learning derived from wider research on partnership working (see for example, Austin 2000, Nuffield Institute 2000). They also highlight some aspects that are more specific. These reflect how an alliance of healthy living organisations has worked with the Big Lottery’s portfolio model.

1. Communicate the benefits to contractors. The consortium has sought to show how the format streamlines the supply chain. This has kept overheads low, promoted prompt front-line delivery, directed efforts and managed quality assurance.

2. Develop common purpose. Given the diversity of approaches to the promotion of health and well-being, consortium members worked to develop a sense of shared identity (a ‘brand’) despite very independent histories. This was part of a longer term process that started well in advance of the programme funding period.

3. Create clear membership criteria. The consortium has learnt the value of developing criteria for assessing both quality of project plans and the capacity of organisations to deliver. Due diligence in applying criteria for membership needs to be in place right from the start of the bid development process.

4. Recognise the distinct legal and programme performance responsibilities of the lead organisation.

5. Commit both to the delivery of the programme and to the development of the consortium itself. Work to develop the consortium has stretched the resources of the project leads own organisations. However this extra effort by at least some of the members has proved essential for the consortium.
6. Build trust and confidence between members. This required investing in the Steering Group as a forum for open and honest communication, as well providing informal opportunities networking and support. Given the democratic basis of the membership, the lead organisation had to act very transparently in all its major management decisions.

7. Commit to mutual support and service development. Consortium members committed to sharing good practice, opportunities for funding and regional intelligence. This has helped some members ‘step change’ their external profile with partners.

8. Work outwards to build new partners. Consortium members have successfully brought in additional front-line organisations to broaden and build capacity of local services for the promotion of health and well-being.

9. Agree, commit to and communicate the core performance requirements and outcomes. Members valued the chance to shape the programme’s aims and objectives. The role of the lead organisation in maintaining a focus on these has been important for member organisations that all have to maintain local commitments.

10. Respect project diversity and the local autonomy of project organisations. A shared vision and common approach has given the programme much coherence. However, an additional strength of the consortium model has been the local tailoring and innovation of projects – led by expert local organisations.

11. The consortium lead needs to be able to draw upon robust governance, agreed processes and members support for managing risks and adversities that may arise.

12. Celebrate success. As a consortium of dispersed projects across the region the achievements of the whole programme are not necessarily visible to beneficiaries, staff and partners in local areas. Celebrating success for the whole region has required commitments from all members of the consortium.
6. Good Practice Case Studies

6.1 Introduction

SWWB organisations are highly experienced providers of community services. All have worked closely with their communities and tailor their activities to meet local needs. In the process of developing services, staff have learnt how to create opportunities and address the challenges that arise. This section of the report presents a series of case studies highlighting how each project has developed their practice in specific areas. Some of the insight demonstrated here has arisen from the sharing of innovative ideas between projects. Over the course of the programme staff delivery teams have convened on a number of occasions to share good practice in the areas of healthy eating, physical activity, mental well-being and volunteering. These events were well attended and have led to ongoing dialogue between organisations across the region.

The case studies presented here were developed in dialogue between each project team and the evaluators. While the SWWB programme encompasses a considerable range of activities, service users and community settings, one aim of the case studies is to illustrate a number of underlying issues that are common to many projects.

The topics addressed in the case studies are presented in table 6.1:

Table 6.1: Summary of SWWB Good Practice Case Studies

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<tr>
<th>Project</th>
<th>Case Study Title</th>
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<td>Positive Well-being Project and Race for Life 2009 : Enabling access to charity sport fund raising events</td>
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<td>6.3 CHLC: Pathways to Health and Wellbeing</td>
<td>Community signposting through a Healthy Living Centre GP Plus database</td>
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<td>6.4 CIOSHPS: Step by Step</td>
<td>The Community Health Development Small Grant Scheme: Stimulating local action through small grants</td>
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<td>The Rock Community Centre Lunch Club: Working with a core group of long term volunteers</td>
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<td>Well Bean: Adopting a coordinated approach to complex family problems</td>
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### 6.2 Positive Well-being (PWP) Project & Race for Life

Many people would like to take part in charity sports fund raisers but are deterred by costs, lack of social support and the demands of physical training. This case study illustrates how the Positive Well-being Project enabled over eighty women to take positive steps to promote both a good cause and their personal well-being.

In May 2009, 81 women from the PWP completed Cancer Research 5K Race for Life on Weston Beach. The women who took part covered the full range of women who use the project and included women with their daughters, older women including several with disabilities and also female members of staff.

The health trainer at PWP had recognised the Race for Life as an opportunity for the project to promote several of its values simultaneously, these included encouraging people to do more exercise, inclusion of those with special needs and disabilities, developing peer support, providing social and recreational opportunities and recognising the value of exercise for lifting mood and reducing tension and anxiety.

Whilst the staff team knew that there was a lot of interest from local women, they were also aware of barriers to taking part in Race for Life. These included the cost of entry; the risk of injury through inappropriate footwear and clothing; lack of confidence in completing the distance through
lack of training and walking/running experience; and transport to the event.

The staff team designed a training programme to run over the eight weeks prior to the event. They also offered alternative training opportunities for those who were not available for training during the day this included the design of a personal training plan to do on their own and the opportunity to attend the local Women’s Running Network beginner’s group. Staff drew upon their in-house expertise in the form of two trained walk leaders and a level 1 running coach. The team aimed to focus their work on people with low level mental health difficulties, but also publicised the initiative more generally through the Healthy Living Centre and its partner services. This helped attract a very wide range of people to get involved.

Working to overcome barriers participation, the project provided everyone who registered with the opportunity to be fitted with running shoes, walking shoes or sports bras. PWP also covered the Race for Life registration costs. This investment was not only intended to reduce the risk of injury but would also encourage the women to commit to the programme. Participants reported that this approach did help their confidence and helped provide motivation for both the training and the event.

The training was held weekly, chiefly on Weston Beach, with an average attendance of ten people. The project provided minibus transport from the centre to the beach. Those regularly attending the training included several people with disabilities so four staff support attended including all those with walking and running leaders qualifications and also a qualified first aider. All the training sessions were risk assessed before taking part and a variety of techniques were used to keep the training interesting. These included a treasure hunt with buried Easter eggs and various games that encouraged people to run and walk at different speeds. By the end of the training programme everyone who attended had completed the full distance and appeared to be confident of taking part. One woman with severe arthritis was very keen to take part but using her walking frame on the beach was very difficult and it was apparent that it was very painful for her so we agreed with the organisers that she could turn round after whatever distance she could manage and still go through the finishing line and receive her medal.

As the training progressed the group became very supportive of one another and were keen to develop a team identity so PWP agreed to provide personalised group T-shirts. PWP encouraged participants to raise sponsorship and gave them ideas as to how to do this as again this raised confidence and provided people with a sense of community and achievement.

On the day of the event all 81 women who registered participated in the event despite poor weather. Nine staff members of HLC took part to assist participants and help record the event through photos. Everyone completed the course to the best of their ability and it was apparent that they felt a huge sense of achievement. The last walkers from the group completed the 5K course in 1.5 hours in heavy rain.

The chief outcomes from this event were:

- All those attending gained a sense of achievement, increased self-esteem and recognition of their own abilities.
- By raising sponsorship money those taking part were able to see the value of their achievement.
- The group were able to work together, build friendships and support one another increasing their sense of being part of a community and able to help one another.
- The majority of those attending increased the level of exercise they were doing and felt the physical and psychological benefits of doing this.
- By providing the appropriate equipment everyone attending appeared to gain confidence in their ability to complete the
training and course. It also reduced the barriers to taking part for many people.

- By paying for the registration we overcame the biggest barrier to taking part and enabled many more people to become involved especially those who would not traditionally have been able to do so.

6.3 Cornwall Healthy Living Centre GP Plus database

CHLC database are installed in GP surgeries to provide information on a wide range of initiatives throughout Cornwall at the touch of a button in order to increase access to wellbeing information and activities for local people to improve their health and wellbeing in a more holistic and proactive way.

The idea for a database was initially developed by the former West Cornwall Healthy Living Centre (WCHLC) in partnership with the former Penwith and Kerrier district councils. It was discussed and debated by the WCHLC Forum in the Autumn of 2005 but it represents considerable commitment and hard work from the project’s partnership links with the district’s Social Inclusion Officer who now works for the new unitary authority of Cornwall Council. The idea of the database evolved in 2005, the CHLC (nee WCHLC) campaigned and worked with local GP surgeries to develop the idea. At the Bodriggy Health Centre in Hayle, Dr Nick Gibson, the Lead Prescription GP for the former West Cornwall area, became a strong supporter and early advocate for the database having had considerable experience of working with local community/voluntary groups to deliver practical health solutions for local people. During its first year the website received over 37,000 hits, with more than 20,000 pages viewed. At that point over 170 health and well-being projects serving the former Kerrier and Penwith districts had signed up to the database, with the majority being quality reviewed by the CHLC. The number of unique visitors to the site was over then over 2,700. The website was seen as a practical solution to getting and signposting important health and wellbeing information to people living in Cornwall. A vital service since users of GP services often live in remote communities. Only 31% of Cornwall’ inhabitants (UK 80%) live in towns of over 10,000 inhabitants and it is acknowledged that the county suffers from a poor public transport and road infrastructure making local people heavily dependent on the car and exacerbating the impact of physical distances for accessing local services (Cornwall, Council, 2009). The GP Plus database, updated and re-launched at a cross-county partnership conference in July 2010, is now installed at seven GP surgeries/health centres and it assists GPs and their patients to find health and wellbeing projects and support groups. Search categories on the site represent the project’s understanding of the health and well-being sector in its broadest sense. There are clear portals for: Health Support Projects, Emotional Support, Community Health, Housing Support, Minority Support, Welfare Support, Families and Children, Young People, Older People, Support for Men and Women, Sex and Sexuality. The largest of these is Emotional Support and this includes links to information, organizations and activities around a broad range of issues associated with mental health. Through each portal are links to specific projects, therapists, practitioners, activities, events, workshops etc. There are contact details, information on geographical remit and other relevant information for users to explore before making a choice to contact. There is a useful lost projects site and new service providers can apply to add their project/activity electronically. The site now receives an average of 358 hits a day.
6.4 Step by Step’s Community Health Development Small Grant Scheme

 Communities often have a considerable reserve of untapped skills, energy and ambition to develop new initiatives. Working with local ideas, this case study illustrates how Step by Step has developed a low cost, small grant scheme to stimulate a wide range of grass roots health and well-being projects.

Through this scheme the Community Health Development Team are able to give small community groups opportunities to develop their group or organization in some practical way. Community groups from the project area and across the county can apply for a grant of up to £300 to promote social inclusion through projects which can support health development through community involvement; support community involvement in active recreation and environmental projects or promote the arts for health in all its forms. The types of projects and activities supported are vast. In many cases it gives the beneficiaries involved a tremendous fillip for a minimal investment.

One group the Cornwall Leisure Activities and Sports (CLASP) was set up initially to provide leisure activities for people who suffer from some disability. They have a team who compete in a Carpet Bowls league and used their grant to purchase two sets of sportswear for their two teams the Crusaders and the Pilgrims. The Liskeard and Looe Mini Junior Rugby Football Club provide sporting opportunities to 140 children from all backgrounds. Their grant helped to purchase balls, bottles, bibs and paint which according to the lead has been a great help. The Landulph Under fives group purchased plants for their sensory garden to help with their disadvantaged members: if rural living is classed as a disadvantaged community? A carers group were able to give their members some time away and it allowed them to all laugh together. The Inbetweenies parent and toddler group were able to support low income families to have new furniture for their group to make play more accessible. Families with disabled children and young people group were able to support climbing, abseiling archery and challenge courses:

Seeing the smiles on their faces when they successfully completed an activity was wonderful especially for those who were nervous about having a go.

6.5 Healthy Living Wessex’s Lifestyle Clinics for Men

Many SWWB projects have developed one-to-one and group based activity programmes that successfully attract women. However males tend to be under-represented, particularly in weight management programmes, despite evidence that obesity and high weight are issues that affect many men. This
case study illustrates how Healthy Living Wessex increasingly refined its services to reach an under-represented group of clients.

Lifestyle mentoring is a personalized one to one service which helps people to put their lifestyle goals into manageable action-focused steps and then supports and motivates them as they take their own steps to health change. A lifestyle mentor is someone qualified, and experienced in a variety of behaviour change techniques such as life coaching, behaviour change counselling and motivational interviewing. They work with clients on an individual basis to help them to make realistic, sustainable lifestyle changes. These can include becoming more active, eating a healthier diet, losing weight or working on improving mental well being.

At initial contact, clients assessed for their readiness to change. Once it is confirmed that the service is appropriate, they are offered three one-to-one sessions initially on a weekly basis. At the end of the first three sessions, it is generally anticipated that clients will have achieved one of the following outcomes:

- a weight loss of 2lb,
- an increase in physical activity by one session per week,
- an increase in the number of steps by at least 1000 steps per day,
- an increase in fruit and vegetable consumption by at least one portion per day.

Any one of these outcomes makes them eligible for up to a further three sessions arranged at appropriate times and usually longer than weekly. During these sessions the mentor will help the client set realistic health goals and break these down into manageable action steps. Each week the actions are reviewed and the next set of actions will be set. Lifestyle Mentoring intends to adopt a personalised approach and works at a pace that is right for the individual. People often find it very powerful to be held accountable for carrying out their agreed actions. This isn’t about telling people what to do or ‘telling them off.’ It is about setting goals and agreeing action steps that will help them move towards their goal. These sessions are very flexible to the needs of the client and take place either face-to-face or on the telephone.

It is suitable for individuals who are ready and willing to make lifestyle changes, but perhaps need additional support in planning and implementing these changes. Lifestyle mentoring is particularly appropriate for people who need to lose weight prior to an operation, or for those who would benefit from improving their general lifestyle for people with diabetes, coronary heart disease, high blood pressure & high cholesterol.

Through the mentoring, and also through another service HLW deliver for NHS Dorset, Healthy Choices (a weight management programme on referral using commercial slimming clubs), Healthy Living Wessex has found that that men were not engaging easily with either service.

Many men were turning down Healthy Choices. Over an 18 month period there were 4474 female referrals and only 768 male referrals. Of the 768, 184 of these male referrals that did not sign up at all, 87 did not make contact at all with the hub and 52 were reported as not ready to change most saying they weren’t interested in a slimming clubs. That was 58% of the men referred into the service not taking it up.

A high percentage of the referrals were male and 61 years old and over (41.5% of male referrals). Talking to the men it seemed that the older males tended to be more receptive to the club. This picture was mirrored for Lifestyle Mentoring also. Here the split was approximately 80% females to 20% males.

This led to discussions with men who were accessing the service and team discussions as to how they could adapt the Lifestyle Mentoring to
meet the need of men who could not engage with the slimming club approach or who did not engage with the lifestyle mentoring service. The team used social marketing techniques to focus the promotion which went into local newspapers.

The format of the sessions stayed largely much the same. However:

- The title of the service changed to Lifestyle Clinic for Men and was marketed through GP surgeries but also the local newspaper magazine which came out every week with the TV listings.
- The length of the sessions reduced to 30 minutes rather than 45-50 minutes. This was based on feedback that men reported not really wanting the ‘touchy, feely stuff’. The shorter sessions are working well & feedback from men has been positive.
- The use of Pedometers for those wanting to increase their physical activity levels proved helpful as a physical gadget which men liked and also could compete with themselves but one which they were also in total control of the results and who they shared them with.

The team has only recently developed the service; however the initial results have been very positive. The specific adverts in the local press resulted in the gender split moving to 60% females to 40% males (from 80/20). The team find that once men have decided to commit to the lifestyle change they do it whole heartedly and can be very focused which means they can achieve really results very quickly.

Overall with the marketing the team has found the hard way that it is important to be really clear at the outset about the target audience. Targeting men is an ideal group to target as there is a genuine gap in services provided. The team intend to develop the service further to make it more attractive to men but the first steps have been very positive.

6.6 Working with Core Volunteers at The Rock Community Centre

Many SWWB funded activities work with volunteers to deliver efficient services that connect with their local communities. This case study examines how the Rock Community Centre has built up a core team of regular and long term volunteers.

The Rock Community Centre’s lunch club aims to provide hot, healthy and nutritious meals for older people in Lawrence Weston. It also gives people the opportunity to leave the house, to meet old friends and make new ones in a warm and friendly setting. The club is particularly important for those who might struggle to get out on their own.

The Rock’s lunch club has been running for over ten years. Three years ago under the SWWB programme, the Rock lunch club extended its provision from one to two days a week. The club has grown in its attendance and now averages at 30 members. Many members have mobility difficulties and are picked up and dropped off at the centre by Lawrence Weston Community Transport.

Whilst the SWWB programme provides a grant to cover the very basics such as hire of the centre and community transport, Sue Hale – the centre manager – has learnt to run the lunch club on a tight budget. Members contribute £3 for their meal and help raise funds for kitchen equipment.
through a weekly raffle. The £1000 currently raised through the raffle will go towards the cost of replacing the oven – which itself arrived second hand from a local school. Meanwhile local suppliers, such as the butcher and grocer, supply food at a discount and on special occasions, such as the Christmas meal, will make gifts to the club.

Much of the success of the lunch club has been down to a core team of volunteers. Take a typical day where the menu is roast beef, roast potatoes, Yorkshire pudding, carrots, cabbage and gravy, followed by fruit sponge pudding and custard. The day starts early when at 8.45am Dick collects the order from Tubbs the butcher. He often calls in at Bobbetts for the vegetables, but today he brings freshly picked cabbage from his allotment. At the centre Christie, Sheila (both volunteers) and Sue make a start with the potatoes before moving on to the other items. Meanwhile, Dick sets out the tables. As the morning goes on others arrive to help organise the final touches. By 12am the members arrive, register and are served the freshly cooked meal. Dick will run meals out to people unable to leave their home. By the end Tom, aged 85, helps with washing the cutlery and the team have the place spotless sometime after one o’clock. It’s a well rehearsed routine and the morning works like clockwork. In total the core team volunteers contribute at least 18 hours of unpaid work per lunch club session.

Sheila has been volunteering for the lunch club for three years. She used to work at a chemical company in Avonmouth. She became redundant and decided that she would like to offer her services to the lunch club. She says:

We concentrate on cooking the meals they [the members] love. Most people are in their 70s and 80s and like pretty traditional food. They tend to go for the meat and two veg meal – the sort of things that aren’t the easiest to cook at home when you’re on your own. I find it very rewarding to cook good food - and we also have a lot of fun. [When I was in full time work] I didn’t know many local people. Now I walk around and chat to people I’ve met through the lunch club.

Talking about volunteering Sue says:
It’s important to have regular people who know what they are doing. You need the mainstays of a core group – we call them the ‘A team’! They then help other volunteers to get on with other jobs that need doing.

The Rock’s core volunteers have been vital for the community centre. The volunteers take a pride in their work. They have helped make sure that the centre’s catering hygiene standards were awarded five stars and have recently kept the club running by themselves when Sue had to take time off work after an accident.

6.7 Well Bean Project’s Coordinated Work with Families

The Well Bean project has found that families facing complex problems appreciate respectful and integrated support services. This case study illustrates the strength of working through a network of local partners and agencies to achieve positive outcomes for families.

Dave is a 23 year old man living in a small market town. He had grown up in a difficult family environment with an absence of any positive male role model. He lives with his partner Carole who works shifts and their two young children, three dogs, two cats and a garden full of ferret cages,
chickens, rabbits, toys and a pond. He is the main carer for the children. Two doors away on their estate live another couple Rob and Jodie, also with young children and dogs.

In May 2009 Dave, Rob and Jodie had been referred to Well Bean by the Health Visitor team due to concerns in each case about their social isolation and lack of confidence to cope with everyday life. It was felt that this situation was having a negative impact on their children. Dave had experience of working on a farm and was interested in growing some food. Well Bean Horticulture Worker Tim secured a new allotment nearby and worked successfully alongside them and their children each week through the growing season. The allotment was productive and the families started eating a lot more vegetables. Soon both families started joining in and enjoying the weekly family swimming sessions that were run jointly by the Well Bean project and Children’s Centre.

At this point existing tensions with the neighbour living between the two families boiled over with issues over general noise, barking dogs, dog mess and concerns over crying children. As a result the two families were referred to the local Community Justice Panel.

At the hearing the families made agreements regarding their animals and Dave was required to attend a parenting course. Tim visited both families the following day and helped them think through the management of the issues that had arisen as a result of making agreements that they had not been fully prepared for. This involved enrolling both Dave and Jodie onto a Webster Stratton (intensive parenting) course that was just about to start at the Balsam Children’s Centre. To enable them to attend, childcare was arranged at the Balsam Nursery along with transport from the local accessible community transport scheme. Tim also brought in the local authority dog warden who provided training for both families with their dogs.

Both Dave and Rob came to the Centre for anger management and counselling with the Centre based mental health worker, while Jodie received counselling for depression with a volunteer counsellor.

Seven months after first being introduced to the project both families have undertaken meaningful change in their lives. The men have continued with the allotment and Dave has also created a new vegetable patch at home in the garden, which is now tidy. There are fewer dogs, which are now properly trained, and relationships with the aggrieved neighbour have improved significantly. Dave and Jodie attended all twelve sessions of the parenting programme and thoroughly embraced the changes that they needed to make as parents in respect of their children’s development and behaviour. Both men have grown through the process and are noticeably more mature and considerate with other people. All four adults are still going through a period of change and will continue to need some support from the Centre.
6.8 Plymouth Relate’s Intensive Support for Families

Family based work is a highly sensitive area for practice. This case study describes how Plymouth Relate built a trusting relationship with a family by working sensitively through a primary school in an area of high social deprivation.

Client B came to counselling as she had taken over parenting role of her two granddaughters after social services informed her daughter that were going to take the children into care. Client B’s daughter has a drug addiction and a physically abusive relationship with her partner, who is the father of the younger girl.

Client B’s problems were:
- Coping with the parenting role of nine and four year-old girls at the age of fifty six.
- Bringing her granddaughters into a family with their 67 year old grandfather who was not well and Client B’s 19 year-old son who has learning difficulties.
- Client’s B’s inability to say no.
- Client B’s need to mother.

Client B didn’t understand why nine year-old granddaughter took out her anger on her by being constantly cheeky and verbally abusive at home. At school the nine year-old is a hardworking tidy student. At home she is a messy, angry girl. When nine year old joined the counselling, she wanted to know why she couldn’t see her mother more often. It was explained to her that the social services were limiting access and stipulating that it would be supervised to ensure she was in a safe environment. She couldn’t see why her mother couldn’t come and live in the same house as her grandparents. She said that her stepfather was fun and played games with her and her younger sister. Her grandmother, Client B, asked the girl why she thought her stepfather was not allowed to see her. Eventually, she agreed that he had been nasty. Client B reminded her granddaughter that he had hit her. The session enabled the nine year-old girl to realise that it wasn’t her grandmother who was making the decisions, it was the social services who were, quite rightly, putting the safety of the children first. The session was also a good reality check on how step-father treated her. In later sessions she talked about working in a team with her Nan and helping her younger sister. The sessions helped the nine year-old hang on to the reality of the situation and not constantly blame her grandmother.

It was evident that the nine year-old liked being in control and this conflicted with Grandmother’s constant desire to mother everyone, which was also a need to control. In individual sessions, Client B was able to consider her over-mothering. She had a daughter from a previous relationship who lived in Hastings. She would visit her twice a year. When she went to Hastings, her eldest daughter took over and wouldn’t allow her mother to over-fuss and over-mother. She thought she was closest to her daughter who lived a long way away and who she only saw twice a year.

Client B considered that maybe she needed to be more distant with her children in Plymouth and allow them to grow up. Firmer boundaries, consequences for inappropriate behaviour and saying no more often would be good strategies. Client B was able to firm with all her children. Her son spent more time with his partner and they were considering finding a place of their own. The nine year-old had a passion for drawing. So, art therapy sessions had been arranged through social services. The situation became more manageable.

Client B would not have been able to access family counselling at Relate without the funding. Both the families of Client A and Client B were heard, with
individuals being signposted to other agencies and services. The Clients grew in confidence and were able to access support. The counselling service also informed the counsellor and Relate of the wider society, people unable to access Relate services because of financial restraints. It ensures Relate develops into an inclusive organisation, actively helping people who are suffering severe social and financial deprivation.

6.9 Upstream’s “Best Foot Forward”

Rural areas in the South West have a high population of older people who often lack the opportunities to engage in physical activities in a social setting. This case study shows how the Upstream project used its knowledge and expertise of local communities to develop a new group for previously isolated individuals who shared similar interests.

“Best Foot Forward” was set up as part of the ‘Health Maps’ project and in response to the need for accessible exercise groups in the rural and market towns of Mid Devon. The aim was to deliver light exercise to music through a fun programme, delivered responsibly in a safe environment. The Upstream ‘Health Maps’ initiative helped identify those who were lacking in exercise and in danger of becoming socially isolated. The objective was to improve independence and regain confidence both physically and mentally. The programme aimed to encourage individuals to meet their full potential and promote exercise and other lifestyle changes that are essential for a healthier future.

The “Best Foot Forward” exercise groups were established in partnership with 5X30 and led by Emma Higgin, who was experienced in work with the elderly. The Crediton group was established in the autumn of 2009 and after a demonstration by this group in Tiverton a second group started in February 2010.

People of all abilities were referred through Upstream by GP’s, health professionals, family, friends and carers. Word of mouth soon spread to the local communities, leading to an increase in social interaction and a diverse mix of people. In Tiverton, after close collaboration with the Hospital, the project was endorsed by the physiotherapists who were now able to signpost ‘onward referrals’ back into the community through the group. As the exercises were achievable either seated or standing, there were no barriers to people with impaired sight and hearing or issues relating to their age, weight or mobility. As one member says “.. we have tried to join the pilates class at the Leisure Centre and the Tai Chi at Heathcoat’s Community Centre but have been told that we are too old”

After registration, part of the mentor’s role, with the help of the participants, was to draw up a health map to visualise and plot the behaviour and lifestyle of new referrals. Records of exercise, distances walked and general behaviour patterns were included along with diet and social or creative activities. Realistic health goals are agreed. “I love dancing but find it difficult going along to anything as I don’t have a partner and always have to borrow someone”. The mentor can offer additional support and accompany the referral to this or other groups if they felt vulnerable or unconfident. Before the new group member started, each participant completed a health check using a Physical Assessment Readiness Questionnaire (PARQ) to identify any
serious health problems. If there were any medical
queries, GP recommendation and authorisation
was sought. Any medical complications were
noted by the provider for special attention and
advice offered through the session.

For those enrolled in the Upstream project, each
referral’s progress was tracked and their outcomes
recorded. This included improved levels of fitness,
increased confidence, new friends, and pride in
their achievements. Quotes recorded by the
provider help evaluate the outcomes qualitatively.

“I’m much more confident walking since I joined
the class. I walk to the class now, but take the bus
back, because of the hill” “I move much more
freely at home now”

In total 24 people have joined the Crediton group,
including 4 men, and there was a regular ‘troupe’
of 16-19 people. Over 30 people have joined the
Tiverton group, with many referred from the
hospital. The age range in both groups was from
50 to 89.

The programme provides mental stimulation by
encouraging participants to memorise dance and
step sequences and to synchronise these with the
music. The imaginative routines and opportunities
for individual expression strongly encourage the
participants to join in. “It really gives you a chance
to stretch out your body”. There is also a high
degree of social interaction, which is widely
regarded as of fundamental importance to mental
health. “Don’t ever stop running the class, it’s the
only thing that gets me out and about”

The Crediton group is now extremely confident,
reflecting a huge impact on their sense of well-
being. They have been interviewed and
photographed by the press and taken part in many
demonstrations, including more recently at a
Carers Festival in Exeter, where the two groups
merged, were filmed on stage wearing feather
boas and watched by the general public. This has
developed strong social cohesion and there is
evidence of new social friendships so important at
this stage in life. “I enjoyed your successful Best
Foot Forward day last Wednesday and made a
friend there”

Since March 2010 the two dance groups have
become independent and self-funded. “We have
gone independent, which we voted for, and even
have our own T-shirts. And do you know we have
got three men?”. The groups are now on course
for a long-term future. They are monitored by
Upstream and remain a highly effective activity,
willling to accept new referrals from a variety of
sources.

6.10 The Fit ‘n’ Fab Group at Knowle West Health Park (KWHP)

Knowle West Health Park has found that short term interventions for people
with mental health or wider life difficulties can be highly effective. However, as
with many organisations, KWHP cannot offer intensive services on an
indefinite basis to clients. This case study illustrates how KWHP established a
simple low cost support group to help people over the longer term.

For people who have a major encounter with ill
health, the road to well-being can be long and
challenging. As part of the SWWB, KWHP has been
running ‘Pathways 2 Health’ [P2H], a popular
course of one-to-one massage and motivational
support. Most clients have recently had medical
treatment for an acute or chronic health problem
and their difficulties are often compounded by
housing, employment or relationship problems.
Over the course of six sessions clients have an
opportunity to refocus their personal goals and to concentrate on regaining a sense of health and well-being. While the course has very successful self-reported outcomes, the KWHP team found that clients often lacked the opportunity to maintain and follow through on these gains. As Sally the activity coordinator, explains:

Six weeks just isn’t long enough for everyone. At the end you’re left on your own and you’re not necessarily ready to go into the outside world. Without support people can easily slip back into needing expensive [NHS] care.

KWHP’s solution was Fit ‘n’ Fab, a group for clients who are ready to move on from one-to-one therapy but who still feel they need regular personal support. From the outset Sally felt that everyone in the group should feel empowered to take an active role. Jill, one of the group members, says:

When we first met we talked about what name we wanted for the group, what we wanted to achieve, how we’d run the group and how much we would be charged. We wanted it to be that no one was excluded if they were on benefits, but we should help [KWHP] by paying for refreshments.

Groups can often feel threatening, but Fit ‘n’ Fab members have found that P2H has been a good bridge into more a social environment. Jill says:

For the majority of people, we hadn’t met each other before. Being in a group is quite scary if you’re new. But because we’d already been to P2H you already know Sally. The ethos of the group is that you are not under any pressure at all – not under any pressure to come. For some maybe just coming once is something good for them.

Each week, the group takes part or explores a different topics relating to ‘well-being’. These topics are very varied and range from armchair exercise, meditation and belly dancing, to healthier recipes, ‘pampering’ and mental relaxation techniques. For Helen, Fit ‘n’ Fab has played an important part in her recovery from ill health:

I’d been increasingly feeling ‘slow’ and - until I’d been diagnosed with a tumour in my thyroid - no one knew quite what was wrong. Then I had a big operation on my throat. After my operation there wasn’t much support: I was really just left to go to my GP for blood tests and a check up. I felt like I was just left in a void really and I was incredibly depressed. I’d not long moved to the area and didn’t really know anyone.

Helen found KWHP’s P2H course extremely helpful in helping her take a positive outlook on life.

Sally helped me set goals – my goal was to try to carry on eating healthily because I’d been unwell my eating habits had got a bit out of control. I also wanted to find somewhere to live and KWHP helped me make the right contacts with the Council.

For Jan, Fit ‘n’ Fab represented a next step in her recovery:

Fit ‘n’ Fab has been a way for me to get to know lots of people. It’s a very eclectic group and we are all very open about our experiences. For me, it’s a place where you can come and just let go. You don’t have to be fantastically sociable, there are no expectations, you can just come in, unwind, and let go. It’s a bit unique. Yes there are coffee mornings – but this is different. At the start I felt I had to come every week because it was my only contact. I feel a lot more confident now: like I don’t have to come every week.

The group is largely attended by women, although it is open to all and the KWHP project team have actively sought to interest men. The team have now broadened their links to other agencies such as Barnardo’s, which have started to refer people who can benefit from the group’s social support. KWHP staff’s vision is that, in contrast to their structured and time limited therapeutic courses, Fit ‘n’ Fab becomes a long term sustainable group for people with longer term needs. Sally says:
We link to other projects and offer options to go on into employment, volunteering or to take up learning communities. But not everyone wants to - or is able to - move on [to be totally independent]. For them, it's a case of holding people and helping to support them. Yes some people will move on but for others it's a case of keeping them up here [points upwards]. I'd say that most people in the group have mild to moderate depression.

In contrast to their one-to-one therapeutic services, KWHP’s Fit ‘n’ Fab is run on a very low budget. For KWHP, this mix of high and low cost interventions helps the organisation provide a holistic range of services that fit well with the diverse needs of the local community.

6.11 Wellspring Community Kitchen: Reaching out to different communities through cooking

Families cooking together is an opportunity for families to learn new culinary skills and enjoy an activity that every member can share.

Wellspring’s Community Kitchen is a kitchen designed, developed and promoted by local people and food practitioners. It aims to improve diets and promote enthusiasm and skills around food and cooking. It works with a very diverse community. Part of the project’s target area is a ward in the most deprived quintile in England. The whole ward is within the most deprived quintile of Bristol (APHO, 2010) and life expectancy is nine years less than that of the most affluent ward in Bristol. The local community hosts a high number of refugee and asylum seekers, a proportion of who are from Somalia (Bristol City Council, 2010). But the kitchen is a resource open to all. They have worked hard to: build and promote local people’s access to high quality cooking facilities in a community centre setting, undertaken community cooking demonstrations, skill development and educational support. The kitchen has hosted a broad variety of cooking opportunities. This has included a Healthy eating for the Under 5’s, Cooking on a Budget, Festive Feast and Winter Store Cupboard. But this course includes older children. Based in the fully equipped community kitchen which accommodates up to 10 people; cooking is taught as a fun, sharing and enjoyable activity. The kitchen is accessible, which enables anyone who may need to use a stool, or access using a wheelchair to use this new space with confidence. Most of the courses (which have been run at regular intervals) are often based around a specific issue such as: Men cooking with confidence or Healthy eating for Single People on a budget. This particular course offers an enjoyable family activity for everyone to enjoy. Participants receive a recipe pack and they can take their food home. The costs of courses have varied from £1 to £3.50 a session; which with the food included is seen as a real bargain by those who attend.
6.12 Lifestyle Assessments at Westbank New Steps

This case study highlights the importance of taking an in depth and systematic approach to learning about the health needs and aspirations of people starting out with a structured programme of lifestyle change.

A founding principle of the New Steps project is to work with people holistically: to treat them as individuals first and foremost and to match them to services accordingly. One approach that the project team adopted is the use of lifestyle assessments. This is a one-to-one appointment with a trained member of staff who has the time to listen and explore, while working within a common questionnaire-based structure. In this way staff have a consistent format to work to (ensuring parity for all service users) and yet they have the time to really get to know the person, to establish a rapport with them and then to action- plan with them for the future.

The assessment asks general questions about the service user’s lifestyle (such as smoking, alcohol consumption, work/home situation) and then explores eating habits, physical activity and areas associated with their mental health. This approach enables the service user to begin to unpick for themselves the areas they might like to address. The member of staff is then able to suggest ways they might begin to work on these areas and to link them in with the relevant services (whether provided by the New Steps project, Westbank in its wider remit or by other organisations).

Part of the commitment of the lifestyle assessment is that the service user will have a named person who maintains contact with them for the duration of time mutually decided. This might be the person who interviewed them, another member of staff who is more appropriately skilled for the lifestyle changes they want to make or a volunteer to mentor them and provide encouragement. This personal approach has worked really well to ensure as many people as possible remain engaged with the process.

The benefits for the staff team of this way of working have been numerous, including: the motivational interviewing training received provided a grounding which has been transferable to other areas of work; the opportunity to link with other professionals when helping people to achieve their goals has forged the way for increased partnership working; and the satisfaction gained in helping people make significant, tangible lifestyle changes.

6.13 Porlock Community Orchard

This case study describes the role of community supported agriculture in promoting healthy eating and in engaging and bringing people together.

The Porlock Community Orchard is run by a group of local volunteers who aim to manage their local orchard as a community asset for local people and wildlife. The orchard is maintained by a dozen regular local volunteers. Originally based on a cluster of 22 original trees, the orchard helps to preserve and sustain old English varieties of apple like Annie Elizabeth, Warner’s King, Lane’s Prince Albert, Bismark, Bramley, Reverend Wilkes, Tom Putt, Robin’s Endeavour, Blenheim Orange and Somerset Robin. In managing the orchard and developing the orchard walk, volunteers have
been enjoying developing a healthy lifestyle through developing the landscape. It gives the community a natural attraction and it has attracted visitors to the area. The orchard is now a focus for ‘cultural’ activities like celebrating apples, including an annual apple pressing day and winter wassailing. They also offer apple services to the Porlock Vale community and the surrounding area of Exmoor. The project encourages people to learn about Exmoor, including its landscape, its wildlife, its farming traditions, its history, crafts and pastimes. The Community Orchard also delivers training and provides opportunities for people to learn new skills in the management of apple trees, orchards and the environment. The community is involved in planning the orchard and members enjoy reviving old customs and rituals like cider making. In the near future they will develop an ‘edible hedge’ along the site’s boundary and it provides local school children with an opportunity to experience seasonal tree dressing.

One local visitor said:
I am proud of the way in which the project has brought together the community and visitors. It has been a steep learning curve. We have been able to call on the help of organisations such as ‘Orchard’s Live’, Exmoor National Park and the ‘Living Well Programme’ to create a very special asset. Making our own apple juice was fantastic!

6.14 Community Activators

5X30 Devonwide established a network of four Community Activators across North and West Devon to deliver the project. The role of the Community Activator has been to help people and groups to identify new physical activity opportunities by using their extensive local knowledge of services. This knowledge enables them to quickly develop networks between community leaders and to spot areas where there are gaps in provision. As Danny Hughes, one of the Community Activators, explains:

A Community Activator should be someone who has the ability to speak to any audience and to find out what excites them. You can think of an Activator as a ‘fixer’ who works with the needs of the group and finds allies in the local area to make things happen. We’ve been incredibly flexible in our approach. Sometimes we work as the lead agency and sometimes as a partner alongside existing health, leisure, sports or community safety initiatives. It’s also a creative role. So, for example, if I find that I can help set up a youth cycle or sports coaching group in one place, I’ll suggest that other community groups might like to try something similar in their area. We are very part-time and can offer only tiny amounts of start up grants so we’re always looking for the best way to help others make a difference.

Tracy Seymour, a practitioner who works for a partner agency called Puzzle Tree, says:

We were contacted by the Community Activator for the Okehampton area, who offered support to us in developing physical activities for our day centre service for adults with Learning Disabilities. Often a problem for us is access. For instance, in the past we would have to travel over 70 miles to go to the nearest swimming pool that would take the group. The Activator met with the local leisure centre and
pool and negotiated access to swimming, gym and studio sessions on that site. Because it was so close to the day centre, people could walk to site - and do some exercise on the way - rather than travelling seated in a minibus.

Since then we have been involved in seated exercise courses and networking events that have helped us develop more and diverse activity for clients with a wide range of abilities. The Community Activator has got us involved in the Okehampton Sports & Fitness Festival which gave us a chance to try a wide range of activities. The Activator passes on any information on initiatives, funding and any opportunities we may be able to benefit from. It has also been a two way relationship: Puzzle Tree organised training for trampoline coaches working with individuals with special needs and this in turn allowed a trampoline club to develop in Okehampton for young people with learning difficulties. Recently we have developed links with the Tavistock area to start up and put training in place for a Boccia League in Devon.

Overall the group of thirty adults with learning difficulties have had a chance to try a wide range of activities. These include use of the gym, seated exercise, football, cycling, tai chi, dance, gardening-bee keeping, fitness and movement classes, fishing, conservation, fencing, rebound therapy and trampolining, walking, table tennis, racquet skills and fun play. We have seen great weight loss and improved fitness levels which have allowed people to extend their experiences. For instance Michael, who suffers from epilepsy, started of using the gym and this has developed into a regular weekly activity. He now also does fencing and, at the age of 60, has started road running.

We have fully adopted the 5X30 message for our clients. It has meant we now offer a wide range of activities into each week and have a very successful ongoing relationship with the 5X30 project.

6.15 Supporting GP services through community-based dance

Dance activities can form one part of a range of community-based services on offer to people who need to improve their levels of physical activity. SWWB-funded work has set out to offer fun and informal services that directly complement provision offered in the statutory sector provision. As with a number of SWWB initiatives, this project has received funding from both SWWB and a local practice-based commissioning group of GPs.

A local authority appointed a lead person to act as Physical Activity Referral Coordinator (PARC). This has included several schemes where professionals could refer individuals to one of several activities, such as health walks or dance sessions.

Participants are referred by their GPs, Practice Nurse or Physiotherapist within the GP Practice at their usual GP appointment or check and given a consultation by the PARC at the start. It takes the form of a 12-week course of salsa dancing classes and at the end of this period they undergo a review. This is carried out by the PARC and uses a similar format to that of the initial consultation. The PARC re-measures physical aspects, such as weight, and reviews the participant’s goals and ambitions that had been set at the start of the sessions.

There have been two courses run so far with 39 direct beneficiaries, the majority of whom reported that they benefited in some capacity, whether that was socially, medically and/or physically. There were some who did not attend the end appointment and therefore any benefits they experienced were not recorded. However, no one reported any adverse effects from the sessions.
Participants were referred for a variety of physical, psychological and emotional reasons, including hypertension, obesity, depression, anxiety, arthritis, asthma, diabetes, back pain, injury rehabilitation and cardiac rehabilitation. Written feedback from clients has been very positive in terms of improvement in mood and weight loss. Comments include:

“Feeling much more mobile and it was great to meet people”
“Mental well-being has improved and increased my confidence”
“Weight loss, asthma improved; less reliant on inhaler”

More general feedback from the beneficiaries included the enjoyment of meeting people and doing something social that was also exercise:

‘I feel more positive in myself and will be continuing with dancing as a social, enjoyable form of exercise’ (Anonymous participant)

“Dance on Prescription, for me, is all about making good friends, having great laughs and keeping fit at the same time!” (Female, 56 years, referred with asthma and stress)

Participants are mainly female but the coordinator is seeking to encourage more men to be referred. Attendance at sessions has been very good, and many have gone on to intermediate dance sessions so that they can maintain their physical activity in the form of dancing. The coordinator noticed a marked increase in those joining the second course, some of whom had heard about it through word-of-mouth and approached their GP or Practice Nurse to ensure that the activity was suitable for them.

Added value

The potential savings and additional value of such a social form of exercise has, for one beneficiary, included substantial weight loss (just over one stone over the 12 weeks) which resulted in the beneficiary being able to stay off her medication. Another found that with the strengthening of her muscles her balance has improved. This may lead to less falls and accidents and therefore less visits to her GP and/or hospital.

Another example comes from woman aged 43 years who was referred to the dance sessions as well as other healthy lifestyles (gym and swimming activities) as well as these dance sessions after having undergone several operations, in order to improve her mental well-being and asthma and. She commented:

“I lost ½ stone in the first few weeks of the course and by making the most of the healthy lifestyles schemes i.e. gym, swimming and dance; I now do not need to use my inhaler! My mood has improved and I am now helping others to take up exercise for their own health!”

Apart from not needing to rely as heavily on medication the participant actively contributes as a volunteer with the scheme, helping to coach others and assist with the general coordination of the dance sessions.

Key themes this case study illustrates

- Referrals to dance exercise are broad and inclusive of physical, psychological and emotional problems.
- Attendance at dance sessions by predominantly female participants who have been referred is high.
- Many participants have progressed to an intermediate course in order to continue long-term physical activity.
- Referring agencies appreciate receiving reports on the outcomes for participants. This information gives partner agencies confidence to continue recommending the well-being service.
6.16 Practical steps to help young people at risk of offending take up a healthy diet.

The CASP project has worked with perhaps some of the most challenging direct beneficiaries in the SWWB portfolio. These are young people who are low achievers and lacking in self confidence. Quite a few are offenders or at risk of offending. Nevertheless the project has aimed to not only encourage healthier eating and develop basic life skills but it has also aimed to provide them with a sense of achievement.

It was clear from initial research that young people accessing CASP’s services had very poor diets. The project learnt that some young people do not have a cooker at home or their parents might not use the cooker because it is too costly to use. In a baseline survey these young people report lower rates of fruit and vegetable consumption and they were less likely to report that they enjoy eating healthy food. The project is aware that there is sometimes peer pressure to resist healthy food and many families think that healthy food is expensive food. So the project found they had many issues to address but they understood that they had to respond flexibly to what young people said about food and cooking. Some of the young people on the project were excluded from school or simply not going. If they are in school they may not have had an opportunity to learn how to cook because some of the schools visited did not have cooking facilities for young people to use. With few cooking opportunities available in their school or at home, cooking and eating healthy food is a life skill that was likely to be absent in their transition to adulthood. To be successful it has therefore proved vital he project to be flexible and they have subsequently developed an informal approach to getting young people enthused about cooking and eating healthy food. This has meant starting by asking some fundamental questions:

- What do young people like to eat?
- What ingredients can be bought from their local shop?
- What cooking facilities can they access?

Assessing these aspects of a young person’s life is essential to develop bespoke sessions that can address their needs and circumstances. It is often meant using simple cooking tools as the majority would not have access to mixers and food processors. But by going back to basics this project believes they are more effectively able to embed key skills in their life and help them develop healthier behaviours for the future. Other skills learnt can include getting families to work and eat together, team building skills, budgeting and decision making. After their initial session young people are invited to suggest food and meals that they would like to cook themselves.

The project co-ordinator says: A lot of our kids are referred to us because they are not getting access to good quality food or because they don’t know and haven’t learnt to cook. They haven’t learnt it in school. Or they have opted out of school and some of our kids haven’t even got a cooker in their house. So from a family point of view they are not eating properly. They don’t know how to eat properly or even how to access any food.

It is often hard to quantify the impact of the project on young people but professionals who work with youth workers know that young people can often give feedback on their experiences and express their gratitude in various ways. The project co-ordinator has witnessed several examples of young people outlining the benefits they have gained from the sessions and the gratitude they hold for the commitment of the staff. These cannot be fully captivated here but the evaluation sheets suggest the young participants enjoy their time on the project and they clearly acknowledge the benefits they have gained:

When other people are away I can make my own food
When I am older I will know how to cook for my child
If I am chef in older life, I will remember.
7 South West Well-being Project Profiles
Introduction
This report provides a profile of the Positive Well-being Project (PWP), an initiative funded as part of the South West Well-being programme.

Project aims and objectives
The Positive Wellbeing Project seeks to provide a service to people with low level mental ill health, concentrating on protective factors such as social networks, participation and self esteem. It intends to support people living within South Ward to improve their physical and mental wellbeing by providing a local, accessible and flexible service that responds to the needs of individuals and the community. Specifically, the project aims are to:

- Ensure a rapid response and range of options for people experiencing mild anxiety and depression, reducing the number of people on medication;
- Develop community alternatives to medical treatments: self help groups; CBT; talking, listening and complementary therapies; varied opportunities for physical activity;
- Support and mentor people who find it harder to access these opportunities, improving inclusion;
- Improve understanding of families and communities of mental health through campaigns, events and similar health communications.
People living and working in the area felt there was no service available for people managing mild depression and anxiety who did not reach the threshold for secondary mental health services. Similarly local clinical staff reported that many consultations with GPs had a social or emotional content for which clinical services had little to offer. Due to FAHLC’s close working relationship with clinical staff there was the potential to link clinical and wellbeing work to the benefit of patients and residents.

The project team adopted a holistic approach to the development of PWP’s services. The team felt that wellbeing has physical, emotional and, for some people, spiritual aspects. These are mutually supportive, for example enhanced self esteem was felt to be closely linked to healthier eating. Activities intended to increase physical activity and improve nutrition were developed to promote mental health. In their own right these activities would act as opportunities for promoting social wellbeing through participation and social inclusion.

PWP has sought to promote well-being at a three levels:

- an individual level, e.g. keeping fit, being listened to, learning about parenting skills;
- a community level, e.g. increasing social inclusion and participation, improving neighbourhoods;
- a structural level, e.g. reducing and challenging discrimination.

At each level, interventions may focus on strengthening factors known to protect wellbeing e.g. developing new skills, creating a sense of belonging and on reducing factors known to threaten well-being e.g. bullying, unemployment.

The purpose of the Positive Wellbeing Project has been to promote wellbeing by providing a range of advice, support and activities which offer opportunities for people to protect and strengthen their sense of wellbeing and reduce the risks which may threaten it.

FAHLC vision and values emphasise the role of the local community in developing community solutions to entrenched problems. Drawing upon this PWP sought to follow a community strengthening and empowerment model. This has involved adopting proven strategies of engagement, empowerment and strengthening of social networks. The project team aimed to work with people in the contexts of their families and communities and to recognise their own influence over health outcomes.

Host organisation

For All Healthy Living Company is a Social Enterprise and a provider of commissioned services. It is committed to being a Community Anchor Organisation thus meeting local priorities and developing the capacity of the community.

For All Healthy Living Centre – the central base for the Company – developed on a site owned by the local Community Association. Local residents and agencies worked together to design, fund and oversee the development of the Centre and the formation of the For All Healthy Living Company. The various partners who were involved included the Primary Care Trust, Local Authority, Sure Start Local Programme, local Church and the Community Association. The Partnership secured funding
from the New Opportunities Fund. All partners who contributed capital occupy dedicated space within the Centre, specified in a sublease.

The Centre has a range of facilities, activities and services which promote the building as one that local residents can use for their own good. There are a variety of professionals who are based there including General Practitioners, Practice Nurses, Health Visitors, School Nurses, Podiatrist, Mental Health Workers and Counsellor. There is a community café (run by volunteers), a twice-weekly fruit and vegetable stall, a Community Swap Shop, a library, Children’s Centre, Church and a community hall. Many of these feed into each other: with residents offering to help in the church activities, the church referring people in for mental health support and so forth.

**Project area**

For All Healthy Living Company is based on one of the four estates in South Ward with a total resident population of 10,000 people. It is an area of higher multiple deprivation with three super output areas (SOAs) in the lowest 10% nationally including one SOA in the lowest 3%. The area has twice as many children and young people per 1000 as the authority area (North Somerset) as a whole and a significantly higher proportion of lone parent families. Health staff estimate up to 50% of their consultations have a psycho-social component, and that these are linked to issues such as poverty, poor housing, parenting difficulties, domestic violence and addiction.

**Project design and delivery**

**Inputs**

The project has received £304,000 funding for three years of project deliver. To assist the project the FAHLC partnership has provided infrastructure and management framework, additional match funding and support in kind, volunteers and volunteer support.

**Activities**

PWP works in the local community with people who refer themselves, are brought in by a friend, or are referred by a worker. The participants are predominantly those who ‘drop-in’ to the Centre to see a project worker - or a health professional in the Centre who then refers them. In addition, they may be referred from a partner practitioner such as the Children’s Centre Family Support Worker.

People are offered different types of support based on what might suit them most with the issues they are dealing with and on what is available. As the relationship develops they may also choose and be encouraged to try other options which will promote and sustain their wellbeing.

At the planning stage, FAHLC looked carefully at how to complement the service with services provided by other local agencies, including the development of a new Primary Mental Health Service, commissioned by the
This has involved developing a balance of both group and individual activities. Some of the group activities have been time limited (e.g. listening courses); some are one off community events and others are ongoing (e.g. exercise groups). The table below summarises the range of services offered through the project.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby Massage</td>
<td>This group provides parents of young babies with the opportunity to learn baby massage skills which help to increase the attachment and bonding between parent and baby.</td>
</tr>
<tr>
<td>Positive Listening</td>
<td>This course is based on the Introduction to Counselling Course run by Weston College, but without assignments and with a greater emphasis on the opportunity to practice conversational and listening skills.</td>
</tr>
<tr>
<td>Stress Management Course &amp; Workshop</td>
<td>This course and workshop provided the participants with the opportunity to learn different techniques to manage their stress.</td>
</tr>
<tr>
<td>Tuesday Multi-Sports</td>
<td>This group runs from a local school with a sports centre attached in the evenings. There are a variety of sports available including badminton, use of the cardio-vascular training and weight resistance machines and occasional use of the trampoline and climbing wall.</td>
</tr>
<tr>
<td>Jewellery, Arts &amp; Crafts &amp; Glass Painting Groups</td>
<td>These groups have provided people with the opportunity to learn the new skills The group aims to help concentration, promote personal achievement and self esteem and provide a social environment with low level mental ill health. Volunteering is an important element for some of these groups.</td>
</tr>
<tr>
<td>Dance Fever</td>
<td>Dance Fever is a group that enables users to build fitness through simple dance to a variety of music. They have gradually learnt new routines based on different themes such as Bollywood, cheerleading and burlesque.</td>
</tr>
<tr>
<td>Keep Fit to Music</td>
<td>Keep Fit to music is an exercise session to music that includes aerobics, yoga based stretching and relaxation including guided visualisation.</td>
</tr>
<tr>
<td>Gardening Group</td>
<td>The gardening group is a group of volunteers who have taken responsibility for a small area of the side garden and keep it tidy, planted up and regularly watered.</td>
</tr>
<tr>
<td>Drop In</td>
<td>The Drop In was set up to offer emotional, social and practical support to people with low level mental ill health. It is jointly run by a staff member, a local volunteer and two Samaritan volunteers who offer confidential advice.</td>
</tr>
<tr>
<td>One-to-one Work</td>
<td>People refer themselves or are referred to the one-to-one service for a wide variety of reasons including low mood, anxiety, stress, practical difficulties in relation to finances and housing, relationship issues and difficulties with parenting. The support offered varies from assessment and signposting to longer term listening support.</td>
</tr>
<tr>
<td>One-to-one work (Health Trainer)</td>
<td>The health trainer works with people who want to make changes in their lifestyle such as losing weight, increasing their exercise levels or giving up smoking. This includes setting up SMART goals to help people to recognise their own ability to make changes.</td>
</tr>
<tr>
<td>Support to Stop Smoking</td>
<td>The health trainers have provided weekly one to one support sessions for people who want to stop smoking. In addition three 6 week groups have been run, in which those attending offer one another peer support as well as the smoking replacement therapies.</td>
</tr>
<tr>
<td>Massage</td>
<td>The massage therapist offers 30 minutes of massage or reiki to people with a variety of physical and mental health problems including back pain, depression following bereavement and poor anger management.</td>
</tr>
<tr>
<td>Lunch Club</td>
<td>The project took over the running of the lunch club in November 2009. It is a long standing community group providing lunches for older people. A minibus is available to transport people to the centre and home again. As well as providing hot, nutritious</td>
</tr>
<tr>
<td><strong>Saturday Group</strong></td>
<td>meals it is also a social activity group with weekly bingo sessions and occasional outings.</td>
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<tr>
<td>-----------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Volunteering</td>
<td>The project has a range of volunteers who chiefly do driving, support groups and work in the second hand shop. All the volunteers are supported by the volunteer co-ordinator/community liaison worker who provides regular supervision. The aim is to ensure that all the volunteers get a sense of purpose, achievement value from their volunteering experience.</td>
</tr>
<tr>
<td>Emergency Provisions</td>
<td>This is a service that provides emergency food for people who have none and have no money. The largest group to benefit from this is people experiencing difficulties with their benefits, may be when making a new claim or after a move. The project also provides supports to young people who are in supported accommodation. Another large group of people who receive this support are single homeless people and this has provided a way of engaging with them and encouraging them to access other services.</td>
</tr>
<tr>
<td>Health and Wellbeing Course</td>
<td>This course was run jointly with Weston College and offered a level 1 and 2 English course with health and wellbeing. Those attending were given the opportunity to discuss and learn about nutrition, exercise and relaxation.</td>
</tr>
<tr>
<td>Theatre Orchard</td>
<td>The project worked alongside a community theatre group to develop a community drama group. The aims of the group were to create community cohesion, to increase the confidence of participants involved and introduce them to performing arts.</td>
</tr>
<tr>
<td>Dad’s Group</td>
<td>This group is run alongside the local Children’s Centre and is aimed at fathers of children under 5 years. It runs fortnightly during the school term time and enables fathers to meet socially and to share experiences and knowledge.</td>
</tr>
<tr>
<td>Stepping Stones Group</td>
<td>This is a volunteer run social group, which was developed by a local resident as she felt there were a number of young families who would benefit from social activities with a structure for the children. The group members provide lunch and they ensure that there are activities for the children.</td>
</tr>
<tr>
<td>Swimming group: women size 16+</td>
<td>This group was requested by several women who did not feel comfortable attending the other exercise groups we run. The service is funded through the “Cheque Book” Scheme run by the sports development team at the local authority. PWP provides transport.</td>
</tr>
<tr>
<td>Walking Group for people with Diabetes</td>
<td>This group was set up jointly with the Practice Nurse at the GP Practice for patients with unstable type 2 diabetes. The majority of those attending are men aged between 50 and 70, a group whom we have found it more difficult to engage and the group offer one another a high level of peer support.</td>
</tr>
<tr>
<td>One off projects</td>
<td>PWP supports groups to take part local fundraising events that promote physical activity and social support for individuals who are on low incomes, have low levels of activity, health problems or disabilities. Examples have been: Race For Life; Midnight Beach Walk</td>
</tr>
</tbody>
</table>
Organisation & Project Services

- SWWB Steering Group
- Board
- Director

Clinical Lead

Clinical Services

- Baby massage, Massage, Stop smoking

Well-being worker

- Multi-sports, Dance Fever, Keep fit to music,
- Gardening, Swimming, Walking groups, One off events like Race for life
- Drop-in, Saturday group, Dads group,
- Positive listening, Stress management, one to one

Service Development/Project

Finance/Resources

Facilities and support services
**Target Beneficiaries**

PWP’s services have been directed towards the residents of South Ward, an area of multiple deprivation. They are people living in a deprived community whose mental health is adversely affected by their social, economic and family situation, compounding the difficulties they face.

The project has aimed to work with 1,500 people over the three year period.

**Performance: Outputs and Outcomes**

The project outcomes have focused on:

- Improved wellbeing for people living with issues affecting mental health in South Ward;
- Positive mental wellbeing for residents of the area;
- Additional options and services for people experiencing low level mental health difficulties; living within the area.

After 30 months of the 36 month project:

- The project has run 25 courses and 7 one off events;
- 655 people have used the activities and services provided by the project;
- Approximately 15 have been seen people each week on a one to one basis;
- 139 people have used multiple activities.

FAHLC uses a standard SWWB programme registration form to collect details of core beneficiaries. Analysis of this registration information provides the following project statistics:

- The modal age range of project beneficiaries is 16-20 years of age (SWWB 30-35 years of age)
- Percentage of males: 24.9% (SWWB 31.4%)
- Percentage of self-defined ethnicity of white: 91.9% (SWWB 92.7%)
- Most popular way of hearing about the project: Word of mouth (SWWB Word of mouth)
- Percentage referred by a health professional: 23.9% (SWWB 18.8%)
- The number of beneficiaries in employment: 19.2% (SWWB 33%)
- Number of beneficiaries who own their own home: 19.6% (SWWB 43.5%)
- The number of beneficiaries self-defined disabled: 12.7% (SWWB 9.4%)

Outcomes reported by the project team have been:

- Improved social networks for many users including development of problem solving skills and peer support;
- Greater community cohesion;
- Increased exercise with the related physical and psychological benefits,
- Social inclusion, improved communication and crisis management skills;
- Reduced medication.
These outcomes are reported to the project team through a range of methods including feedback forms and informal evaluations of activities. Reports from individual beneficiaries show considerable impact on, for example, reduced use of clinical and other services; wider impact on family life; increased use of the centre and the consequent benefits from this; and volunteer confidence in developing and running activities.

Using the standard questionnaire developed as part of the SWWB programme FAHLC collected health and well-being evidence from 22 people. Records were collected at the point of enrolling with the project and then six months later. The findings from this study show improvements in health and well-being across a number of measures. At baseline FAHLC respondents scored an average of 5.29 on Life Satisfaction item. This rose to a score of 6.04 at follow up, which is closer to the UK average score of 7.2. There were also shifts in beneficiaries reporting that they felt happy. The modal response at Baseline was never and at follow up it was on a few days. On the item for feeling depressed the modal response shifted from at least once a week to never. The CESD7 scale for depressive symptoms and the SWEMBS scale for personal well-being both showed improvements that would be statistically significant (p=0.037 and p=p0.052). However the number of respondents was low for a t test (under a recommended threshold of 25).

There were no gains in terms of self-reported physical activity apart from gardening. Thus the number of people reporting that they do three hours or more gardening in a week doubled from 23% to 55%. Whilst the number of respondents was small and therefore need to be interpreted with caution, these findings reflect the qualitative findings reflected in the project case studies in this report and the Year 1 evaluation report.

**Beneficiary Case Study**

Michele is a 25 year old young woman who lives with her family. She was referred to our service by her GP in September 2008 soon after the project was established. She was one of the first referrals to the listening support service.

Michele was referred to the service as she was suffering from very low mood, was self harming, agoraphobic and isolated. She had a history of a difficult childhood and had also been involved in abusive relationships as an adult.

The project worker visited Michele at home and talked to her about the project and what she would like to get out of working with us. Michele’s biggest concern and what she wanted to change was her agoraphobia. She had previously been referred for counselling but had felt unable to keep appointments. Following the initial couple of visits the project worker felt that a specialist service was required to work on her agoraphobia and that PWP’s role should be to support Michele to access the specialist services, something which she has always found extremely difficult. In consultation with the GP a referral was made to the primary mental health service for support for Michele.

In the mean time the project worker started going out for very short walks with Michele, initially
these were just to the gate and then to the first lamp post and gradually increasing the distance by very small amounts. Michele had also expressed an interest in giving up smoking and a referral was made to the health trainer working as part of the project who was able to make home visits to support her.

Over the course of more than 2 years Michele has received support from a variety of services all working together. She has continued to see her GP regularly who monitors her, she has received long term support from primary mental health services that have used cognitive behavioural therapy to help her deal with her agoraphobia and the PWP project worker continued to provide at least weekly support. This support has ensured that she has kept appointments and has helped her to put the CBT into practice at home.

Over time Michele’s agoraphobia has reduced significantly and she became able to come to the centre and have a cup of tea and we then started to introduce Michele to a variety of the group activities that she enjoyed these included the jewellery making class, the dance group Dance Fever and glass painting. With her project worker she has started going out including going shopping, for lunch and to play crazy golf.

As her agoraphobia has reduced Michele has become more self aware and has requested further counselling but feels that she will now be able to access it. The project worker has helped her to find an appropriate counselling service which is affordable for her and has liaised with the primary mental health services to ensure that the counselling is offered at the right time for her. The project worker accompanied her to the first appointment and has now made arrangements for subsequent appointments to be at the Centre so that Michele is able to attend independently.

Michele has made considerable progress over the past two and a half years and the role of the project has been pivotal, acting as advocate and liaison person for Michele, ensuring she gets the correct services that will support her and that there is good communication between all those involved. In addition, we have introduced her to a number of social and recreational activities which she has enjoyed, have increased her confidence, reduced her isolation and given her positive motivation to leave her house.

Processes
During the course of the project FAHLC has adapted the project to work alongside a newly commissioned Primary Mental Health Care service which was not in place when the PWP project plan was devised. The project has also sought to refine its working practices. This has involved discussing and clarifying the model and purpose of one to one work; balancing resources between one to one work, small group and larger group work – comparing the value of longer term, one to one, resource intensive work with the value of larger groups, for example, participating in exercise. Finally the project team have been planning a succession strategy for the project which manages the expectation of users and doesn’t leave them “abandoned”.

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Conclusions

Key lessons
Some of the learning arising for the project team has included:

- The value of increased social networks for service users,
- The value of linking clinical and wellbeing work,
- The value of using this type of project to support the training and employment of local people,
- Offering a wide range of different activities has drawn people in and then given them the confidence to try other activities provided both by PWP and also other local agencies,
- The difficulties of providing activities and services that are sustainable in a short term funded project,
- The value of the health trainer role and how it can be used.

Opportunities for the future
PWP has helped provide a model for the future development of new activities and services in the area. Drawing upon this learning, there are a number of areas where FAHLC is seeking to develop services, for example:

- Development of a social prescribing project in partnership with Positive Step, the local primary mental health service;
- Development of a project to provide Mental Health First Aid courses to the local community;
- Development of a Community Garden;
- Employment of a second health trainer to increase the strength and role of the health trainers.
Pathways to Health

Host organisation: Penwith Community Development Trust.

Location: The former Cornwall local authority districts of Penwith and Kerrier.

Introduction
This report profiles Pathways to Health and Well-being: a project funded by the Big Lottery and local partner agencies.

Project aims and objectives
The project seeks to encourage and enable patients to move away from a culture of self-dependence and reliance on GPs by supporting them to take responsibility for their own health and wellbeing. CHLC Pathways to Health and Well-being project aims to empower and support individuals and families in deprived communities, people who have low level mental ill health and people aged 50+, and assisting them in overcoming barriers to access new pathways of health and well-being.

Background and rationale
CHLC has identified that there are people living in local towns and remote communities who have difficulty accessing health and well-being activities. Working in partnership with GPs and health professionals, the project has sought to promote people’s well-being by supporting them to make positive lifestyle changes through the adoption of health and well-being pathways. This project has provided and developed new connections and sees itself as a central signposting information and support service. As a volunteer organisation, it also harnesses the potential of volunteers to support people to access wellbeing pathways.

CHLC targets deprived communities in the former Cornwall local authority districts of Penwith and Kerrier. In particular, it aims to reach communities through the construction and development of the CHLC website and through the recruitment of volunteers and the provision of wellbeing activities. Volunteers have been supported to act as ‘health heroes’, ‘champions’ or ‘buddies’ and in so doing, the project also aims to improve volunteers confidence and self-esteem.
Host organisation

Penwith Community Development Trust (PCDT) is the lead organisation for Cornwall Healthy Living Centre (CHLC). PCDT was formally established as a charitable and not-for-profit organisation in 1999. The Trust is registered as a company limited by guarantee and is a member of the National Development Trust Association. The aim of CHLC is to provide a vehicle for health professionals, voluntary and community sector organisations and individuals to work together to improve health and well-being and reduce health inequality across Cornwall through active support to a variety of health and community based projects. CHLC represented a merger of the Penwith Healthy Living Network and the Kerrier Healthy Living Centre in 2004. The Trust works mainly in partnership with three key organisations: Cornwall Council, Volunteer Cornwall (VC) and Penwith Volunteer Bureau.

PCDT and VC are the members of the Cornwall Infrastructure Partnership. Through this partnership, PCDT is involved with improving and extending the voice of the Voluntary and Community Sector (VCS) across Cornwall. PCDT leads on the work of Cornwall Inter-Link, which provides effective infrastructure at a local level to enable VCS organisations (especially smaller 'grassroots' groups) to get together on a regular basis in locality areas to network, and share information, resources and good practice. PCDT has been developing the Inter-link Capability Model (ILCM), which will enable organisations to benchmark themselves against specific criteria to demonstrate their capability to deliver high quality services. Also, PCDT also provides Implementing PQASSO workshops to VCS organisations in Cornwall, along with follow-up sessions that support them to implement PQASSO within their organisations.

The VC is positioned within the Cornwall Infrastructure Partnership to provide volunteering infrastructure support for the community and voluntary sector. They help other organisations to recruit, support and develop the volunteers they need to deliver their services. The CHLC Strategic Management Group that oversees the project is made up of representatives from the partners on the project, the Cornwall and Isles of Scilly Primary Care Trust, Pentreath Ltd, a GP from a local partner surgery, the Cornwall and Isles of Scilly Health Promotion Service, Cornwall Works and Cornwall Council. The Strategic Management Group members meet bi-monthly to provide strategic directions, advice and support to the project.

Project area

This project was targeted at people in the former Penwith and Kerrier districts of Cornwall. Overall, their health is close to the English average, but there are particularly high levels of socio-economic deprivation around the communities of Penzance, Gulval and Heamoor in the former Penwith district area and Camborne North and Redruth South in Kerrier. In Penwith, men who live in these most deprived areas have over five years shorter life expectancy than those living in the least deprived areas in the district. In both districts, the number of people receiving incapacity benefits for mental illness is significantly higher than the national average. Other health issues include high levels of hospital admissions in Penwith for alcohol-related issues, while in Kerrier, the number of young people under 15 declaring that they are not in good health is significantly worse than the national average.
Project Design and Delivery

Inputs
In addition to Big Lottery funding £335,698 the CHLC has been supported with funding from a range of sources since its inception. This has included Gap funding from Cornwall Works (£32K). Before the county of Cornwall gained unitary status in 2009, it received funding from the former Kerrier District Council (£30K) and Penwith District Council (£30K). In the past it has also received funding from the Neighbourhood Renewal Fund (£97K), the Duchy Health Charity (£67K) and West Cornwall PCT (£20K). Further support has been received from Cornwall Council (12 hours per week in-kind for Project Manager’s post) and from their partner GP practice Stennack Surgery who provides joint line management support, office costs and admin and the Friends of Stennack Surgery (£3,650). Cornwall and Isles of Scilly Primary Care Trust also provides £20K annually for the CHLC project and £3,550 for the Wellbeing Facilitator Scheme.

Activities
CHLC has developed an active approach to ensuring they can promote local people’s well-being. Much of their work is based around two local volunteer bureaux based in the former local authority districts of Penwith and Kerrier. Key to their approach are the close links they have created and fostered with local GP surgeries. They have established a GP referral scheme, and at two local general practice surgeries a Wellbeing Facilitator now encourages patients to consider alternative activities to improve their health and well-being in a more holistic and proactive way. CHLC’s widely-publicised website and healthy activity database allow the project to access remote communities in this largely rural county.

The GP Recommendation Scheme is central to the project and defines CHLC’s links with the health sector. Known as GP Plus, it has created opportunities for GPs to refer patients to lifestyle/exercise/well-being activities. Now, local GPs in seven surgeries can also refer patients online. Additionally, the project’s website (accessible from GP surgeries) has enabled individual clients to discover a range of activities or opportunities available for healthy living. Those seeking new pathways can access over 200 well-being activities and organisations from their Health and Wellbeing database. This was jointly developed with Cornwall Council and re-launched in July 2010 at a celebratory partnership event. As an extension to this early work, CHLC also works with GPs at Stennack Surgery and Bodriggy Health Centre to signpost patients to activities that support patient well-being. Between them, they have 23,232 registered patients. With the support of a Wellbeing Facilitator based at each surgery, patients are encouraged to try activities to improve their health and well-being, ranging from training and volunteering to sailing and swimming.

The project has additionally hosted and supported a range of wellbeing activities such as lifestyle mentoring/coaching, self-esteem, life skills and confidence training, counselling, volunteering, physical activities/exercises and healthy eating/cooking events. This programme included complementary health sessions up to October 2009 and a free counselling service since February 2009. This is delivered in partnership with Cornwall College and sessions are provided by student counsellors studying for the Diploma in Person-Centred Counselling and Therapy. This service is free or available at a low cost to people on low incomes. These services were initially delivered solely…
from the Penwith Centre in Penzance, but CHLC now also provides sessions from a library and two children’s centres. During the summer of 2010 CHLC worked in partnership with the NHS and community organisations to deliver an annual summer programme of sports taster sessions for people with mental health problems.

As a volunteer service the project has also been able to harness resources from volunteers to support vulnerable people in the community. The *Wellbeing Volunteer recruitment programme* enables CHLC to offer a range of support to people in need, as well as provide new opportunities and challenges to volunteers.

**Organisation and Project Services**

**Target beneficiaries**

There are two groups of direct beneficiaries. Firstly, there are people who are referred onto the project, including participants who are deprived, disadvantaged or socially excluded, on low incomes, have low mental ill health or low levels of confidence or self-esteem, and those who are overweight. Secondly, beneficiaries include volunteers who have been identified by the project or
CHLC’s partners and recruited as champions and/or buddies providing direct participants with a network of support. These champions were largely recruited through project partners, the Penwith Volunteer Bureau and the Volunteer Cornwall. The indirect beneficiaries included contacts with close links to direct beneficiaries, and one-off contacts who may have attended an organised community event or people who log on to the web-site or receive a newsletter.

Performance

Outputs
The initial project plan sought to work with 885 direct beneficiaries and 345 indirect beneficiaries. To date the project has considerably exceeded this target:

2432 beneficiaries have taken part in activities based around

- Healthy eating (687)
- Mental health (1740)
- Physical activity (480)

CHLC uses a standard SWWB programme registration form to collect details of core beneficiaries. Analysis of this registration information provides the following project statistics:

- The modal age range of project beneficiaries is 30-35 years of age (SWWB 30-35 years of age)
- Percentage of males: 29.8% (SWWB 31.4%)
- Percentage of self-defined ethnicity of white: 96.6% (SWWB 92.7%)
- Most popular way of hearing about the project: Word of mouth (SWWB Word of mouth)
- Percentage referred by a health professional: 9% (SWWB 18.8%)
- The number of beneficiaries in employment: 31.9% (SWWB 33%)
- Number of beneficiaries who own their own home: 59.6% (SWWB 43.5%)
- The number of beneficiaries self-defined disabled: 8.4% (SWWB 9.4%)

Perhaps the greatest success of the project is CHLC’s aspiration to be at the forefront of developing a wellbeing programme in situ at two GP surgeries and encouraging GPs to think about alternative approaches to tackling their client’s wellbeing needs.

The project’s website, which includes a 200+ activity/organisation database has proved a great success. Initially locally focused, it was launched county wide in July 2010 at a celebratory event attracting over 100 partners. The initiative is attracting a lot of interest and remains a potential beacon for other voluntary and community sector organisations serving remote, rural, communities.

The project initiated and developed exciting taster day sessions for their target communities, where a broad range of therapies and activities have been offered, including reflexology, Indian head
massage, reiki, Bowen therapy, aromatherapy, Emotional Freedom Technique, counselling and massage. These were enjoyed by beneficiaries not simply because of the degree of skill of the practitioners, but because they showed a degree of commitment and passion for taking complementary therapists into deprived communities where no previous opportunities for such therapies had ever existed before.

A broad range of activities have already been initiated and developed by the project. Even with limited time left on the programme, CHLC anticipate that they will expand their counselling service and complementary therapies and support new additional sessions in Tai Chi, Healthy Eating and Keep Fit classes.

**Outcomes**

Using the standard questionnaire developed as part of the SWWB programme CHLC collected health and well-being evidence from 84 people. Records were collected at the point of enrolling with the project and then six months later. The findings from this study show improvements in health and well-being across a number of measures. The number of people reporting that their health was either very good or excellent over the previous week increased from 31.8% at the start of their involvement in this project to 67.8% at the end. One participant reports giving up smoking and there were also reported improvements in the number of people walking for three hours or more in the previous week (53.6% to 58%). Also, the number of people reporting that they do three hours or more gardening in a week doubled from 16.4% to 31.3%. The number of people reporting that they felt ‘lonely everyday’ declined by 48% following engagement with the project.

Overall 53% (n=42, missing data 1) report improved personal well-being. For mental well-being we condensed seven items from the questionnaires to develop scores on the Short Warwick Edinburgh Mental Well-being Scale (Short WEMWBS). There was a statistically significant (p=0.002) increase in reported baseline (M =22.19, SD 5.6) to follow up (M=24.73 SD 5.4) t (83) =-3.94. The mean increase in mental health scores was 2.54 with a 95% confidence level of -4.14 to -0.953. The eta squared statistic (0.04) indicated a small effect size.

**Wider impact**

The biggest impact of the project is that the partnership that has been developed between local GPs and the CHLC has led the project to work together to apply to the Department of Health’s Third Sector Investment Programme for further funding to sustain their work with the well-being worker. Those involved consider their approach to be sufficiently innovative that they would like to find more funds to expand their person-centred, preventative and joined-up approach to delivering healthcare services in Cornwall.

The project has learnt from a local GP practice that patients have on average 10 minutes consultation time with their doctor, which is insufficient to deal with individual patients’ health needs, and in particular, those with complex social and health issues. Learning from the complexity of their client’s needs, they continue to broaden their services to improve people’s well-being.
The project’s philosophy of encouraging patients to move away from a culture of dependence on GP services is bold, in that they seek to transform the dynamic between those in need and the wider healthcare system. Interviews with volunteers who have taken on new roles and support within this project are effusive in their praise of the personal rewards and health benefits they have enjoyed since being involved with the Pathways to Health and Well-being project and helping others.

CHLC has been very successful in developing close links with partners across Cornwall. Their conference in July 2010 to launch the updated website saw over 100 attendees from a range of organisations including the local authority, the health service, two universities, several third sector organisations, education and business.

The new economics foundation and the Centre for Local Economic Strategies, who are undertaking the nationwide evaluation of the Big Lottery Fund Well-being programme, are seeking to include this project as an example of good practice.

The success of the website with its intention to reach remote communities cannot be underestimated. It attracted 20332 hits in August 2010; more than any other project in the South West portfolio.

There have been increasing calls from other agencies and third sector organisations to roll out CHLC’s well-being activities across the county.

**Conclusion**

**Key lessons**

Having volunteers at the centre of service delivery is challenging. Training and supporting volunteers takes a lot of time and limits the amount of capacity that can be developed and sustained. With funding only available for three years, insufficient time is available to fully utilise the resources that volunteers offer. The first year of the project was about development, recruitment, planning and making links, which leaves only two years for delivery and finding funds to sustain innovation. Attracting funding to sustain the work is extraordinarily hard. Funding from the two previous district local authorities has ended, making the future seem less certain.

Maintaining and developing partnership working with the voluntary sector is also extremely challenging. Despite this, the project has embraced partnership working and has viewed the opportunities provided by Big Lottery funding as an important opportunity to embed their ideas about well-being and working with GP practices at the core of their business.

The free counselling service started with four student counsellors and has now grown to nine. This service has offered a practical solution to delivering support to vulnerable people with diverse problems. It also offers support to people facing severe financial constraint and therefore reaches very challenging well-being issues. However, the range of issues that different clients bring to
counsellors reminds the project of the challenges they face and how much work and support is needed.

This project has chosen to be challenging. In their development CHLC has discovered the difficulty of getting some GPs to focus on a broader definition of well-being that embraces ideas that are broadly accepted by the World Health Organization (1947) as essential for well-being namely: physical, mental and social health.

**Opportunities for the future**

The project remains ambitious, and aims to roll out its activities across the county now that Cornwall has moved to being a unitary authority.

It is the clear intention of CHLC to maintain and review the database and website to be a key signpost service to people in the future.

The project continues to actively search funding to sustain the Well-being Facilitator scheme, and they continue to plan to roll out the approach to other GP surgeries in the county.

The project and CHLC will continue to support a culture shift in GP services to address well-being using a multiplicity of approaches.

The project has learnt that it is dealing with diverse well-being problems, ranging from abuse to loneliness, and it continues to foster joined up partnership working to ensure that statutory and third sector service organisations address people’s well-being needs.

**Beneficiary Case Study**

**Bernie and Rosalind: Well-being for clients and volunteers**

The Penwith Volunteer Bureau (PVB) provides over 400 different volunteer opportunities. Potential volunteers often drop into the bureau. But they can make contact through the PVB website or can check out volunteering opportunities on line search engines like: [http://www.do-it.org.uk](http://www.do-it.org.uk). Current postings include calls for: beach watch volunteers, bereavement volunteers, leukaemia care charitable collectors, needle exchange receptionists etc. Potential volunteers may wish to be part of the Penwith PALs project; a project which started in 2006 and receives referrals from across the county. Referrals have been received from adult social care services and other professionals like community matrons. The project is primarily a befriending service that supports elderly people who live alone and who feel isolated. Cornwall has a high retired population. 22.9% of the population are
of pensionable age (UK 20.3%) which is primarily due to its rural and coastal geography increasing the county’s popularity as a retirement location, and the emigration of younger residents to more areas with greater education and employment opportunities. Thus the befriending service is becoming vital to those who particularly live in smaller, remote locations. Volunteers visit regularly and offer befriending support which can extend to offering transport to visit GPs or hospitals, DIY, gardening or shopping. Over 150 older people annually have been supported by this project including Bernie whose wife passed away two years ago. A retired teacher he has enjoyed the support that volunteer Rosalind has bought to his life. Rosalind is also a retired teacher who responded to an advert for the project in the local newspaper the Cornishman. They usually have coffee, but can do crosswords together and engage in philosophical conversations. Bernie particularly enjoys discussing current affairs but the benefits gained from the befriending service is mutual:

Bernie: I don’t know how I would have got by without it because I have lived a lonely existence and this has sheltered me from the worst agony of that existence

Rosalind: It has brought a great friendship, a lovely new friendship which I wouldn’t have had if I hadn’t been introduced to the voluntary service...and I know that this is a mutual thing because we enjoy each other’s company.

Bernie: Loneliness is a very common disease in this world. And so all those people who suffer from it could be benefitting from some similar parallel experiences. It is something that works magnificently well.

Reference

Cornwall Council (2009) Cornwall Heritage and Culture Strategy Appendix B: Cornwall: the Economic and Socio-Demographic Context

Step by Step project

Host organisation: Cornwall and Isles of Scilly Health Promotion Service

Location: Cornwall

Introduction
The Step by Step project aimed to promote the engagement of local people in health and well-being activities through a combination of community group development and one-to-one support. It aimed to empower individuals at risk of poor health through promoting personal confidence to take their health and well-being as a personal responsibility therefore engendering a desire to change.

Project aim and objectives
At the onset of the project it aimed to work with forty community groups utilising a strategic network of statutory and voluntary and community sector providers. The Step by Step project targets areas with higher social deprivation in the four former local authority districts of Cornwall: Carrick, Restormel, Caradon & North Cornwall.

Objectives
The initial aim of the project was to develop a community centred approach through work with community groups to reduce health inequalities. One worker provided one-to-one support for people in need aiming to empower and encourage clients to make changes in their lifestyles. The other worker concentrated on community development work. At the community level the project aimed to target people in 40 community groups and work collaborative with them. The project aimed to develop contacts in the strategic network of statutory and voluntary providers to cover areas across the county and extend their work to address the LAA health inequality targets discussed above.

Thus key aims were:

- Promoting the engagement of local people through community development and a holistic foundation intervention approach
Empowering local communities through personal confidence to take their health/well-being as a personal responsibility engendering a desire to change

Project design and delivery
The Step by Step project’s ethos developed through previous local work primarily with the Eatsome and LEAPActive projects. LEAPActive worked throughout the county utilising activators to encourage people to become physically active. It was aimed at two target groups - young people aged 11 - 16 years and older people aged 50+ - and provided activities to promote well-being and ensure participants had clear exit routes into sustained healthy activity. The Eatsome Project delivered a range of healthy eating activities with children and young people. It also promoted healthy and active life amongst older people. These initiatives suggested that more work was required to encourage sustained activity beyond the completion dates of the projects. The Step by Step approach drew upon this learning to develop an integrated package that had three levels of delivery:

- One-to-one motivational services for people deprived, disadvantaged or socially excluded; on low income; with low mental ill health; have low levels of confidence or self esteem or are overweight. These services were based upon a Health Trainer model that has been extensively piloted locally.
- Volunteers were to be supported to act as champions or heroes who then cascade informal health promotion through their social networks.
- Local community groups were to be supported through a small grants scheme to meet things like basic running costs, marketing, accessibility and so forth.

It was anticipated that these three forms of engagement were linked in a community development cycle. For example, some individuals may become health champions, who would then help develop community groups, which in turn provide a resource for new target participants. The project was intended to be delivered by a Well Being Worker and the Community Health Development Worker (CHDW) who coordinate their individual level and community level behaviour change work.

Host Organisation
This project is hosted by a statutory sector organisation: the Cornwall and Isles of Scilly Health Promotion Service (CIOSHPS). Their Healthy Living Initiative developed from 2002 as a department within CIOSHPS. Working alongside a Health Action Zone it specifically aimed to support innovative approaches to engage with local communities with high levels of deprivation to empower local people to take an active part in the regeneration of their area through community health development. Internal changes within the CIOSHPS saw the approach retained but repositioned within the Health Inequalities Community Health Development section of the service. CIOSHPS has delivered successful projects through various funding streams including: New Opportunities Funding, Health Action Zone, Neighbourhood Renewal Funding. The Healthy Living Initiative had over a thousand network members.

The Step by Step project is clearly linked to local public health priorities. CIOSHPS has been committed to delivering on LAA targets to reduce health inequalities. The steering partnership for
the LAA was the Healthy Neighbourhood Partnership which grew out of the county’s LSP that included the County Council, the (now former) District Councils, members of the public, voluntary and business sector partners. The County Council held grants received for delivery of the LAA. It was also responsible for their payment to outcome leads, for ensuring that spending on each outcome meets the eligible criteria for each grant and for the monitoring of the performance of each outcome. There were 22 outcomes in the LAA tackling barriers to enjoying the best quality of life. The three year agreement established in 2006 which helped to inform the development of this project aimed to provide additional momentum to transform local public services by promoting the building of joint working over the subsequent three years to provide clusters of service provision tailored to meet the needs of natural geographic communities. One role of Step by Step is to specifically work with local groups to develop an understanding of local health needs.

When the county moved to unitary status in 2009 the Cornwall Strategic Partnership (CSP) started considering the adoption of four long term areas for action as part of its long term strategy to develop and sustain the county. CSP has suggested that one long term strategy (Long Term Strategy 3) should be Good health and wellbeing for everyone: To make it easier for people to lead healthy, active lifestyles and to get involved in their local community (Cornwall Strategic Partnership, 2010). The partnership’s second long term strategy of building community resilience to future challenges (LT2) suggests that CIOSHPS and the ethos behind the Step by Step project will continue to be relevant in future years.
Project area
Cornwall is characterised by small towns and remote communities. 46% of the county’s population live in dispersed settlements of less than 3,000. It has a demographic skew towards the elderly with 26.1% of the resident population aged over 60 compared to an average in England of 20.8%. Anecdotally there is evidence that younger people consider moving from the area to enhance their training and to access improved employment opportunities. Each of the four former districts targeted by this project faced specific issues that pose different health challenges e.g. the former district of Carrick has a higher rate of households in temporary accommodation than the English average. This is seen as a key issue affecting well-being in Carrick (SWPHO, 2008).

Whilst overall statistical indicators show low social deprivation and health poverty for the former target districts, there are pockets of deprivation in Carrick, Caradon, North Cornwall and Restormel. Each former district scores better than England as a whole on all estimated adult lifestyle indicators: smoking, binge drinking, healthy eating and obesity; as well as physical activity for adults and children. However the county as a whole performs badly on smoking during pregnancy indicators which are significantly worse than the rest of the country. The former district of Carrick has significantly less physically active primary school aged children and in Restormel the healthy eating habits and lifestyle in adults is a cause for concern (SWPHO, 2008). Recent data also suggests that Cornwall as a whole has significantly worse than the English average of people claiming incapacity benefits for mental illness (Department for Health, 2010).

Project design and delivery

Inputs
In kind match funding came from Cornwall and Isles of Scilly Health Promotion Service (£10242) and Cornwall Centre for Volunteers (£2560).

Activities
This project has created two staff posts: A Community Health Development Worker and a Well-being Worker (with a Health Trainer approach) who were encouraged to provide support and encouragement to empower people to make positive changes in their own lifestyles. This was in line with the Choosing Health (2004) White Paper, which set out plans to develop a new public health work force in the form of Health Trainers charged with helping people to help themselves through support from and advice. Health Trainers were specifically employed to support people in the geographical areas of higher health inequalities and it was suggested that they could help a client to identify their barriers to living a healthier lifestyle. Thus they encourage clients to identify where they need the help and support. Techniques used to assist clients were things like establishing SMART goals and monitoring success.

The CHDW supports the Well Being Worker to provide a more holistic approach. However the work of the CHDW was to deliver a community development approach with local community groups supporting them through their development, thus empowering members of local communities. A key aim was to liaise with service providers to ensure the delivery of services is relevant, appropriate
and accessible to local communities. The role also assists in providing ready participants to begin to make changes to their lifestyles.

The third strand of activity was the Community Health Development Small Grant Scheme. This is a way for the Community Health Development Team to give local communities of Cornwall and the Isles of Scilly an opportunity to deal effectively with their own identified needs. The scheme particularly looks to promote social inclusion through projects which can:

- Support community health development through community involvement and participation
- Support community involvement in active recreation and environmental projects
- Promote arts for health within the community

Grants can be up to the value of £300 per application and a typical example from last year was an award to the Rural Community Link Project an eight week arts and craft group directed to people with mental health issues.

**Target Beneficiaries**

The project was tasked with reaching 1500 beneficiaries

- The modal age range of project beneficiaries: 16-20 years of age (SWWB 30-35 years of age)
- Percentage of males: 26% (SWWB 31.4%)
- Percentage of self defined ethnicity of white: 100% (SWWB 92.7%)
- Most popular way of hearing about the project: Word of mouth and GP or other health professional (SWWB Word of mouth)
- Percentage referred by a health professional: 28.6% (SWWB 18.8%)
- The number of beneficiaries in employment: 20.6% (SWWB 33%)
- Number of beneficiaries who own their own home: 49.3% (SWWB 43.5%)
- The number of beneficiaries self defined disabled: 31.7% (SWWB 9.4%)

**Performance**

**Outputs**

Remaining faithful to the health inequalities agenda this project successfully targeted groups of low income families through networking with Childrens’ Centres and schools. The Small Grants Scheme was successfully used to reach out to smaller community groups. The CHDW has built several links in
what is essentially the largest geographical remit of all the projects in the South West Well-being portfolio. The project made or re-established partnership contacts with: Cornwall Neighbourhoods 4 Change, Cornwall Waste Action, Interlink, the former District Councils, Cornwall Funder’s Advisors Network, Registered Social Housing Associations, Sheltered Housing Associations.

Through their partner, the Cornwall Centre for Volunteers, the team developed initially bases in four Cornwall towns which proved to be useful essential network hubs.

The Small Grants Scheme made numerous successful awards to a variety of groups in the including the Cornwall Women’s Refuge Trust for healthy activities for members of the Women’s Refuge, Greenbank Care to provide day trips for the elderly to reduce isolation and the Colourful Women’s Health Group to fund an opportunity to offer different physical activities for BME women. Grant sizes varied from £50 to £300 and up to 30 groups receive awards with each call for applications.

A broad range of health focused organizations and campaigns have benefitted from the development work and support given by the Well-Being Worker and CHDW including: West Cornwall Healthy Living Centre, the Cornwall Centre for Volunteers, Eatsome, LEAPActive, Stop Smoking Service, Cornwall Neighbourhoods 4 Change, BTCV, Cornwall Works and East Cornwall.

The Well Being Worker has become a ‘Jack of all trades’. This is because clients not only need one central point to gain support and access to knowledge and other partners who may be able to help; but they also need to develop a broad knowledge to be able to signpost clients to the specialist support and this can be anything from dealing with health issues through to referrals to legal or housing advice.

Organizations linked to client referral include: Citizens Advice Bureau, Link into Learning, Young People and Family Services, Cornwall Drug and Alcohol Service and local colleges. Over 30 clients have gained employment after working with a HT and many after a considerable amount of time unemployed (See the beneficiary case study)

Many clients have begun volunteering as a result of their contact with the project. For some this can act as a gateway to future employment opportunities for example: For NVQ01 voluntary work acted as a gateway to a paid position at the local children’s centre. For others the act of volunteering is a means of socialising with others and contributing to their local community.

The Well-being worker has supported and offered advice to many clients (more than 26) regarding financial issues, the three main areas covered are:

- Help with accessing benefits
- Debt management advice (signposting, support and in some cases advocacy)
- Help to access funding re: training courses
Outcomes
Using the standard questionnaire developed as part of the SWWB programme CIOSHPS collected complete health and well-being evidence from 40 people. Records were collected at the point of enrolling with the project and on completion. The findings from this study show improvements in health and well-being across a number of measures. The number of people reporting that their health was either very good or excellent over the previous week has increased significantly (p=0.25) from 28.9% at the start of their involvement in this project to 56.1% at the end. Beneficiaries also reported significant (p<0.001) increased life satisfaction from a mean score of 5.41 to 6.59.

For mental well-being we condensed seven items from the questionnaires to develop scores on the Short Warwick Edinburgh Mental Well-being Scale (Short WEMWBS). There was a statistically significant (p<0.001) increase in reported scores from baseline (M=22.20, SD 4.24) to follow up (M=25.1, SD 4.43) t (39) =-5.40. The mean increase in mental health scores was 2.9 with a 95% confidence level of -3.98 to -1.81. The eta squared statistic (0.079) indicated a moderate effect size.

Beneficiaries also report significant gains in feeling optimistic (p=0.036), useful (p=0.046), relaxed (p=0.002) and an ability to handle problems (p=0.027). This tends to validate their claim to feeling happier at the time of follow up compared to baseline (p<0.001); where baseline scores (M=3.17, SD 0.892) to follow up (M=3.76, SD 0.799) t (39) =-3.848. The mean increase in mental health scores was 2.9 with a 95% confidence level of -0.893 to -0.278. The eta squared statistic (0.03) indicated a small effect size.

A survey of the project’s partners revealed that they perceived that the project was rated as excellent (31%) and good (46%) in supporting people’s needs. And they were rated as excellent (31%) and good (69%) in working with local community needs. Partners also revealed that they were generally well informed about the project’s target and priority groups and the aim of the activities delivered.

However, partners reported that they were less well informed about the participant outcomes and how they fitted with local services because they felt that local statutory bodies did not have a good awareness of project services.

The extent of support and impact given to individual clients by the CHDW and the Health Trainer has been extensive and documented. The evaluation team’s recording of client testimonies have not only been demonstrably moving but it illustrates the depth of the problems and needs that clients often present to the project and the considerable resource and skills required of those employed to meet and support client’s onto healthier pathways. The impact of their intervention cannot be underestimated and depth of recipient gratitude has always been substantial.

Wider impact
The Cornwall and Isles of Scilly health Promotion Service were winners of the Local Government Chronicle and Health Service Journal Sustainable Communities Healthy Communities 2009 Award for their work including the Step to Step project.
By being on the project the Health Trainer has been able to network and join other health trainers, health champions and the admin worker in completing their City & Guilds Level III Health Trainer Certificate.

**Processes**
The project’s delayed recruitment and training of the first Well Being Worker (August 2008) and the Community Health Development Worker delayed Step by Step’s engagement with individual direct beneficiaries. In the first year there were no direct activities such as walking groups or exercise classes developed directly under the project.

The project recruited volunteers but did not feel in a position to provide health promotion training to underpin Health Champion competencies. These volunteers instead acted as tended to act as ‘health heroes’: lay advocates for health and personal exemplars of positive behaviour change. However the role of health heroes has initially intended was never fully developed.

The main challenge for the project has been recruitment and supporting the right personnel to deliver the project. The project has rightly sought people who are passionate about helping communities and people to make positive changes to their lives. However issues around health and capacity to handle training and self motivate in the role has seen the project endure change in delivery staff which stymied its early development and ability to reach its full capacity.

The CHDW focus changed over the duration of the project. It was proving difficult to maintain a focus on and build capacity in specific communities so attention switched to helping to support specific groups and individuals with health interests or issues outside the geographically defined areas worked by other Health Trainers.

We have noted that the Step by Step project has the largest geographical remit of all the projects in the South West Well-being portfolio. This poses challenges for resources. The CHDW and the Well-Being Worker can be forced to travel considerable distances to meet clients and offer their support. In the long run this could impinge on the number of cases they are able to respond too.

**Conclusions**

**Key lessons**
The project initially supported one Healthy Living Forum in Caradon to be active in taking on the role of distributing Small Grants. This is one of the few examples across the portfolio of direct beneficiaries engaging in participatory decision making about project spend. Empowering decision makers and supporting their aims is a difficult aim to achieve but further thought needs to be given to development and support if future community based empowerment is considered again.

When staff have been recruited this project has been keen to engage people who are passionate about helping communities and people to make positive changes to their lives. This was more important than recruiting people with a high level of education or previous work experience.
However clearer consideration could have perhaps been given to staff’s capacity to be sufficiently self-motivating to deliver to targets.

**Opportunities for the future**

There is continuing uncertainty about some elements of the strategic direction of local services. The dissolution of district authorities and the movement to unitary status on the 1st April 2009 created a degree of uncertainty. It appears at the moment that the CSP considers *Good health and wellbeing for everyone* to be a key long term strategy to adopt. So although the issue of health inequalities may not be as central the importance of health promotion remains a key policy concern for key services in Cornwall an opportunity that the Step by Step approach could continue to address.

Clearly careful consideration of developing and enhancing the positive work the project has delivered in the community is going to be important to sustain for the future to enable the CIOSHPS to be a vital partner to deliver on CSPs vision of making *it easier for people to lead healthy, active lifestyles and to get involved in their local community*.

It is positive news to hear that the success and impact of the work delivered latterly on the project has been sufficient to encourage the permanent mainstreaming of the two posts into the health promotion service.

The challenges of geography remain an issue. A clear approach to sustaining services in the future and provide equality of spread will require the front line staff to think beyond district lines and address spread in areas where little ground has been made in the past.

**Beneficiary Case Study**

**Eileen  “I felt I had been listened to”**

Eileen grew up in Cornwall but has recently returned back to her routes after living in Ireland and later in London with her husband. She was a victim of domestic violence from a husband who worked for a uniform service. Escaping violence she moved five times in five months. She had always worked all of her life as a manual worker but has recently suffered from a series of redundancies that has left her unemployed. The last company she worked for was a book publisher. Facing a world without employment and violence she escaped back to the world she used to know. On her return she discovered that she suffered from chronic fatigue being unable to exert as much energy as she did in the past. Her family has a history of multiple sclerosis and she feels that she may also suffer. She has managed find some living space in a communal property and but it lacks security. She could not host visitors because a neighbour has made accusations and is abusive to her family and her guests. This has left her feeling extremely vulnerable and has undermined her confidence even more.
Eileen began to suffer from shingles. However, visiting her local GPs she felt that they had little time for her manifold needs and that they lacked sufficient patience and understanding to do anything to tackle her experience of chronic fatigue. She self referred to the Step by Step project and the health trainer who agreed to visit her regularly. The health trainer has offered support around dieting but also importantly also signposting to appropriate services like Domestic Violence support, Housing Services. Eileen says:

*I have felt that no one has been listening to me and no one has given a damn for what I have been experiencing and going through with the abuse and violence and feeling so ill. But with Step by Step I felt that I had been listened too. Basically she (the health trainer) rescued me when I was being bullied by housing and various other agencies. As a single woman you are rarely listened too. Doctors tend to see you as neurotic because they focus on the anxiety depression and give tablets for that without focusing on the real causes. But she did. And even when they don’t seem to be doing much just the listening and time has really helped and it is really important. It is important that they are warm people and really helpful.....If there isn’t anyone out there to offer support like health trainers the most vulnerable in society are really going to suffer particularly in really hard time. So I say a really big ‘thank you’ to projects like this who have literally saved my life.*

Eileen short term goals are to tackle issues around memory loss and keep to her new diet developed by the health trainer taking account of her food intolerances. In the long term she wants to pace herself back into work and avoid suffering from chronic fatigue.
Activate Your Life with a Lighter Weigh to Live

Location: Weymouth & Portland, Bournemouth

Host Organisation: Healthy Living Wessex

Introduction
This report provides a profile of the Activate Your Life project, an initiative funded as part of the South West Well-being programme.

Project Aims
Activate Your Life aims to reduce inequalities in health for individuals and communities in most need through the provision of services. The project adopts a holistic approach to improve physical health for individuals within communities by encouraging positive lifestyle changes. It also seeks to improve mental well-being of individuals and communities by enabling them to reach their full potential. In the wider context, the project enables Healthy Living Wessex to act as a voluntary sector advocate for health promotion in Weymouth & Portland and, in partnership with Health Links (HL), Bournemouth.

Project Rationale
This project fitted in well with the health priorities in each partner’s delivery plans and Strategic Partnership Strategy. It is also supported by the County Sports Partnership Business plan and supports the PCT priorities and health agendas for both areas. The project brought together two recognised centres of excellence in Dorset (Weymouth and Portland, and Bournemouth) which are operating in the most deprived communities in these areas. Both centres are recognised, co-ordinated brokers for the individual, are able to refer and negotiate access to other health and social service where appropriate and are delivering support in motivation, lifestyle change and weight management. They have a record of attracting hard to reach groups through making activities accessible and fun and encouraging further development through the creation of social networks and the promotion of sustainable change. These help those individuals who access the activities to
take responsibility for improving their own physical and mental health. Both run community interventions based on an holistic approach to supporting people, both already manage a portfolio of preventative healthcare services and have partnerships established with other more specialist service providers that beneficiaries of this programme will be able to take advantage of. The ethos behind this project is that there will be a reduction in health inequalities when targeted individuals and communities are enabled to take advantage of local opportunities and make positive lifestyle changes.

**Host organisation**

Weymouth and Portland Healthy Living Project was an initiative established by a partnership of local agencies in 2002. In 2004, the project was one of five Big Lottery funded Healthy Living Centre schemes to be awarded Pathfinder status for its innovative work in this area. In September 2006, the project adopted the new title Healthy Living Wessex (HLW) and was formally incorporated as a company limited by guarantee now established as a not for profit social enterprise.

The project is managed from the HLW offices located within Weymouth & Portland Housing Company head office but the activities are delivered in different community venues within Weymouth and Portland, with Healthlink being commissioned to deliver at the Littledown Centre in Bournemouth (a sports and leisure centre).

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**Project area**

Weymouth and Portland District has concentrations of deprivation with 17% of the district’s population living in areas that are defined as amongst the fifth most deprived in England. Roughly four out of ten people living in the 10% most deprived output areas in Dorset County live in Weymouth and Portland (Dorset County Council 2005).
All districts within Dorset, apart from Weymouth and Portland, have significantly higher life expectancy rate than the national average. Services that address the development and maintenance of a healthy lifestyle have not been very accessible for those most at risk due to the lack of resources in health and social care. However, it was also clear at Healthy Living’s inception that the voluntary and community sector in Dorset generally, and in Weymouth in particular, was under-developed. Links between the voluntary and community sector and local authorities have also been hitherto perceived as quite poor.

In Bournemouth & Poole the Joint Strategic Needs Assessment stated that tackling heart disease and cancer as two major causes of premature death (i.e. before age 75) will contribute the most to reducing inequalities in life expectancy, and all-age all-cause mortality. When viewing the maps of deprivation scores for Bournemouth and Poole, there are clear associations between areas with higher deprivation and higher rates of coronary heart disease. The evidence also shows that the health of people in the most deprived areas of Poole is deteriorating in relative terms and the gap in health inequalities widening.

**Project Design and Delivery**

**Inputs**
The project has been funded £314,947 under the SWWB programme. The project business plan anticipates £15,000 income from weight management courses, lifestyle mentoring and training and £3000 match funding from Bournemouth University.

**Activities**
The project has an emphasis on health, fitness and well-being and family weight management. A holistic approach is used to support people by promoting healthy ageing, and providing preventative healthcare for those at risk of low mental health.

HLW’s activities are delivered in close coordination with the NHS Dorset who commissioned HLW in 2008 to coordinate their ‘Healthy Choices’ pilot which is a weight management referral programme linking the client with commercially available providers such as Slimming World, Rosemary Conley and Weight Watchers. HLW acts as a referral hub where the client is first assessed for their readiness to change and matched with locally available services.

HLW’s Activate Your Life Services consist of the following initiatives:
Family Weight Management Programmes
The family weight management programme consists of 10 courses, 12 sessions/weeks per course per year with 15 families per course. Each course cost includes venue, tutor time (per hour of delivery and development time), use of Physical activity centres, travel and printing and altogether comes to £25 per session per family. It was planned to charge a nominal fee of £25 to families to encourage ownership and commitment to the sessions but not to act as a barrier to engagement. However, this has proved difficult.

Lifestyle Mentoring Sessions
Lifestyle Mentoring is a personalised one to one service which helps people to put their lifestyle goals into manageable action focused steps. Participants are then supported to take their own steps to improve their health. The sessions are led by a Lifestyle Consultant who is someone qualified, and experienced in a variety of behaviour change techniques such as Life Coaching, Behaviour Change Counselling and motivational interviewing. They work with clients on an individual basis to help them to make realistic, sustainable lifestyle changes. These can include one or a combination of becoming more active, eating a healthier diet, losing weight or working on improving mental well being.

Originally, it was planned to charge the average cost of £25 per 6 sessions but this must be measured against the fact that these will be more vulnerable adults. It became clear that the clients did not expect to pay for a service and finally only a commitment fee of £5 was charged. This did not seem to be a barrier to engagement.

Behaviour Change Counselling Training
This is based on 2 x 2day courses for 36 tutors and associated specialist local staff to have Behaviour Change Counselling Technique training from the nationally recognised centre of excellence from Southampton University. This form of behaviour change support has been recognised in the HDA’s review of effective interventions when encouraging increased physical activity.

Target Beneficiaries
The project has sought to deliver 2000 beneficiary outputs for the three programme themes over 3 years. Lifestyle mentoring and Family weight management is intended specifically for people who would benefit from a lifestyle change:

- families for whom and weight management skills would be beneficial
- individuals with low level mental ill health for whom self esteem support/stress management and confidence building would provide a quick response solution and prevent deterioration into serious mental ill health.
- individuals approaching older age (45yr +) would benefit from the development of social networks
- people who have been newly diagnosed with a health condition and whose quality of life could improve, or be positively maintained
- those who are inactive or unfit and those who are isolated by way of age, race, gender, environment or through lack of social networks and skills
Performance

Outputs & Outcomes
Over a 30 month project period 934 individuals have undertaken the programmes. These consisted of:

- 357 lifestyle mentoring clients,
- 566 family weight management clients (286 adults and 280 children under 16 years)
- 11 individual weight management clients

654 adults were asked to complete the SWWB Well-being questionnaire. These included 297 adults undertaking Family weight management and 357 engaged in lifestyle mentoring. Table 1 provides a breakdown of the questionnaire respondents. Of the 488 who completed the baseline, 235 completed the follow up questionnaire – a completion rate of 48%.

Table 1: The HLW Questionnaire Respondents

<table>
<thead>
<tr>
<th></th>
<th>Lifestyle mentoring</th>
<th>Family Weight management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>357</td>
<td>577</td>
</tr>
<tr>
<td></td>
<td></td>
<td>297 adults</td>
</tr>
<tr>
<td></td>
<td></td>
<td>280 children under 16</td>
</tr>
<tr>
<td>Requested to complete</td>
<td>357</td>
<td>297</td>
</tr>
<tr>
<td>baseline questionnaire</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed complete</td>
<td>357</td>
<td>131</td>
</tr>
<tr>
<td>baseline questionnaire</td>
<td>All completed the first questionnaire</td>
<td>Only 1 adult per family completed a questionnaire</td>
</tr>
<tr>
<td>Requested to complete</td>
<td>180 (approx)</td>
<td>286</td>
</tr>
<tr>
<td>baseline questionnaire</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed follow up</td>
<td>104</td>
<td>131</td>
</tr>
<tr>
<td>questionnaire</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The questionnaires were analysed in SPSS using a paired T test. The following results focus on the outcomes for beneficiaries taking part in the lifestyle mentoring course.

Demographic characteristics of respondents
Of the 104 lifestyle mentoring respondents, 83.7% were female. 44% were aged between 51 and 65, and 19% were aged between 66 and 80.

General health
Direct beneficiaries were asked to rate their health on a five point scale at baseline and follow up. The scale showed the 55.8% reported improved general health at follow up. This represented
a significant improvement (t=5.63; p<0.001). Table 1 shows the main improvements were for participants reporting ‘poor’ or ‘fair’ health.

**Table 2: Self Reported General Health in the Last Week (n=104)**

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>2.9%</td>
<td>18.4%</td>
<td>35.0%</td>
<td>33.0%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Follow-up</td>
<td>5.8%</td>
<td>36.5%</td>
<td>37.5%</td>
<td>16.3%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

**Physical activity**

Two measures were used to examine changes in physical activity. The General Practice Physical Activity Questionnaire (GPPAQ) generates a classification from ‘inactive’ to ‘active’. A general physical activity question (Sport England) provides a simple calculation of the extent to which respondents are meeting the 5x30 public health guideline.

Using the GPPAQ, there was a significant improvement in self reported physical activity (t=2.646; p=0.009) in the study sample. Chart 1 shows that on enrolment 22.7% of participants were moderately active or active using the GPPAQ scale. This increased to 30.7% at follow up.

Overall 34% of participants improved their level of physical activity using the GPPAQ scale. A similar proportion increased their level of physical activity for areas not formally included in the GPPAQ calculation. For example, overall 30.8% of participants increased their amount of time they spent walking in the last week.

The general physical activity question produced results with a similar trend to the GPPAQ results. Participants were also asked to estimate days spent engaged in 30 minutes of physical activity such as brisk walking, cycling, sport, exercise, or active recreation over the last 4 weeks. Using this measure, overall 60.4% of participants reported an improvement. Chart 2 shows that the percentage of participants following 5x30 public health guidelines for physical activity increased from 4.8% to 23.0%.

**Chart 1: Changes in physical activity.** GPPAQ (General practice physical activity questionnaire) scale (Percentages, N=104).
Chart 2: Number of days spent undertaking 30 minutes physical activity, such as brisk walking, cycling, sport, exercise, or active recreation over the last 4 weeks (Percentages, N=104).

Healthy eating, weight loss, tobacco and alcohol consumption
Participants were asked to estimate the average daily number of fruit and vegetable portions they consumed, with the aid of guideline quantities. 58.7% of the participants reported eating more fruit and vegetables on completion of the lifestyle mentoring course. This represented a significant increase (p=0.004) in fruit and vegetables intake from an average of 3.9 portions to 4.8 portions. This is almost an increase of 1 portion and brings the participants close to the public health guideline of 5 portions per day.

For the programme as a whole, of the 235 participants sampled there was a significant increase (p<0.001) in self reported average portions of fruit and vegetables consumed from 3.8 to 4.4: a 0.6 portion increase.
From a sub-sample of 133 participants taking part in either the family weight management or the lifestyle mentoring programme additional information on weight was collected. This showed that 76% lost an average weight of 3.17Kg.

- 47 males had a mean weight of 95.9kg at the start of the programme. 79% (n=37) lost an average weight of 3.4kg.
- 86 females had a mean weight of 79.7kg at the start of the programme. 76% (n=65) lost an average weight of 3.0kg.

Weight at enrolment and project completion was measured for a sub-sample of 28 participants taking part in the lifestyle mentoring course. The average weight at enrolment was 102.3Kg and, on average, these participants lost 6.1Kg in weight.

Participants were asked to estimate how many units of alcohol they had consumed in the last week. Ten percent fewer participants reported drinking alcohol on completion of the course (66.7% to 56.3%). Chart 3 shows a significant reduction in the units of alcohol reported being consumed (t=4.62; p<0.001).

**Chart 3: Number of units of alcohol consumed in the last week** (Percentages, N=104).

Ten per cent of participants reported smoking on enrolment. There was no reported change in smoking behaviour on course completion.

*Mental ill health*

Using the seven item version of the Centre for Epidemiological Studies Depression Scale (CES-D), we found that there was a significant improvement in self reported mental health (t=-7.07; p<0.001). Overall, 73.8% of participants reported reduced depressive symptoms (n=96). There was over a 23% fall in the percentage of respondents reporting substantial depressive symptoms from 40.0% at baseline to 16.7% at follow up. These findings can be put in the context of research that finds that
20.8% of general adult population reported substantial depressive symptoms using the same CESD-D scale (NWPHO, 2007).

**Mental well-being: life satisfaction**

Participants were asked how satisfied or dissatisfied they were with their life on a scale from 0-10 where 0 was *extremely dissatisfied* and 10 *extremely satisfied*. Using this measure 68.3% of respondents reported an improvement in life satisfaction on completion of the course. This reflected a highly statistically significant increase a baseline (M=5.0, SD 2.47) to follow up (M=7.1, SD 2.03) (t=-8.26; p<0.001). This measure is a good predictor of wider aspects of psycho-social well-being that can be compared to other survey data. The average scores for the following surveys are:

- SWWB baseline average = 6.1
- BIG Well-being portfolio respondents = 6.6
- UK adult population survey (Defra, 2007) = 7.2

A comparison therefore shows that lifestyle mentoring participants self-reported life satisfaction is below the average for the UK adult population at start of their activities. Following participation in project activities self-reported life satisfaction is similar to the UK average (7.1 compared 7.2).

**Mental well-being: positive functioning and feeling**

Using measures derived from the Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS), we found a significant improvement in self reported mental well-being. Overall, 65.9% of respondents reported an improvement in their personal well-being.

Using the SWEMBS score, this reflects a statistically significant mean increase from 22.6 to 25.2 (SDs: 5.2 & 4.7; t=-5.53; p<0.001). In the context of other studies, Table 2 shows that the percentage of respondents reporting low mental well-being fell by almost 40% (59.2-36.5%) over the course of participating in programme activities. By the end of the evaluation period participants were reporting mental well-being that were closer to the English average.

**Table 3: Mental Well-being scores (Short WEMWBS): comparison between national, SWWB and Lifestyle data.**

<table>
<thead>
<tr>
<th></th>
<th>Mean score (out of 35)</th>
<th>Low well-being</th>
<th>Moderate well-being</th>
<th>High well-being</th>
<th>Bases</th>
</tr>
</thead>
<tbody>
<tr>
<td>England population*</td>
<td>27.7</td>
<td>16.8%</td>
<td>62.8%</td>
<td>20.4%</td>
<td>18,500</td>
</tr>
<tr>
<td>SWWB baseline</td>
<td>23.3</td>
<td>42.4%</td>
<td>54%</td>
<td>3.4%</td>
<td>671</td>
</tr>
<tr>
<td>SWWB follow up</td>
<td>25.5</td>
<td>26.9%</td>
<td>66.9%</td>
<td>6.2%</td>
<td>671</td>
</tr>
<tr>
<td>Lifestyle mentoring</td>
<td>22.6</td>
<td>59.2%</td>
<td>35.7%</td>
<td>5.1%</td>
<td>96</td>
</tr>
<tr>
<td>baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle mentoring</td>
<td>25.2</td>
<td>36.5%</td>
<td>56.7%</td>
<td>7.3%</td>
<td>96</td>
</tr>
<tr>
<td>follow up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* North West Mental Wellbeing Survey 2009
Social well-being

The questionnaire used a series of social capital measures to assess changes in participants’ sense of social well-being. Paired T tests showed significant (p<0.05) positive changes in social well-being for the following measures:

- Perception of belonging to a community
- Personal help form people who really care
- Social interaction with friends and relatives
- Help from people in the local area
- Satisfaction with local neighbourhood

For example, 24.8% more respondents (25/101) reported that they regularly met socially with friends and relatives on completion of the course compared to enrolment.

There were no significant changes for measures concerning:

- Participation on activities in the local area
- Opportunities to meet people who share similar hobbies or interests

This may reflect the focus of the programme on individual behaviour change rather than group and community participation.

Although we have not made direct comparisons with other study results, the findings clearly lend supporting evidence for the wider social benefits of participating in Healthy Living Wessex’s Lifestyle mentoring project activities.

For Lifestyle mentoring better programme, outcomes appear to be associated with participation in the course of six sessions. The outcomes for participants who attend fewer sessions appear to be less marked.

Beneficiary Case Studies: Lifestyle mentoring

Howard
Age : 65
Start weight : 17 stone 3 (6 ft 3 inches)
End weight: 15 stone 6lb
Weight loss: 1 stone 7lb

Howard referred himself response to newspaper advert for Lifestyle Clinics for men. He initially reported wanting to lose weight and feel more energetic.

Howard initially wore the pedometer to record how many steps he was walking per day and he also completed a food diary. He gradually increased the number of steps he was doing each day and recording his meals and snacks meant he naturally began to reduce his snacks and focused on eating...
only when hungry. He then joined the gym and is now attending twice each week.

**David**
Age: 67
Start weight: 15 stone 8Lb
End weight: 14 stone 08Lb
Weight loss 1 Stone

David self-referred in response to advert for Lifestyle Clinics for men. David initially reported eating the ‘wrong snacks’ and knew that he needed to get more active. He has had both hips replaced.

David wore the pedometer for a week and kept the food diary. He then agreed to increase the number of steps. He started out with a target of 5000 steps and by the end of our meetings he had a target of achieving a minimum of 6000 steps per day, with at least 8000 steps twice each week.

David reported feeling much more aware about which foods he should be snacking on. In fact reducing his ‘treats’ was the main change he reported. He enjoyed feeling less out of breath when he walked and this also increased his confidence about walking more even with his hip replacements. David had also signed up for the Ease into Exercise and continues to attend the classes.

**Additional self reported goals and outcomes**
From a sub sample of 133 participants 58% provided written accounts of their initial goals and 78% reported benefits at the end of the programme. At the outset of the programme, 30% reported that they wanted to address medical conditions or health conditions such as diabetes, rheumatoid arthritis, fibromyalgia, chronic back pain or depression. At the end of the programme participants reported a wide range of benefits that were not recorded through the SWWB Well-being questionnaire. These included the alleviation of pain, greater mobility, improved social confidence, reduced use of medication and improved self image.

For Lifestyle mentoring better programme, outcomes appear to be associated with participation in the course of six sessions. The outcomes for participants who attend fewer sessions appear to be less marked.
Wider impact
The project team have reported the following successes, challenges and key lessons that they have drawn from delivering the project.

Processes

Successes:

- Establishing a good partnership with a local GP Practice in Hamworthy which has shown what is possible with proactive primary care.
- Establishing a Lifestyle Mentoring service within Dorset Bournemouth & Poole as there are no Health Trainers or any Health Promotion, public health services for the public to access in support of lifestyle changes. This service has shown the effectiveness of the approach in these areas. It is a service which has been used by dieticians, diabetics nurses, cancer care and Macmillan nurses as well as GP’s and recently the NHS Health Check service. All are desperate for such a service.
- The development of the Men’s Lifestyle Clinic [see the Good Practice Case Study in this report].

Challenges:

- Maintaining communication and exchange of ideas/progress between the host and the commissioned organisation Healthlink. This worked both ways in trying to keep Healthlink involved with the SWWB Steering group and feeling part of the whole as well as trying to get appropriate information and data back.
- Engaging with local GP’s to refer appropriate people into the service.
- The NHS Dorset Healthy Choices Scheme meant that engaging with people and families within Weymouth & Portland was very difficult at the beginning as the commercial weight management providers have a socially acceptable face and the service is also free. It meant that the team had to cease offering family weight management in Weymouth & Portland and focus on Lifestyle Mentoring.
- Family weight management is a very sensitive issue and the team could not engage with families within Weymouth & Portland effectively as they do not routinely work with parents. With Healthlink working through a sports centre parents felt as though they fitted in with the many others who use the services there. Littledown is a special place having 30 000 people through the doors weekly so to come to use the service did not mark someone out as different hence their ability to engage. The team tried different methods such as groups, one to ones, targeting mums who wanted to lose weight themselves but who wanted to understand how they could help their family as well but all to no avail. The team tried linking with school nurses, with schools directly through head teacher but could never engage sufficiently.
Conclusions

Key lessons

- Make sure there is ownership and support of primary and secondary care for all new initiatives, from the beginning. It cannot be assumed the support will be there based on previous projects experience.
- When partnerships are linked through a contract then it is a business partnership and this should be understood by all parties and the expectations each partner has for each other should be clear from the beginning and documented. Changing a networking relationship to a business relationship is very difficult.

Opportunities for the future

The Director of Public Health is moving into Local Authority management with a ‘ring fenced’ budget. With this reform, the project team envisage that funding for public health will be available to support local community preventative initiatives rather than being drawn upon to fund secondary care overspends.
Lawrence Weston Health Steps

Location: Lawrence Weston, Bristol
Host Organisation: Barrowmead Project Ltd

Introduction
This report provides a profile of the Lawrence Weston Health Steps project, an initiative funded as part of the South West Well-being programme from 2008 to 2011.

Project Aims
Lawrence Weston Health Steps aims to develop a range of group-based and community-led health promotion activities through network of local venues. These activities include befriending groups, cooking classes, allotment-based growing, gentle exercise groups and lunch clubs. The activities are available to all age groups in Lawrence Weston area of Bristol, but have a focus on low-income families, older residents and people with long term health conditions and disability support needs.

Background & Rationale
The Health Steps initiative emerged directly out of the previous work conducted through the Barrowmead Healthy Living Centre. The project draws upon this existing work and acts as one aspect of a wider range of services offered by partner organisations. Whilst the overall outcomes were set out in the initial plan, the project has had some scope for flexibility in terms of the specific activities delivered. This has enabled the project team to pilot activities and allow for community consultation on service development.

Host Organisation
Established in 1999 under the Lottery funded Health Living Centre initiative, The Barrowmead Project arose from a consortium of community organisations operating on the estate. Whilst it has always offered services directly, a key role of the Project has been to act as a fund manager for a range of partnered delivery organisations. The services supported have included:
- cardiovascular exercise
- cookery groups
- generic counselling
- out of school activities
- therapeutic support for people with alcohol problems
- financial support services for people on low incomes
- community transport

South West Well-being portfolio is currently the main source of funding for The Barrowmead Project. The Project does not have facilities to deliver activities from its premises. The construction of a multi-purpose healthy living centre has been part of the organisation’s development plan, but is currently under review. Under the Lawrence Weston Health Steps Project, The Rock Community Centre is both a key delivery organisation and a source of managerial support. This organisation has an established track record in delivering group based social, exercise and creative activities. It runs a lunch club with the aid of its kitchen facilities.

**Project area**
Lawrence Weston is an outer city local authority housing estate in North West Bristol with a population of around 9,000. The area is in one of the top ten most deprived wards in the UK and suffers from high levels of poverty, physical and mental illness, isolation and unemployment. It has high levels of poor health (limiting life long illness 24.2%), a large proportion of older people (41.8% aged 45 years +) and higher than average numbers of people suffering from mental illness.

**Project design and delivery**

**Inputs**
The project has received £335,720 of funding from the SWWB portfolio for three years of project delivery. The project started in February 2008 and will end in April 2011. The project does not have direct match funding, although partner providing agencies – notably the Rock Community Centre – provide low cost venues and support from practitioners and volunteers. The project expenditure is largely apportioned to core staff costs and sessional worker costs.

Volunteers play an important role in the project activities. The project recorded an average 13 volunteers contributing 195 hours per week. Over a period of 141 delivery weeks this amounts to 2,7495 hours of voluntary time. Based upon the national minimum wage of £5.93 per hour, this equates to an economic contribution of over £163,000 towards the project’s delivery.

**Activities**
Accessibility is notable element of the project in terms of the use of multiple local venues, transport and household promotion via a project funded newsletter. This newsletter publicises the activities to all households in the area. It also invites ideas for activities and offers advice and tips on health and well-being. A community minibus scheme subsidises transport to and from activities and is designed
to help beneficiaries who live at distance or have mobility problems. Both of these activities have been delivered and are available to the community as a whole.

Other activities are mainly group-based and, whilst each focuses on either: physical activity, mental well-being or healthy eating, all include social networking as a common theme. Some established activities include a clear role for participants and volunteers in the delivery, although all are led by a salaried tutor or project worker. All activities are free apart from a small fee for the Lunch Club of £2.50 per meal. Activities are summarised in the table below:

Table 1: Activity Summary: Lawrence Weston Health Steps

<table>
<thead>
<tr>
<th>Activity</th>
<th>Providing organization</th>
<th>Status at the outset of the project</th>
<th>Targeting and referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Befriending Group</td>
<td>Fundholder</td>
<td>New activity</td>
<td>Over 50s, focus on socially isolated and/or in poor physical or psychological health</td>
</tr>
<tr>
<td>Lean and Green</td>
<td>Fundholder</td>
<td>New activity</td>
<td>People with learning disabilities. School children. Other interested community members</td>
</tr>
<tr>
<td>Family Cycling</td>
<td>Fundholder</td>
<td>New activity</td>
<td>Families with poor access to cycling and leisure facilities</td>
</tr>
<tr>
<td>Lunch Club</td>
<td>Sub-contract</td>
<td>Development</td>
<td>Over 50</td>
</tr>
<tr>
<td>Gentle Exercise</td>
<td>Sub-contract</td>
<td>Continuation</td>
<td>Open access</td>
</tr>
<tr>
<td>Local newspaper</td>
<td>Fundholder</td>
<td>Continuation</td>
<td>Every household in Lawrence Weston</td>
</tr>
<tr>
<td>Community Transport</td>
<td>Sub-contract</td>
<td>Continuation</td>
<td>People with low access to transport and/or with mobility difficulties</td>
</tr>
</tbody>
</table>

The service costs for project were found to be relatively low. Using the national PSSRU formula, the unit costs for group based activities such as the Lunch Club and the Befriending Group range from £3.20 to £9.40 per session. This compares national figures of £36 unit cost for voluntary day care service session for older people, although it should be recognised that these services are likely to specifically target individual with higher levels of social care needs (PSRU, 2011). Further details on costings were reported in our Adding Value SWWB evaluation report (Jones et al, 2009).
Target Beneficiaries
The project is primarily focused on residents of the Lawrence Weston Estate. A wide range of groups are targeted through the project activities. These groups include older people, people with low level mental health problems or experiencing social isolation, people with long term health conditions and families with young children.

Over the funding period the project aims to benefit 1900 target beneficiaries.

Performance

Outputs
The project is funded to run for 3 years and four months – or 13 annual quarters. Up to the point of the 11th quarter – almost three years – the project monitoring returns show that the team have worked with 912 direct beneficiaries. The project has also engaged with the wider population of Lawrence Weston through its newsletters and contributions to large community events.
The project has maintained a register for beneficiaries who are engaged in group session based activities. Over a two year period the project registered 363 direct beneficiaries. These individuals provided the following demographic data.

- The modal age range of project beneficiaries is 6-10 years of age (SWWB 30-35 years of age)
- Percentage of males: 34.6% (SWWB 31.4%)
- Percentage of self-defined ethnicity of white: 95.2% (SWWB 92.7%)

217 of the 363 beneficiaries were under 16. Of those providing information, the employment status of 146 beneficiaries over 16 year old was:

- 46% retired
- 18% full time/ part time carer for another adult or child
- 16% unemployed/seeking work
- 20% employed

The main types of accommodation reported were:

- 47.9% council or social housing
- 10.4% nursing home/extra support housing/residential care
- 37.5% own home

Of the 146 adults, 13% reported that they considered themselves to have a disability. Whilst we do not have socio-economic data on under 16 year old participants, these are children and young people attending local schools with significantly high numbers pupils eligible for free school meals. Taken together these data suggest that the project has successfully been attracting people from lower income and more socially disadvantaged groups.

Tables 2 and 3 show that personal community networks and the project newsletter are important routes for finding out about the project activities. The tables also highlight the role of practitioners in local partner agencies in signposting or referring individuals to the project activities. These findings confirm the Year 2 evaluation report on the importance of the project for local agencies – particularly in the adult health and social care sectors (See Jones et al, 2010).
Table 2: How did you hear about the project activity? Adult beneficiaries

<table>
<thead>
<tr>
<th>Source of Information</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Word of mouth</td>
<td>22</td>
<td>15.1</td>
</tr>
<tr>
<td>GP Nurse or practitioner</td>
<td>18</td>
<td>12.4</td>
</tr>
<tr>
<td>School, children’s centre, nursery</td>
<td>3</td>
<td>2.1</td>
</tr>
<tr>
<td>Newspaper, newsletter, poster, leaflet</td>
<td>44</td>
<td>30.1</td>
</tr>
<tr>
<td>Project worker</td>
<td>46</td>
<td>31.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Website</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Not known</td>
<td>10</td>
<td>6.8</td>
</tr>
<tr>
<td>Total</td>
<td>146</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 3: Who referred you to the project activity? Adult beneficiaries

<table>
<thead>
<tr>
<th>Referrer</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I referred myself</td>
<td>69</td>
<td>47.3</td>
</tr>
<tr>
<td>A GP or other health professional</td>
<td>21</td>
<td>14.4</td>
</tr>
<tr>
<td>Someone working for project</td>
<td>6</td>
<td>4.1</td>
</tr>
<tr>
<td>Other professional or group (social worker, community worker, employment advisor, children’s worker etc)</td>
<td>33</td>
<td>22.6</td>
</tr>
<tr>
<td>Not known</td>
<td>19</td>
<td>13.0</td>
</tr>
<tr>
<td>Total</td>
<td>146</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Well-being outcomes

As part of the programme study on well-being outcomes a sample of 52 beneficiaries completed the SWWB Well-being baseline and follow up questionnaire. The beneficiaries sampled were mainly older retired people who lived on the Lawrence Weston estate. Of the respondents:

- 70% were retired
- 68% were over 65 years old
- 80% of the respondents were female
- 45% lived in council housing, social housing or extra care supported housing
- 40% were living alone
- 10% of reported that they were disabled and/or were entitled to disability benefits
These individuals all participated in a combination of community based activities consisting of a befriending group, gentle exercise and/or a dance group, and a lunch club. All the groups were social activities and over half of participants took up the opportunity for community transport from their homes. Some participants also took part in additional health and well-being sessions such as podiatry as an add-on to the group based activities.

About one third (35%) had been referred to the activities by professional in health care, social services or community/voluntary sector. According to the project staff these were more likely to be individuals who vulnerable to isolation and to have higher levels of health and social needs. However less formal community networks played a part: 41% reported that they had also heard about the activities through ‘The Local’ newsletter.

Project workers, practitioner in partner agencies, volunteers and peers encouraged the new participants to come to the activities of a weekly basis. Participants completed a baseline questionnaire at the outset of joining an activity then at a point approximately six weeks later. Out of 70 individuals approached 58 agreed to complete the baseline questionnaire and of these 52 completed the follow up questionnaire.

A paired sample T- test of the baseline and follow-up questionnaires showed positive changes for the following outcome measures:

- Overall life satisfaction (t=-2.784, df=50, p=0.008)
- Feeling happy or contented (t=3.045, df=51, p=0.004)
- Feeling engaged or focussed (t=3.913, df=50, p<0.001)
- Feel life is an effort (t=2.841, df=51, p=0.006)
- Feel useful (t=-2.466, df= 51, p=0.017)
- Feel dealing with problems (t=-2.034, df=51, p=0.047)
- Thinking clearly (t=-2.761, df=51, p=0.008)
- Feeling close to other people (t=-3.821, df=51, p<0.001)
- Attending activities on the local area (t=-7.717, df=49, p<0.001)
- Short Warwick Edinburgh Mental Well-being scale (t=-3.125, df=51, p=0.003)

The results suggest that participation in Lawrence Weston’s Health Steps community based activities is positively associated with improvements in personal well-being, social well-being and mental health for older people. For example, for the 52 respondents:

- 43.1% reported improved overall satisfaction with their life
- 481% reported improved personal well-being
- 39.2% reported reduced depressive symptoms
- 10% reported improved general health in the last week

These outcomes reinforce impressions provided at the First Year Evaluation (Jones et al, 2009) which suggested that the activities targeted at older people particularly at the Rock Centre were positively
valued by beneficiaries and well regarded by partner agencies (see case study example in boxed section). However, the findings do need to be interpreted with caution given the small sample size and the possibility of self selection of the respondents.

**Beneficiary Case Study**

**Edna**

SWWB activities are proving very popular with older people in Lawrence Weston. People like Edna have found that, together, the different activities can play an important part in their lives. A major worry is the making sure that newcomers also have a chance to become involved.

*When I found out that it was open for people like me, I started coming to the lunch club. I have nothing but good to say about it. For £3 I think it’s whole lot more. You couldn’t get such good value anywhere else. But I think I’m the awkward one! I need a special cup because my hands shake so much.*

I’ve been going to Tidy Toes since it started [at the same venue]. A lady puts on the music and makes the place nice. She massages your feet then trims your toe nails. It’s a service that’s really needed. I’ve had rheumatoid arthritis for a while now. My right wrist has it badly so I can’t look after my feet at all. I’ve been twice now so I think I’ve had my share for now so I’ll wait. You can’t get seen down at the hospital because they’ve only got space for people with diabetes.

I’ve been going to the Befriending group for over a year. I had a fall before Christmas so it has been difficult for me to get out and I do live on my own. It’s been lovely getting to know new people. There are so many people wanting to go to Befriending that now people have to move on- but people don’t want have anywhere else to go on to.

**Wider Impact & Processes**

Through the SWWB fund, Barrowmead has been able to continue working alongside its two key partner organisations. The Rock Community Centre, as one key delivery partners has been able, with their venue, to provide classes to the local community along with the Monday Lunch Club. These classes and the Lunch Club have been a much needed resource in Lawrence Weston, and have developed in response to local community interest.

The Lawrence Weston Community Transport Group, as a second key delivery partner has been able to provide the transport to enable members of the community to get to activities. Without this service available to the community many people would be stranded in their own homes, not only can they get to the above activities but also are able through the community transport system to get to much needed doctor appointments, shopping and so forth.
Conclusions

Key lessons
The project’s Befriending service has enabled all the beneficiaries to make gains in confidence and friendship. It’s a way of encouraging people who are nervous, anxious, lonely or isolated to meet together and share their worries and realise by sharing that they are not alone and others are going through exactly the same experiences as them. It helps to raise their confidence levels and make friendships at the same time, which hopefully will carry on long after the funding has ended. The project team feel that there are still many people out there that still need support like this and are working to find more funding to carry on this work.

The Lean & Green Project has enabled people to learn how to grow their own vegetables and fruit while working together as a group and to grow in knowledge of gardening and confidence with one another at the same time.

The Monday Lunch Club has proved to have been highly successful in terms of take up. For the project team it is a valuable weekly event that enables people who are elderly, lonely, isolated, disabled to have a good home cooked meal and also meet and chat and spend time together in a safe environment. The Cub has many referrals from the local Doctor’s surgery, Age Concern, and social care services.

Some of the additional services offered during this current funding situation, have been requested by members of our local community, and the attendance at these services indicate that they have high levels of support.

Opportunities for the future
The project team feel that:

Although there are very few facilities available within Lawrence Weston, the SWWB programme has proved that members of the community appreciate what has become available to them and we have also gained many volunteers to help with delivery of our services. These volunteers have gained a vast amount of knowledge, confidence and a “feel good” factor on how they are needed and can make a difference to their community by their work and support to the projects.
Well Bean Project

Host: Wincanton Community Venture (WCV): The Balsam Centre

Location: Wincanton, Somerset

Introduction

The Well Bean project is a rural outreach project, focusing on improving wellbeing in five settlements in South East Somerset. The project is based at the Balsam Centre in Wincanton, which serves a rural population of around 25,000 people. Some wards in and around Wincanton are in the second least deprived quintile for England however there are pockets of deprivation and it is in these communities that the project seeks to specifically address health inequalities.

Project aim

The Well Bean Project aims to use the medium of food growing to engage families and older people in supporting their dietary, physical and mental health. Primarily focusing on the promotion of fruit and vegetable gardening it seeks to encourage sustainable activities that are accessible in a rural setting with a limited range health and leisure services. The direct participants are families, socially isolated people, people with low level mental ill health and older people. The project operates through five rural settings in south Somerset and intends to address health and social inequalities that exist at a small scale community level. Some of the wider anticipated outcomes include improved personal independence and active participation in community groups and social networks. Through the medium of the project has the aim of improving mental health, raising physical activity levels.
(especially for older people) and improving diet, nutrition and patterns of consumption. It was felt that a one to one approach followed by group activity would be the most appropriate approach.

**Project rationale**

Acknowledging that some people are very unlikely to visit the centre and use their facilities, outreach work targets areas that are characterized by extreme social, cultural and economic divisions; poor transport links and inadequate access to affordable food. Earlier outreach work had shown a need for general mental health support for many people living in the target settlements. It was also clear that a number of potential beneficiaries had difficulties with transport, childcare or logistics in terms of accessing the Centre and would be more able to engage with services offered very locally.

**Host organisation**

Wincanton Community Venture (WCV), otherwise known as The Balsam Centre, in Wincanton Somerset. The Balsam Centre achieved healthy living centre status in 2002 and received capital and revenue funding to improve and extend the centre. This multifunctional base hosts WCV’s Healthy Living Centre, a Children’s Centre for Wincanton and South East Somerset and a base for a health visitor team and a Yeovil College of Further Education outreach team. Private and third sector partners offer additional centre based activities including alternative therapy and pre-school provision and it has evolved into the principal local venue for community and interest groups hosting a social and therapeutic garden known as the Growing Space which started in October 2000. This has received practical support from the probation service and provided young offenders with an opportunity to become involved in the life of the centre. The Centre also hosts a varied range of activities and weekly services including activities for children and family health services. Trilith’s Rural Media charity serves farming communities in Somerset.

At a strategic level the Centre works in partnership with South Somerset District Council (SSDC), South Somerset Health & Well-being Partnership, South Somerset Primary Care Trust and Somerset County Council. It combines all three strands of the PCT’s Health and Well-being programme, meets Somerset’s Local Area Agreement health outcomes (specifically priorities on healthy life expectancy, early deaths from circulatory disease, obesity, promoting physical activity and healthy lifestyles and developing healthier and stronger communities) and SSDC’s corporate plan and Health and Well-being strategy.

**Project area**

The project is based at the Balsam Centre in Wincanton, which serves a rural population of around 25,000 people. This is a rural area of about 70 square miles taking in five main settlements and many smaller ones. Some wards in and around Wincanton are in the second least deprived quintile for England however there are pockets of deprivation and it is in these communities that the project seeks to specifically address health inequalities.
Project design and delivery

Inputs
The project received grant funding of £287,374 from the Big Lottery Well-being fund. This went towards some capital costs and staff costs for specialists in mental health, horticulture, physical activity, volunteering, cooking and sessional workers.

Activities
The project delivers a range of activities including food growing, country dancing, setting up and supporting village social and specialist peer support groups, foraging, apple juicing, working with school children, textile group, art therapy group, carers support group, walking and talking, flexercise and one to one support for older people with limited mobility, weight management, creative workshops, seasonal cooking and preserving, gym sessions, community choir & more.

Project organisation and services

Target Beneficiaries
The project intends to focus on families where one or more member has a mental health problem that impacts on family life, people who are overweight or obese, older people who are inactive or have mobility problems, people who are socially isolated and those finding it difficult to cope.
Beneficiary Case Study

Claire is a 34 year old woman, who has now been involved with the Well Bean project for over two years. She lives in a large Somerset village.

Claire was referred to the Balsam Centre by her Parent Support Worker, who was becoming concerned that her long term depression, isolation and associated agoraphobia was having a damaging effect on her three children and that family relationships as a whole were deteriorating badly.

A Wellbeing Worker from the project visited Claire to start to get to know her and make an initial assessment of her needs. Claire had gained a considerable amount of weight following the birth of her children and part of her withdrawal from society was the shame, low self esteem and self loathing that she felt in connection with her obesity.

After some initial time with Debbie, considering the changes she would like to make in her life, Claire achieved her first goal, after only a few sessions by leaving the house together with Debbie to go for a short walk. Other successes followed: a change of diet in the household, which the rest of the family embraced and then following Claire’s desire to work with children, with support from Debbie, the initiation of a small after school activity group, meeting in the local church hall.

The small group rapidly expanded and has been supported by the local authority, local community and primary school. Claire has gained confidence and focus, and although it has been very hard to do and she has some way still to go, she has lost weight and improved her fitness levels. In the summer she organised and participated in a 12 hour tennis marathon to raise funds for her group. This was actively supported by the community and has been a high point in her recovery.

Claire is still on medication for depression, but is generally coping well with life. Her family are immensely proud of the transition she has made and her experience has encouraged others to do more in the community e.g. one of her friends is hoping to start a youth group for older children, another is helping children to swim.

When she has a ‘dip’ she is able to contact Debbie for encouragement and support to get her back on track. Claire is a warm, empathic person and has recently trained as a Flexercise instructor to help older people in her community. The ‘icing on the cake’ has been part time employment as a teaching assistant in her children’s school and contact from the local Sports Support for schools in the area who have invited her to work alongside them and have encouraged her to enrol for her tennis coaching certificate.

A direct quote from Claire: Thank you for believing in me. I have been offered the job!
Performance

Outputs and Outcomes
The project has so far worked with 1011 people. Beneficiaries have used the resources of the project to e.g. learn to cook, grow food, forage, create beautiful or useful items, improve their fitness, lose weight, improve their confidence, self esteem, social networks and general mental health. For each person supported the ‘ripple’ effect from their positive outcomes will extend to several more people – family, carers, friends. Using the standard questionnaire developed as part of the SWWB programme the Wellbean project collected health and well-being evidence from 14 people. Records were collected at the point of enrolling with the project and then six months later. The findings from this study point to some long term impact with improvements in health and well-being across a number of measures. The number of people reporting that their health was either good, very good or excellent over the previous week increased from 50% at the start of their involvement in this project to 64% at the end.

Processes
The project has involved many more successes than challenges. The Balsam Centre had already established strong working links with the local authority and health professionals on site and this enabled Well Bean to get off to a good start with referrals and partnerships in place on the ground, including having established contacts with key people in the settlements. Through good publicity, relationships were established with local farmers in two of the target areas and areas of land secured for some of the food growing activities. However the greatest success has perhaps been in achieving very high levels of targeted referrals and equally appropriate self referrals, meaning that our resources have been used effectively.

The two main challenges have been a) around the difficulty of ‘marketing’ a highly targeted project without stigmatising the beneficiaries and b) working with schools to access parents in need of support – despite time spent with head teachers and the ‘extended schools’ agenda, the local primaries have lacked understanding of the ‘family specific’ support role that Well Bean could play, beyond food activities with children.
Conclusions

Key lessons
The Centre’s relationships and partnership working with its on site and local partners (both statutory and voluntary sector) providing different areas of knowledge and expertise is key to effective delivery in a large, under resourced, rural area.

Meaningful, preventative work undertaken at a time when people are ready to make changes has the power to transform lives. In working with families with children this is effective in more than one generation at the same time.

There are huge numbers of people in rural communities whose personal circumstances and lack of accessible opportunities make life tough. Well Bean has proved that the answer often lies in simple, local, low cost initiatives that are relevant and have long term impact.

Opportunities for the future
With the break-up of PCT’s and intense competition for funds in the voluntary sector, the project team feel that the Balsam Centre is unlikely to receive local funding for the project activities.
South West Well-being Programme in Plymouth

Location: Plymouth inner city wards

Host organisation: Local delivery organisations with management by Westbank Community Health and Care

Overview
This report profiles the South West Well-being funded projects in Plymouth. The programme supports a range of voluntary sector organisations to deliver personalised lifestyle activities and community led services. Operating in neighbourhoods with high social deprivation, the projects work with families, older people, people with poor access to services, people with sedentary lifestyles and people with low level mental ill health.

South West Well-being funded projects have developed in co-ordination with the newly emergent Plymouth Third Sector consortium and the PCT Public Health Development Unit. The Unit operates on a community model in which officers are based in local NHS or partner offices in city neighbourhoods with higher health needs. Both statutory and third organisations work within the framework of Healthy Plymouth 2007-2020: the over-riding strategy for health, social care and well-being for the City. Drawing upon public health intelligence this has prioritised health inequalities, investment in illness prevention/health promotion, mental health promotion, accessibility and uptake of specified services; and promoting independent health supporting behaviour.

The focus on early and systematic involvement of Third sector providers (Plymouth LSP, 2007) clearly indicates an important role for local voluntary sector organisations in the promotion of health and well-being for wards with higher social deprivation. In the second half of the funding period South West Well-being funded projects have been directly overseen by the programme management team based at Westbank HLC based in Exminster.

Plymouth has wards with some of the highest indicators for health deprivation in the south west of England. According to the local Joint Strategic Needs Assessment “indicators show that there remain stark inequalities in both real and perceived health especially across the neighbourhoods of Plymouth. This is despite the inequality gap in the biggest causes of death, heart disease, stroke and

cancers narrowing, illustrating the complexity of causes underlying this picture. Thus mental health is a significant issue for Plymouth and one that also consumes much of the available health and social care resources.4

The following sections provide profiles of three of the main SWWB projects funded in Plymouth. These are:

- Elder Tree older people’s services
- Eklipse Contact
- Relate Family Counselling

Project profile: Elder Tree older people’s services

Introduction
There are two elements to this project. The Initial Grant is in its third year and delivers a weekly Cardio Fit class in the East End of Plymouth and the provision of weekly Access to Swimming. The Second Grant is in its first year and delivers two weekly Tai Chi classes in Efford and the East End of Plymouth.

Background
Elder Tree Ltd is a Voluntary Support and Befriending Service that has operated in the South West, Central and South East neighbourhoods of Plymouth for the past 15 years – predominately inner city and areas of recognised social deprivation. The service reaches out to socially isolated and vulnerable older people to promote their continued independent living, social engagement and access to social and health related activities.

Elder Tree offers a range of support, although dedicated ‘one to one’ Befriending for the more vulnerable and socially isolated is a core activity. The service offers social and health themed activities that include Lunch and Supper clubs, Silver Surfer IT classes, weekly ‘Advice Drop Ins’, Dance and Movement classes, Access to Swimming, Tai Chi, Cardio Fit for the over 60s and Quiz and Craft activities.

The Elder Tree currently has 62 volunteers and 350 beneficiaries who we are in contact with weekly. The service is QUAF level C validated and Adult Social Services and Supporting People recently commissioned Elder Tree to manage the delivery of a Befriending Umbrella Service in all six neighbourhoods in Plymouth over three years. The Umbrella has over 100 volunteers and reaches 640+ beneficiaries weekly.

4 Plymouth PCT/City Council 2008 Joint Strategic Needs Assessment
Project Area
The main beneficiaries of this project are resident in the East End, Efford/Laira areas of Plymouth. The social housing stock here is predominately pre 1950 and the areas are typical inner city estates where there is significant social deprivation and ‘elder isolation’

The project rationale was based experience of providing support in the areas over a 3 year period informed by consultation conducted by the City Council’s Estate Regeneration teams and the Public Health Delivery Unit. Both consultations identified a desire by older residents to take part in the type of exercise delivered by this project.

Project design and delivery
The Tai Chi classes have been specifically developed for the elderly and are suitable for able bodied and armchair/wheelchair participation, and they will compliment and help develop our existing activities in these areas. The activities are not delivered in isolation – they are part of established ‘drop in’ sessions managed by a project worker and volunteers that provides general advice and companionship.

Inputs
The budget for the Initial Grant was £13,584 over three years. The Second Grant was £4800 over one year. The total grant over the period was £18,384. Over the period of the grant the Elder Tree provided match funding of £1780 a year for the Initial Grant and £3355 for the Second Grant. The total match funding from the Elder Tree was £8695.

Activities
The Initial Grant funded two activities; a weekly Fitness Class for older residents in the East End of Plymouth and access to the older adult sessions at the community swimming pool at Plympton. The swimming initiative was innovative as prior to the introduction of the service, beneficiaries would have depended on public transport which requires a change of bus on each direction of the journey and a long walk for some to and from the bus stop. Under the project, they are now collected by Plymouth Disability Federation transport that has been optimised for use by the elderly and disabled which means they can attend throughout the year.

The Second Grant has funded two weekly Tai Chi classes held in Efford and the East End.
Target Beneficiaries
The target beneficiaries are predominately resident in the East End and Efford/Laira areas of Plymouth. They have been referred to the Elder Tree as being socially isolated by statutory and non statutory organisations and partners in the Voluntary Community Sector. The service supports older people over the age of 50 but beneficiaries tend to be 65 or over.

Performance

Outputs
The Initial Grant delivered 2 weekly activities for 48 weeks over three years. The Second Grant delivered 2 weekly activities over 48 weeks.

Outcomes
In the initial grant, Elder Tree’s SLA outcomes for the postcode areas of PL1 and PL4 are to:

- Provide activity opportunities for 25 older people via weekly exercise classes.
- Provide access to swimming opportunities for 25 older people

In the second grant, Elder Tree’s SLA outcomes for the postcode areas of PL3 and PL4 are to:

- Introduce a new Tai Chi class to the East end area of Plymouth for people over the age of 50
- Sustain the existing Tai Chi pilot project at Efford aimed at people over the age of 50.
- Introduce Tai Chi to a combined total of 75 people in the PL3 and PL4 areas of Plymouth.

To date, the service has engaged with 101 beneficiaries across the project and the team anticipate that this will reach 130 by the end of the grant period. The Initial Grant has supported 57 beneficiaries to date. The Second Grant has supported 43 beneficiaries to date.

The outcomes have been particularly positive with all beneficiaries verbally reporting an overall improvement in the self esteem and a general improvement in their ‘wellbeing’. This has been evidenced both anecdotally and in their Evaluation Form responses.

Plymouth Elder Tree: Beneficiary Case Study

Roger : It’s opened up the old doors that I thought were closed forever

Roger aged 65 has become a regular member of Elder Tree’s gentle exercise group:

Two years ago I was out with my wife when I suddenly collapsed. I was rushed into hospital where I ended up spending the next six and a half weeks. During that time I had a cardiac arrest and found that I needed a heart bypass. It was all a total surprise. In the end they fitted me with a defibrillator as a backup.
After doing a rehab programme I still felt very frail. When you have a bypass you feel very vulnerable. You feel like you’re doomed. I was feeling low and very brittle. When I started going to the Elder Tree’s weekly fitness class I think I gradually got my confidence back. Every week the instructor takes you through a set of steps where you warm up and warm down.

There’s a real mix of people at the group: I’ve made some good friends and there are always new people coming in. As a group we talk a lot about things and compare notes. There’s a lot of laughter that goes on. I wonder what people would be doing without it? Probably they’d just be sitting at home by their selves. The instructor has a nice way with him and, I suppose, we want to please him really.

I’d never been to this sort of class before. It’s now a regular engagement in the week and I really look forward to it. In between I go for a thirty minute walk every day. I thought I’d never do the decorating or mow the lawn again. You could say it’s opened up the old doors that I thought were closed forever.

**Wider impact**

All the funded activities are now fully embedded and they have made a positive contribution to local community cohesion. The beneficiaries, as members of the Elder Tree, have also been able to access the wide range of activities that the charity offers and importantly, the charity has gained new volunteers who have been able to support the less able and less fortunate amongst us.

**Processes**

The team report that the main success has been energising older people through various activities to *get up, get out and to join in*. Evidencing this is less straightforward as the project manager reports:

> Measuring their Wellbeing can be like nailing jelly to the ceiling. What we do know however is that they all feel mentally refreshed, they really enjoy the company and for some, it is the highlight of the week.

The Elder Tree depends almost entirely on community partners for access to inexpensive facilities and partners depend on the Elder Tree for engaging and supporting local people where they
operate. This understanding keeps costs and overheads to a minimum and brings a huge benefit to individuals and importantly for commissioning organisations, real value for money.

The biggest challenge to the Elder Tree going forward is attracting sustainable funding for a mature project – older people need stability in their lives and they tend to stay with activities until they have ‘moved on’ in one way or another. It is therefore extremely challenging to continuously generate new beneficiaries on a weekly basis. Eight week courses with some sort of qualification are mostly an irrelevance for the type of referrals that the service receives.

Conclusions

Key Lessons

The key lesson that the project team have drawn to date is that this type of project is needed and is very popular with older beneficiaries. Delivering the activities as part of a ‘drop in’ service has encouraged wider participation and the team have been able to engage the more socially isolated and vulnerable members of the community. Simply running a fitness activity has little or no attraction to the project’s target audience. The project manager also comments:

Supporting the elderly with this type of activity needs to be more than *bums on seats and head counts*. It is a challenge to maintain the group intact over a period and this important metric needs to be understood and recognised – continually feeding through new clients may be attractive to funders but this is not a formula that works well for the elderly who need stability and routine.

Future opportunities

The main opportunity to take forward is the development of an ‘Active Steps’ programme. Elder Tree has employed a project worker to manage all health related activities and to also deliver the seven dance and movement classes held weekly across Plymouth. At present Elder Tree depends on five separate funders to support health/exercise activities and the organisation is now working to attract funding to pay the salary of the Project Worker and a part time Tai Chi instructor. The rationale is that service will not be paying sessional/agency fees and will be able to deliver much more activity for the same money.
**Project profile: Eklipse Contact**

**Introduction**
This section provides an outline of Eklipse Contact: a supervisory service providing ongoing support for people assessed as having low mental health needs.

**Background**
Eklipse Contact evolved through Eklipse Counselling: a service that provided a free ‘at the point of need’ professional Practice for over six years. The team realised that towards the end of the counselling process clients often needed a supervisory approach in enabling and empowering them to access other services which would in turn help them develop broader social networks in order to fully integrate back into the community. From this identification the idea of Contact germinated. New clients accessing Contact are supplied with a full range of services, and where appropriate, offered counselling. However, clients with high needs will be offered more intensive therapy, and in some cases, will be referred on to clinical services.

The Practice is founded on a respect for people’s individuality and their ability to direct their own lives. Whilst doing so the counsellors enable clients to realise that they can take control of their lives, focusing on their potential to make lifestyle changes. By seeing clients as individuals the team also enable them to address their issues rather than addressing any label they may have acquired. The counsellors will continue to encourage clients to evaluate Eklipse’s provision which in turn enables monitoring of the quality of the service through the eyes of the people who use the service. Through reflective practice, counsellors have put into place initiatives which have enabled them to increase the accessibility, efficiency and effectiveness of the services that they provide. They continue to liaise with agencies fostering good practice which is in the best interest of clients.

**Project design and delivery**
Eklipse Contact is intended for people who wish to make lifestyle changes but are initially anxious to take the first step. Clients are enabled and empowered to access other services and agencies that may be of benefit to the improvement of their lifestyle and supported through that change. Examples include: entering or re-entering into the employment market or voluntary sector, broadening social networks, dietary advice, keeping fit, etc. Regular interviews are encouraged as part of the monitoring & review process.

**Inputs**
The budget for the Grant was £69k over three years.

**Activities**
Clients can access contact through referral or self-referral. Initially, they are supplied with information about the project and what it offers, including a frequently updated directory containing other community resources. Throughout the process, they are supported with on-going supervision to make decisions and act on them to affect changes in lifestyle.
Clients are also encouraged to provide evidenced-based evaluation and statistical data as part of the ongoing monitoring process. From time to time, clients may exhibit behaviours beyond the remit of Contact. In such cases, they may be referred or re-referred by mutual agreement i.e. for Therapeutic Counselling or on to more clinically-based services.

**Target Beneficiaries**

The focus for this project is on clients with low mental health needs wishing to improve their lifestyle. Eklipse define Low Mental Health Needs as clients who:-

- At a given time, are not a danger to themselves or anybody else.
- Are not waiting, currently undergoing or in need of ongoing clinical treatment.
- Are still able to carry on their normal duties.

These clients are predominately from PL1 to PL4 Plymouth district. The aim of this project was to reach 40 - 45 clients per year however the team have exceeded this and estimate that in excess of 250 ‘first-time’ client beneficiaries have accessed this project since its inception in February 2008.

**Performance**

**Outputs**

The Eklipse project uses a standard SWWB programme registration form to collect details of core beneficiaries. Analysis of this registration information provides the following project statistics:

- Percentage of males: 40.5% (SWWB 31.4%)
- Percentage of self-defined ethnicity of white: 99.1% (SWWB 92.7%)
- Most popular way of hearing about the project: GP, nurse or practitioner (SWWB Word of mouth)
- Percentage referred by a health professional: 16.7% (SWWB 18.8%)
- The number of beneficiaries in employment: 48.7% (SWWB 33%)
- Number of beneficiaries who own their own home: 0% (SWWB 43.5%)

**Outcomes**

We received only 21 baseline and follow up well-being questionnaires from direct beneficiaries. Unfortunately this is too few to run standard t-tests and scale scores. We note that two beneficiaries report giving up smoking and alcohol over the duration of their time with this project; but there was little change on items on: self reported health, physical activity and healthy eating. But there were some positive changes on the mental health and well-being asset items to suggest that with a larger dataset statistically significant impact may have been recorded. The modal score on the life satisfaction item where 0 is low satisfaction and 10 is high satisfaction there was a modal shift from 4 to 8. The number of beneficiaries who reported not feeling lonely rose from 2 to 7. Those who never felt depressed during the week rose from 1 to 4; those who said they never feel lively fell from 9 to 3 and those who often feel optimistic increased from 2 to 10.
Plymouth Eklipse: Beneficiary Case Study

Sue: Strong, confident, self-reliant and focused

Sue, aged 49, had had an eating disorder for the past 20 years and has attempted suicide on numerous occasions. Abandoned at birth by her biological mother, Sue was brought up by neglectful step-parents, who favoured their own biological daughter above her.

After several failed relationships and now aged 37, she settled and subsequently married her partner, who was later to turn out to be both controlling and violent. Twelve years later, and after continual domestic violence from the partner, she split from the relationship acrimoniously. Shortly after, she lost her job in the civil service, which she held for a period of eight years. What followed was a referral to Eklipse Counselling via her GP after another failed suicide attempt.

Through therapeutic counselling, the client was able to identify her responsibilities, self-value and self-worth. Over the next ten months the client moved from having high mental health needs, dependant on high daily dosages of medication to having low mental health needs with reduced medication for night use only. Sue was then referred to Eklipse Contact where the focus was on lifestyle objectives and targets through on-going supervision (6 sessions in total), during which the client was sent for healthy eating and dietary advice, initially through Public Health and employment advice, initially through Workroute.

Sue currently holds voluntary position with a charity whilst actively seeking employment. Since the sessions had ended Eklipse have received correspondence from her on two separate occasions reporting that she remains strong, confident, self-reliant and focused.

Wider impact

During the process of monitoring and supervision, clients have benefited from being enabled to access many services in conjunction with Eklipse Contact. Through a directory of services and ongoing support, clients have been encouraged to access many other service-providers such as: healthy living, benefit advice, employment advice, legal aid, advocacy and other statutory and non-statutory agencies.

Conclusions

Key Lessons

In order to progress the project fully, focussing on rigid geographical boundaries may not be the answer. Often it is said that other groups feel marginalised and excluded in prosperous areas where there are pockets of social deprivation and therefore a city-wide approach is needed. By benefiting the community as a whole we are more likely to benefit the whole community thus paving the way to supporting a more permanent and prominent fixture.
Communication at the grass-roots level has a fundamental role to play in sustaining and developing good community services. Unfortunately, inter-agency involvement, particularly from the statutory sector, appeared at times, to be non-existent or at best convoluted when dealing with client referrals. The team would therefore propose greater agency involvement at local level in order to develop a ‘fast-tracking’ process for vulnerable clients identified through our assessment process.

**Future opportunities**
The continuation of the work using a process of reflective practice with new emphasis on providing services city-wide.

**Project profile: Relate Family Counselling**

**Introduction**
This profile outlines a project working with families through a school setting in an area of high social deprivation in Plymouth.

**Background**
Relate is the largest counselling agency in the UK with over 70 years experience of dealing with relationship difficulties in the family. Relate Plymouth is part of a National Organisation and has been working in the city since 1964. It currently has 12 counsellors who work in the centre on North Hill. These 12 counsellors offer couple counselling, family counselling, sexual therapy service, children and young people’s counselling and Life Skills training courses. Relate Plymouth sees over 600 couples each year, offering 2,000 hours of counselling. All counsellors receive specialist training in Domestic Abuse and Violence, Child Protection and Mental Health training.

Relate aims to give its clients the very best experience of counselling. The team prides itself on the quality of the service that they offer. Highly skilled counsellors seek to enable clients to feel more confident about their relationships. This positivity impacts on their ability to work and to maintain a stable home and get involved with their community.

**Project Area**
The project is focused on the Cattedown area of the Plymouth. This is an area of high deprivation and evidence shows that there are high numbers of vulnerable families who live in this area:

- There are a high proportion of one parent families
- A high proportion of low income/dependent families on benefits
- A high proportion of depressed/mentally ill parent
- A high proportion of children 0-5 in famines reliant on benefits
- A high proportion of very young parents

Project design and delivery

Inputs
Funding for this project, from February 2008 to January 2010, is £13,844.

Activities
From previous work, the Relate team have found that delivering family counselling in an accessible location was the key to client engagement. Relate sought to make the service accessible by offering counselling and support to children and families at Prince Rock Primary School: the local school in the Catterdown area.

The project provides three hourly sessions a week. Clients can access between 6-10 sessions dependant on the issues presented. Issues presented are quite complex and can range from bullying, poor school performance, self-esteem and confidence issues, poor parenting, step-family issues, family and relationship breakdown and the impact of job loss and financial pressure on families.

Target Beneficiaries
Relates Family Counselling is directed towards young and vulnerable families. The project team anticipated that they would help these families to deal with issues impacting on them before they become serious problems requiring more specialist interventions. All families have their difficulties and often they are unable to cope or find solutions. Sometimes the problems become so big that parent may split up leaving the children feeling very unsafe and vulnerable. With very young families and single parents families there can be issues around:

- domestic violence and abuse
- financial difficulties
- relationship difficulties
- self-esteem and confidence issues
- depression and mental health issue
- past sexual abuse
- step-families

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5 Atlas of Child Health. Neighbourhood level data for Plymouth
Performance

Outputs
The initial target from the start of the project was to work with fifteen families – the project has seen up to 25 families for each year of the project. There is often a waiting list; the counselling has been quickly integrated into the school and is valued by the teaching staff and the support staff alike as a responsive service. The counsellor works closely with the staff and they have expressed confidence in the service provided.

Outcomes
The project has worked closely with the self defined goals of its clients. These are varied and, in many cases, only become clear over the course of the sessions. This means that the project does not prescribe tightly defined outcomes for beneficiaries at start of sessions. Relate practitioners have sought to empower clients to understand their situation and make choices about how they manage things. They have also sought to give clients a more effective way of anticipating and managing areas of conflict and difficulties within the family.

Other anticipated outcomes have been improvements in: family communication; family relationships; parenting skills; mental health; self-esteem and confidence; and – for children- to feel safer within the family. The outcomes are measured by the counsellor through evaluation forms and also verbally. 96% of clients are satisfied with the service that they receive and have reported that their relationships have improved with both their partners and their family as a whole. The team also get feedback from the Parent Support Advisors and the teachers at the school regarding the children: all are very positive.

Plymouth Relate: Beneficiary Case Study

Alice: Firm boundaries were essential

When Alice first came to Relate, she had just broken up with partner. They had been with in a relationship for the last five years. She had and still has seven children living with her in social housing. Her initial concerns were:

- How ex-partner treats their two year old son.
- How to cope with seven-year anger.
- How other children would adjust to single-parent household.
- Where to access support.

The Relate counsellor discussed her overall family situation and how she could cope with the extra workload and the children’s conflicting emotions. Alice agreed that firm boundaries were essential to maintain a sense of security for all family members, not least herself. She involved a solicitor and he was able to send the ex-partner letters detailing access. Alice was able to use the solicitor to address problems such as the two year old feeling scared at seeing his father as well as issues she
had with ex-partner’s previous inappropriate behaviour to her teenage daughters and eleven year old son. All incidents were documented and Alice was able to retain a distance from the ex-partner and ensure that the ex-partner stuck strictly to all access agreements that were clearly documented in solicitor’s letters. Social services were also involved.

Alice’s seven year old son joined the counselling. He said he didn’t like his mother’s ex-partner and would like to find out if he could contact his biological father. After this session, the seven year-old didn’t resort to so many angry outbursts at home. He had been given a voice and his mother had listened.

The eleven year old also joined the counselling at a later session. He considered his own inappropriate behaviour at home and was able to recognise that at times it was similar to his mother’s ex-partner’s. He wanted to help his mother and like his younger brother, he wanted to meet his biological father. Again he had been heard, took responsibility for his own inappropriate behaviour and considered how he could use his energy to help his mother, brothers and sisters. Alice obtained help from the children’ mental health team for her fifteen year-old son. She also helped her fourteen year-old daughter to see a counsellor at her community college.

The counselling sessions enabled Alice to access support, put in firm boundaries with the ex-partner and children while at the same time finding the forum for her seven-year-old and eleven year old sons to express themselves and feel heard. Alice was also able to use the counselling sessions as a means of realising she could be in control of her family without being too reliant on other people. It built her confidence and self-esteem.

**Wider impact**

The service has been responsive to the needs of the clients and also signposts clients to other services where appropriate, such as Harbour Centre (drug issues), Plymouth Domestic Abuse Service, Plymouth CAB and Plymouth and District MIND.

**Conclusions**

**Key Lessons**

The key issues that the team have identified are that counselling in schools is needed by both the children and also by their families. The team have also recognised that alongside the work with children they need to work closely with the parents to promote change. By placing a counsellor in the school that has specialised training in children and family work they feel they have become more effective.

It is also vitally important that the staff at the school are totally ‘on board’ and support the service. They refer pupils and families to the service and are the key to referrals – the service is seen as an integral part of school life. The Parent Support Advisor is also vital to any schools project succeeding. The PSA’s are the strongest link to the parents, talking to them in a very informal way that encourages them to use the service and get the help and support that they need.
The marketing of the service is also important: the team offer coffee and a chat rather then come and have counselling. This sounds much more informal.

**Future opportunities**
The outcomes from this Project may help to gain further funding to support school counselling. In the current climate it may be difficult for schools to fund projects such as these themselves. The team are constantly seeking new incomes streams to support this work, as they recognise that this is service that is badly needed.

One future opportunity may be to provide volunteers to work in school to achieve their counselling hours – the team may explore that at a future date.
Upstream Health Maps

Host; Upstream, a Registered Charity and Limited Company

Location: Mid Devon, focusing on a largely rural farming community centred on three main market towns of Crediton, Cullompton and Tiverton

Introduction
The Upstream ‘Health Maps’ project was designed specifically to motivate people to take responsibility for, and to improve, their own health activities. The project engages with people who are, on the whole, older and less able, with an emphasis on preventing them from falling into ill-health and requiring more serious and costly intervention at a later date. Upstream’s target population is people aged 50 and over whose lives may have changed or be about to change in some way. These transitions include retirement, bereavement, moving home, loss of income, and the onset of illness.

Project Aims
The project’s mission is to stimulate people to take greater control of their own health and well-being:

- To provide motivation for personal and social healthcare improvement
- To prevent people falling into ill-health
- To identify those less likely to access health opportunities for whatever reason
- To disseminate successful techniques for health improvement

The objectives of the project are to:

- To devise programmes and activities for health improvement in exercise, nutrition and mental health.
- To initiate new groups, or to engage existing groups, through which the programmes and activities can be delivered.
- To effect methods and to identify champions that will support the sustainability of the activities.
- To work closely with other community organisations and statutory authorities in the delivery of the project in order to embed the methods and outcomes of the project in their planning.
**Rationale**

Rather than providing a standard intervention, Health Maps offer multiple routes for personal development. Typically, a referred participant is assigned and assessed by a mentor, who then supports them to make a personal ‘health map’ as a visual representation of their social, psychological and physical environment. This is used as a practical basis for looking at simple steps to address specific issues, improve general well-being and for setting goals. Mentors focus on helping the participant make small changes to physical activity, diet and social and creative activity. For example, the participant may use a pedometer and a record sheet to track daily walking routines. Working with the choices of the participant, the mentor sign posts or initially accompanies the person to group activities. These range from art and craft activities to gentle exercise and day outing activities. Some of these are directly organised by Upstream whilst others are delivered by partner agencies or community groups. The health map is revisited as a metaphor for charting personal progress over this period and after approximately three to six months, depending upon the needs of the participants the mentor will reduce their level of support. Some participants take on an active role in supporting peers or helping to organise groups. These ‘veterans’ can also advocate for the project at community events.

Through ‘Health Maps’, people learn how best to map and modify their daily lives to increase physical, mental, nutritional and social activities. For example, some have mapped their daily routes around their homes and communities, both graphically and symbolically, to produce practical, imaginative representations of their current exercise and nutrition behaviours and encounters with friends. Their baseline maps provide discussion points which lead to fresh ideas about how they can increase these physical and social activities or, where appropriate, control their diet. Follow-up mapping provides clear evidence of improvement or indicates where different approaches are necessary. The participant can quickly obtain graphic encouragement from even quite small improvements, which in turn increases motivation for further improvement. The maps have an added advantage in that they can provide clear pointers to communicate needs to mainstream and other voluntary services. Frequently, the simple act of discussing a theoretical map is enough to enable people to rethink and change their behaviour.

Through maintaining independence and improving health Upstream’s model anticipates individuals will have less need for statutory services, particularly in health and social care. This not only alleviates service pressures but also builds local capacity with communities.
Host Organisation
Upstream is a Charity and Limited Company, founded in 2002. Its main work has focused on identifying older people who are isolated or at risk of isolation and depression and to build their self-confidence and social integration through creative, learning and social activities, as well as health and well-being, and to enable them to remain independent for as long as possible.

Upstream’s work with isolated older people and the use of creative and social activities to motivate behaviour change has been independently evaluated by the Peninsula Medical School (2005) and recognised by the 2008 NICE Award for Public Health. The use of health maps in various forms has been used in developing countries to help communities to identify and tackle issues arising from the widest determinants of health and well-being.

Project area
Upstream focuses on the area of Mid Devon, which is a largely a rural farming community with three main market towns of Crediton, Cullompton and Tiverton. Tiverton in particular has substantial aspects of social deprivation but the area as a whole has widespread pockets of isolation and existing and potential issues of mental health and depression. Some parts still suffer fall-out from the foot-and-mouth outbreak a decade ago.

Project design & delivery

Inputs
The project has been funded £326,773.00 over 3 year period through the South West Well-being programme. Project expenditure includes the following staff costs:

- Co-ordination: 0.4 per week
- Community mentors: 4 x 0.4 per week
- Marketing, promotion, data: 0.4 per week
- Management: 0.3 per week

Other costs relate to event delivery, venue hire, materials and transport. A range of resources are provided in kind, including office space, telephones, internet access, heating and electricity.

Activities
Over the lifetime of the project 14 ‘gatherings’ have been arranged along with 62 weekly events and small groups. In addition there have been 358 individual visits by mentors, to engage people and for research and evaluation.

Project Organisation

Trustees → Director → Business Development
Consortium Management
Project Manager → Project delivery
Mentors in the field
Administration, Promotion, data collection
Evaluation
External service deliverers
Target Beneficiaries

Project activities target older people in the rural and market town communities of Mid Devon, in particular those less able or less likely to access health opportunities close to home, or take control of their own health (for reasons of deprivation, disadvantage, isolation, lack of self-confidence, limited social engagement, disinterest, or any other similar obstacle), including those nearing retirement or experiencing redundancy, with a view to tackling prevention as much as occurrence.

Beneficiaries include those who are visited at home, those who attend events (including weekly events and small groups and larger gatherings) and those in the community, family, friends, carers and other voluntary and community sector services who experience health impact techniques and behaviour change benefits from the involvement of the direct beneficiaries.

Upstream used a standard SWWB programme registration form to collect details of direct beneficiaries. Analysis of this registration information from 75 beneficiaries provides the following project statistics:

- The modal age range of project beneficiaries is 81-85 years of age (SWWB 30-35 years of age)
- Percentage of males: 21.3% (SWWB 31.4%)
- Percentage of self-defined ethnicity of white: 100% (SWWB 92.7%)
- Percentage referred by a health professional: 40% (SWWB 18.8%)
- The number of beneficiaries in employment: 1.4% (SWWB 33%)
- Number of beneficiaries who own their own home: 69.4% (SWWB 43.5%)
- The number of beneficiaries self-defined disabled: 8% (SWWB 9.4%)

Performance

Outputs and Outcomes
From the perspective of the project team the main outputs have been individual mentoring visits, organising gatherings/weekly events/small groups, making contacts with other organisations and data collection.

1185 people improved their understanding and practice of better nutrition and were more likely to continue to eat more nutritious food and a more balanced diet on their own.

1695 people took more exercise, learned new ways to take daily exercise, and established regular routines that made it more likely they would continue to take more exercise.

2370 people experienced greater mental stimulation and learned new creative activities that will motivate them to continue practising what they have learned and to join in social activities that improve their communication and mental alertness.
15 other community organisations (see list below) have become more aware of the combined importance of physical activity, better nutrition and mental health as a result of the involvement of their own participants in the ‘Health Maps’ programme and as a result of presentations made by staff of the ‘Health Maps’ project.

Analysis of 30 SWWB baseline and follow-up questionnaire also records significant improvement in a number of outcome areas for the programme. However caution needs to be interpreted in the interpretation of the data given the small sample size. In addition the well-being outcomes reported in the questionnaire did not show a consistent trend across all the measures. This may be because the health of some clients is inevitably deteriorating with later life.

Participation in Upstream activities was found to be associated with following benefits:

- 54.8% of respondents reported improved levels of physical activity such as brisk walking or active recreation sufficient to cause deep breathing over a 28 day period. This finding used a Sport England questionnaire measure (N=30; SEM0.422; t=-3.88; p=0.001).

- There were improved levels of physical activity involving hours of active leisure over the last week. This finding used the General Practice Physical Activity Questionnaire (N=30; SEM 0.0369; t=25.95; p<0.001).

- 66.7% of respondents reported reduced depressive symptoms at follow up, using the CESD7 scale (N=30; SEM=0.711; t=-2.58; p=0.015).

- Participants were more likely to say that they enjoyed putting care and effort into eating healthy food at follow up (N=30; SEM=0.286; t=-3.34; P=0.001). However self reported fruit and vegetable intake declined from an average of 4.3 to 2.3 portions per day.

- 54.8% of participants reported that they were more likely to attend activities organised in their local area. This is an indicator of improved community participation although other measures of social participation did not show a statistically significant improvement.

**Additional outcomes: Foot Sure Fall Free Programme**

Alongside the SWWB project, Upstream has piloted and rolled out a Falls Prevention programme, over a 2 year period, Jan 2009-Jan 2011, with additional funding from the Department of Health. After a successful Sheltered Housing pilot model, supported by the local GP surgery, Upstream developed a Community Based model in Tiverton, taking referrals targeted by another GP surgery, and with the support of Tiverton hospital. After rigorous screening by GP’s and authorisation by the individuals, the 3-month intervention was designed as a holistic pathway to improve their balance, reduce the incidence of falls, raise awareness of the benefits of healthy exercise and nutrition, and improve confidence and general well being.

With the inevitable ageing process of this target group in mind, the anticipated outcomes were to ‘maintain’ a level of fitness, balance and agility. The Berg Scale test was used to evaluate any direct
physical change. The actual results showed improvement in both the ‘Less Able’ and ‘More Able’ groups. One individual from the ‘Less Able’ group improved her Berg Scale score from 10 to 26 (on a scale of 0-56, an improvement of 160%) and continued by joining a local light exercise class. When asked, ‘Have you changed the way of doing things as a result of the service?’, she replied: “yes, I can right myself if I start to lose balance, I can also put my bra on by doing it up at the back”. Soft outcomes included enjoyment of the activities and nutrition information and the benefits of a social gathering.

The findings from this activity case example lend additional support to the other positive improvements reported for Upstream physical activity initiatives.

Processes
Successes and challenges in the process of delivering the project for example including partnership working, marketing, support and onward referral.

A range of statutory authorities, including the NHS, County and District Councils have experienced the benefits that community-based organisations and projects such as ‘Health Maps’ bring to the delivery of their own statutory priorities, and are more likely to commission the voluntary sector to deliver some of these priorities in the future. Evidence for this derives from the resultant commissioning by Devon PCT and Council of voluntary sector consortium delivery of services relating to physical exercise and mental health (falls prevention in particular) and nutrition (obesity programme).

Wider impact includes increasing awareness in local Mid Devon communities of nutrition (e.g. Crediton ‘healthy eating’ fair), physical activity for older people (e.g. Tiverton and Crediton ‘Walk and Talk’ groups, and dance groups) and creative mentally stimulating activities (e.g. Crediton ‘Libraries Alive’ group and Stoke Cannon lunch activity groups). These are all activities in which the Upstream ‘Health Maps’ project has played a role, either starting or stimulating the activity. These activities provide solid evidence that the awareness and practice of physical exercise, nutrition and mental health are becoming embedded in the community and will outlast the SWWB programme.

The project team identified a range of successes and challenges associated with delivering the project.

Successes:
- Older people quickly understand and respond well to the potential benefits of greater and better planned physical exercise. They feel the benefits quite rapidly. This makes it easier to involve them, especially if the exercises are fun and sociable.

- Dance groups in particular have been a great success, where the dance activities have been imaginative, appropriate to older people, and have not been patronising.
• Mental stimulation has been most obviously and readily successful when it is built into the exercise activities, as for example in memorising a succession of movements in a dance routine and in synchronising the movements with the music. Participants are strongly motivated to join in, develop social cohesion, and continue the activity.

• Building physical, nutritional and mentally stimulating activities into the programme of existing social groups has very often proved to be a successful way to broaden people’s experience and get their attention, often more successful than attempting to start a new group dedicated to one or other of the activities. For example, an existing lunch group might meet earlier for some light exercise and use the lunch as a focus for nutritional learning.

Challenges:
• Mental stimulation through creative activities, involving participation in whole or in part, is more attractive to those who already have creative interests, and more difficult for those who do not to see the connection with better health. However, once people do get involved, in creative activities and the socialisation that goes with them, they often experience the greatest impact on their sense of well-being, particularly if they were initially sceptical.

• Involvement in nutrition is also more difficult with older people than involvement in exercise, and the two need to be linked carefully. The difficulties lie partly in the sense of ‘teaching your grandmother to suck eggs’ – these are people who have been cooking all their lives and who have adapted their diet to what is available, what they can afford and what is convenient to cook. Why change, if it’s seen them through 70, 80 or 90 years? However, when they share recipes and are shown how they can make simple adaptations that ensure good nutritional content and make use of readily available healthy foods, and when they are persuaded to pause to appreciate the benefits to their physical health also, then they become open to change. Sharing recipes and building on what they already know is the key to success. ‘Health Maps’ has produced a number of very successful recipe cards.

Conclusions

Key lessons
• Activities must be fun and involve people in participation.
• There must be some quick clear benefit, even if other benefits are built in to the activity that are less obvious but equally important in the long term.
• Socialisation is an important aspect of success but at the same time people must be able and motivated to pursue activities individually in their own time.
• Combining all three of the key elements (exercise, nutrition and mental health) is a good way for people to see the connections with health and well-being.
• Dance can be a highly effective activity but it is more difficult for people to continue independently without an experienced leader.
Opportunities for the future

- There are many more existing voluntary sector community organisations that could extend the range of what their participants do, and improve their health and well-being alongside their established activities. This would further embed the health-based activities into the daily life of the community.

- Although statutory authorities have begun to commission small pieces of work in the community, in general there are many that have not yet put out whole services into the community. More substantial commissioning would enable the development and strengthening of what can be achieved by the community itself.

- Lessons learned from the programme will be clearer after a slightly longer period of practice by the community; it will be seen which activities became well-established by community groups and individuals, or where they had problems in sustaining activities and groups. This experience would enable any extended or subsequent programme to work with existing groups to modify their approach and to ensure that any new groups and activities were adapted to have the greatest possibility for long-term success. There has always been a risk that any programme can only see short-term results, and it is vital to build in these health improvements permanently – if only to get the confidence of the health professionals in the economic benefits.
Beneficiary Case Study

Joan: Just the pointer I needed

Joan, 84 years old, was self referred after reading an article in the local newspaper about Upstream. At the time of the first mentor visit, Joan was somewhat isolated having moved to the area to live nearer to her daughter. She was living in temporary accommodation, which she found unsettling. Joan felt lonely from time to time and was keen to get to know people and be part of the community. In her past she had always been active and recognized the importance of keeping both physically and mentally active. She had an interest in healthy eating and physical activity and described her mobility as ‘good’ despite hip problems. It was apparent from the Upstream health mapping exercise, which revealed no social or physical activities since moving house, that Joan would need local community activities identified and mapped for her. In the past she had been actively involved in voluntary work but had decided she would now just like to be a participant in community activities.

Although keen to get involved in groups and community activities, she was uncertain as to what suitable opportunities existed. Her first goal was to increase the opportunities to leave the house, to meet more people, make friends and gain confidence. The Upstream mentor recommended Esther Spa ladies only morning, U3A and a local history group. The second goal was to create more opportunities for physical activity such as Walk and Talk and the Upstream Best Foot Forward light exercise to music group, which was to be launched at the ‘Winter Warmer’ event in Tiverton. Also attending would be a representative of Walk and Talk who could talk to her about the suitability of the routes.

Joan took up the suggestions enthusiastically, attending Best Foot Forward and making a friend there. She also tried a keep fit class, Walk and Talk and Phoenix Ladies Group. These new activities have contributed to greater feelings of being in control, improved self confidence and meeting people again, and helping Joan to remain fitter more active and independent for as long as possible. It was agreed that her goals have been achieved and she no longer needed mentoring. As Joan explained in her letter, Upstream’s intervention was just the pointer she needed. This is illustrated in the letter below.

Dear Carol
Thank you for giving me your time and advice when you called the other day. Also for your follow up letter with all the information which I find very helpful. I enjoyed your successful Best Foot Forward day last Wednesday and I made a friend there. I have joined the U3A and Phoenix groups and am going to the History of Tiverton course, which starts this Thursday. I also joined the short walks Friday morning. Thank you for your help. It was just the pointer I needed. I hope to join a computer class next.

Yours sincerely, Joan
Knowle West Pathways to Health

Location: Knowle West, Bristol

Host Organisation: Knowle West Health Park Company

Introduction
This report provides a profile of the Knowle West Pathways to Health project, an initiative funded as part of the South West Well-being programme.

Background & Host Organisation
Knowle West Health Park Company developed from the Knowle West Healthy Living Centre, which opened in 2001. It is established as a three way partnership between the local community, the PCT and Bristol City Council working to address health inequalities in south Bristol. The Health Park is a 10 acre site that currently accommodates the organisation offices and activity rooms, an NHS Walk-in Centre, a community cafe and other local services. The Health Park is located in Knowle West which was originally a council housing estate developed in the 1930s, although today almost half the homes are privately owned.

KWHP operates as a local strategic organisation, a community advocate and a direct deliverer of services. The services address the following preventative health issues:

- reducing obesity, promoting healthy eating
- increasing physical activity
- low level mental health support
- smoking cessation and sensible drinking
- improving sexual health

Health inequalities are addressed as a thematic element in these services. In this context the Well-being funded project is one relatively small element of the overall work of KWHP.
KWHP’s previous Strategic Plan\(^6\) takes a comprehensive review of the organisation in the context of local and national developments. The strategy has mapped against the Choosing Health Agenda, Local Area Agreements and comprehensively set out a plan of implementation across the organisation. It is informed by a set of community centred values. The plan itself covers:

- operational partnerships with local providers
- strategic networking with other Health Living Initiatives
- community, volunteer and service user involvement
- diversification of funding sources
- social enterprise income and
- site management of the Health Park

**Project area**
Pathways to Health responds to needs identified in local community consultations and public health data for south Bristol. This highlights the high incidence of households with a smoker, early deaths, reported mental health problems and child and adult obesity.

**Project rationale and theory base**

KWHP markets its services through a range of local outlets and has focused on building relationships with primary care professionals for direct referral or recommendation. Residents within defined wards/super output areas are eligible for the service, although there is scope for individuals outside the area to access services under special circumstances.

Pathways to Health project offers four main services: an integrated package of motivational guidance and massage therapies; a weight management course; diet and exercise based activities for younger people; and subsidised massage and complementary therapies. These activities are either delivered on an individual basis or through small groups. Whilst the specific arrangements and target groups for each activity vary, they share some common elements. These include:

\(^6\) Knowle West Health Park Co, 2007
- a structured programme of activity that has a negotiated end point and is delivered by a trained health worker for adults,
- an emphasis on the self-defined health and well-being goals of participants themselves,
- motivational support to help participants to incorporate small lifestyle changes into everyday routines,
- a broad, or holistic, approach to health that includes an emphasis on social and psychological well-being,
- advice and motivational support to help participants engage with other community-based activities.

The core project team draw upon a range of health promotion theories and methods to inform this approach. Previous work under the NHS Health Trainer scheme has supported the team to adopt the Stages of Change model\(^7\) and motivational interviewing\(^8\). One element of the project is to disseminate best practice to both local and regional partner organisations particularly with regard to integrated counselling and massage therapy.

**Project design and delivery**

**Aim and Objectives**

Through focused individual support, family support and group-based activities, Knowle West Pathways to Health adopts a holistic approach to improving health and well-being. It works with people with poor physical health or weight management issues, people with low level mental ill health, and people with diet-related health risks. The project delivers its services within the Knowle West estate and intends to develop community-led response to locally defined health inequalities.

**Inputs**

Knowle West Health Park was funded £143,727.00 under the SWWB programme. The funds are mainly dedicated for revenue costs. Over the delivery period the project has a match contribution of £20,250 through the PCT and local authority provides for crèche, reception and management expertise costs.

**Target Beneficiaries**

The project aimed to work with 430 individuals per annum, of which 85% would be adults and 15% children or young people. 250 individuals would indirectly benefit as a result of their spouses, carers, family members participation per annum. 10 local organisations would benefit by receiving referrals, partnership working and general support of their activities and services, per annum.

\(^7\) Prochaska, DiClemente & Norcross, 1992

\(^8\) Miller & Rollnick, 2002
Activities

Project organisation and services

SWWB Steering Group

KWHP Chief Executive & Management Board

Centre Project Workers & Administrator

Knowle West Health Park and other local centres

Get The Balance Right. Healthy Eating Group

Pathways to Health
Massage and motivation for health & well-being

Bodyworks
Massage and complementary therapies

Dance, diet and exercise groups for young people

Performance

Outputs

Table 1 summarises the range and characteristics of the activities delivered as part of the project.

Table 1: Summary of activities delivered by Knowle West Pathways to Health project

<table>
<thead>
<tr>
<th>Activity</th>
<th>Well being theme*: primary (others)</th>
<th>Providing organisation:</th>
<th>Type of staffing</th>
<th>Status at the outset of the funding period</th>
<th>Individual or group delivery</th>
<th>Type of group, length and size</th>
<th>Targeting and referral details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get the Balance</td>
<td>HE Fund-holder</td>
<td>Sessional staff</td>
<td>Continuation</td>
<td>Group</td>
<td>Open group</td>
<td>Fixed term</td>
<td>Targeted at those with weight management</td>
</tr>
</tbody>
</table>
Pathways to Health

MH (PA, HE)  Fund-holder  Salaried staff  New activity  Individual  Group mode  N/A  Fixed term  Targeted at those with low level mental ill-health and/or poor physical health

Body works

MH (PA)  Sub-contract  Sessional staff  New activity  Individual  Group mode  N/A  Continuous  Targeted at those with low level mental ill-health and/or poor physical health

Dance and Exercise for Young People

PA (HE, MH)  Sub-contract  Sessional staff  New activity  Group  Open group  Fixed term  10-20 people  Targeted at those with weight management problems

* Wellbeing theme: MH – mental health, PA – physical activity, HE – healthy eating

Outcomes

Monitoring returns for the SWWB programme show that the project considerably exceeded its target number of beneficiaries. After 9/10ths of the programme delivery period, KWHP recorded contacts with 2049 beneficiaries. This figure includes core beneficiaries who have actively participated in a course of activities as well as those who have had less intensive contacts.

For the core beneficiaries, Knowle West Health Park maintained a register and database for those who participated in project activities. These include SWWB funded activities along with those that are supported through other funding streams. For the period February 2008 to Sept 2010 731 beneficiaries were recorded on the project database.

Of these, 74.3% were female and 4% were from Black or Minority Ethnic Backgrounds. The organisation worked with a wide range of age groups:
- 44.5% were under 16
- 39.9% were 16-64
- 14.4% were 65 or over
- 1.2% did not report their age

Of the 397 beneficiaries aged 16 or over, the main route to accessing the services was through word of mouth (45.1%) followed by the organisation’s publicity and contacts (26.7%); a GP, health visitor or midwife (8.6%) and 13.1% via other routes.

A majority described themselves as self referred (70.3%) whilst a minority stated that they had been referred by health or social care professional (7.8%) or a local community organisation or school (6.5%). These figures may under-record recommendations and referrals from partner organisations. The UWE survey in an earlier evaluation report of 16 practitioners from partner agencies found that 13 (81.3%) recommend or refer clients to KWHP (Jones et al, 2009).
For the 397 beneficiaries aged 16 or over, the main work status brackets were
28.9% employed or self employed
6.5% long term sick or disabled
19.6% unemployed
27.7% retired

12.3% considered themselves to be ‘carers’ and 19.1% considered themselves to have a disability. At
the outset of taking part in project activities 11% of participants described their general health as
‘poor’. This compares to 8% in a national adult population survey (NWPHO, 2009) who said their
general health was bad or very bad. These data suggest that KWHP has had success in targeting a
substantial number of individuals with higher levels of health need or at risk of social exclusion.

Health and Well-being outcomes
Shortly before the start of the SWWB programme, KWHP had undertaken a comprehensive piece of
work to develop an in-house monitoring and evaluation system. This made use of before and after
questionnaire health related measures that are somewhat different from the standard SWWB
measures. In addition the KWHP questionnaires collected information on the self reported outcomes
for clients.

Overall the data show a marked contrast between quantitative measures and the self reported
qualitative data. Using a paired T test for a sample of 73 respondents, there were no statistically
significant changes in mental health (sleeplessness, feeling depressed); physical activity (activity
level, breathlessness); and healthy eating (fruit and vegetable portions). These results may be due to
the characteristics of the in-house questionnaire measures themselves which may not have had the
sensitivity to record behaviour changes.

Table 2: Participants personal ‘ultimate goals’ for the Pathways to Health project activity. Sample
n=67 Jan-Sept2009. Participants could identify multiple goals

<table>
<thead>
<tr>
<th>Ultimate Goal</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lose weight</td>
<td>39</td>
</tr>
<tr>
<td>Get fit / Increase exercise</td>
<td>20</td>
</tr>
<tr>
<td>Look after self / Get well / Time for self</td>
<td>20</td>
</tr>
<tr>
<td>Increase mobility</td>
<td>12</td>
</tr>
<tr>
<td>Beat depression</td>
<td>3</td>
</tr>
<tr>
<td>Reduce cannabis smoking</td>
<td>3</td>
</tr>
<tr>
<td>Relaxation / Reduce anxiety</td>
<td>6</td>
</tr>
<tr>
<td>Stop smoking</td>
<td>10</td>
</tr>
</tbody>
</table>

Nevertheless other data suggest positive results in terms of self-reported outcomes. For the
Pathways to Health project activity, participants were asked to state their personal goals at the
outlet of activities. Table 2 shows the importance of physical activity and mental well-being related
goals for many participants.
At follow up, 82.9% (30 of 41 reporting) had completed the project activities and 73% of these individuals stated that they had achieved their main goals.

Children and young people formed an important focus for the project. The monitoring data show that the project has successfully initiated a number of activities with wide range of children and young people from the local area. The project team encouraged participants to give ongoing feedback on their experience of the activities. These have helped refine their delivery and to ensure that focus on individuals who might not otherwise have opportunities for health-related group activities. The beneficiary case study below illustrates how one of the activities sought to offer alternatives to mainstream leisure provision.

**Beneficiary Case Study**

**April “He never forgets to ask”**

Fitness Fun is a group for 4 to 10 year old children that offers a mixture of games, skill tests, challenges and match activities. It has been part of KWHP’s drive to provide a wide range of family based services alongside its adult focused work. April started bringing her nine year old son Connor to the group soon after it started. She says:

*Connor has intractable epilepsy and dyspraxia which means that he finds it hard to follow instructions or coordinate himself. He loves being active but it wasn’t easy to find any sport or play groups to join. We’ve tried going to different clubs – like after school football- but with Connor they just haven’t worked out. Some of the instructors said that they couldn’t accommodate his special needs. In others he couldn’t fit in with all the rules... We started coming here [to Fitness Fun]. Barry has been really calm and patient- he’s just great with Connor. You get all sorts of kids coming and it’s been really good for him to pick up team skills. Connor has just loved it. Now when it’s Thursday he never forgets to ask about going along. Connor has even asked if Barry can do a special group for his birthday in [the Health Park] hall.*

Barry says “I wanted to set up a different group from some of the others around here – one where any kid could fit in whether they are a bit overweight or don’t feel like they get along with sport in school. Fitness Fun is open for all children but especially those who aren’t as physically active as they should be.” For April and other parents, Fitness Fun has helped open up a range of other services available through the KWHP such as the Pathways to Health massage, aerobics classes and social groups that run throughout the week.
Wellspring Community Kitchen

Host: Wellspring Healthy Living Centre

Location: Easton and Lawrence Hill, Bristol

Introduction

Wellspring Community Kitchen aims to improve diets and promote enthusiasm and skills around food and cooking. This has been achieved by promoting access to high quality cooking facilities in a community centre setting, undertaking community cooking demonstrations, skill development and educational support. The project is not simply limited to promotion of healthier eating, it has aimed to improve mental well-being through active participation and the development of supportive community networks.

Objectives

WeHLC objective was to use the grant to pay for the fitting out of the kitchen, equipment, and revenue costs for a full time development worker/cooking tutor to: promote the project, set up and run courses/activities and work in partnership with local people and service providers. There was also an additional aspiration to develop outreach work to attract people to the WeHLC. But the primary aim was to improve diets and promote enthusiasm and skills around food and cooking, improving mental and physical health/wellbeing by increasing people’s knowledge, skills and confidence.

Subsidiary aims included:

- building social networks
- promoting positive mental well being
- share food and cooking skills with people from different cultures and backgrounds
- link with other community projects
Background & Rationale

The community kitchen is situated in the Wellspring Healthy Living Centre (WeHLC). It is embedded within the local health community and has the support of many different local organisations such as the Barton Hill Settlement, Somali Family Project and the Older Peoples Forum. The ethos behind the community kitchen is that people will gain cooking skills in a supported environment. It provided them with opportunities to build social networks to promote mental well-being, share food and cooking skills with those from different cultures and backgrounds as well as linking in with other community projects. The community kitchen is based on successful models currently operating in other locations – Filwood Community Kitchen in south Bristol is a local example (FoodVision, 2010). It provides access to a range of healthy eating activities and courses in a purpose built community kitchen. A steering group of local residents and workers agreed the detailed design and specifications for the kitchen which took account of their specific needs.

The project aimed to include different groups including: older people, parents, young people and those with low mental ill-health; while ensuring that the project is fully accessible to people from Black and Minority Ethnic backgrounds is a priority. A full-time project worker promoted, organised and ran the activities. The project works in partnership with local people and service providers. The kitchen area is large enough so that it can be shuttered off and the ‘café’ area can be used by other activities, trainers and groups. This promotes rental income for the WeHLC. There is also space within the kitchen half for a dining room table so that this can be used by any group in the kitchen. The ‘Chat café’ is a weekly café open to all residents, users and professionals at lunch time. Reasonably priced drinks and sandwiches are available as well as soup and a main meal. To support professionals in the WeHLC to use the café, since their lunchtimes are so varied, they are able to book their lunch. The crèche facility is provided outside the WeHLC. This enables a larger capacity than if it was located on-site due to lack of space and staffing for the crèche. The payment for the cookery sessions are organised on an individual basis. Payment can be up front in the form of a lump sum but for those who are unable to do this they are able to pay before each individual session.

In addition to centre based work, the project worker undertakes outreach work, for example, to an Over 50’s group by taking a portable cooker top. This has helped the worker to develop cooking skills in a wider range of settings and to also promote activities available at the WeHLC. To date the
project has largely relied on professional networks to promote the service: this is reported to be simple and effective.

**Host organisation**

Wellspring Healthy Living Centre (WeHLC) opened in 2004; it is a community-led organisation with the building located at the heart of its catchment area with a good track record of providing statutory and voluntary sector health related services to meet community needs. Wellspring has always worked closely with NHS Bristol and the project’s delivery was in partnership with Senior Health Promotion Specialist from the PCT’s Public Health Department; but now they liaise with a Community Health Improvement manager. There are approximately 12-15000 users per year who visit the GPs, PCT clinics and community services. The space in WeHLC for the community kitchen was originally planned to be a community café. The space had been used for a café since the building opened as it was not sustainable as a commercial kitchen or café due to the lack of footfall. However, the resident-led board for the HLC wanted the space to be kept for a food-oriented activity and therefore the space had remained available. The original Health and Well-Being Strategy developed for the area served by Wellspring, and agreed by the Community at Heart Board in October 2006, was based on the Primary Care Trust’s (PCT) local needs assessment and local priorities and it is also in line with local area agreement targets. This helped to inform the project’s early development. Subsequent Joint Strategic Need Assessments (Bristol City Council, NHS Bristol and Bristol Local Involvement Network, 2009) have demonstrated the relevance of the work and the importance of addressing the needs of the target community identified in this project. The range of services offered by the HLC includes a GP practice, practice nurses, counselling and health visitors. In addition, activities available include yoga, various keep fit sessions, infant massage, men’s well-being, support to lose weight, women’s health and lifestyle, bicycle loan, and various arts-based sessions.

**Project area**

The population (30,000 people) of the Easton and Lawrence Hill ward in which WeHLC is located experience significantly poor health and have particular health concerns, including a high incidence of cancer, coronary heart disease and mental ill-health. In addition, there are high numbers of low birth weight babies, high levels of teenage pregnancy, sexually transmitted diseases and drug and alcohol misuse. The north section of the ward is in the most deprived quintile in England, the whole ward is within the most deprived quintile of Bristol (APHO, 2010) and the life expectancy is nine years less than that of the most affluent ward in Bristol. There are also high numbers of refugee and asylum seekers, a proportion of whom are from Somalia and which have a high birth rate (Bristol City Council, 2010). Figures for alcohol-related and specific hospital admissions are higher in Bristol than most core cities but residents living in Lawrence Hill are over-represented. In fact fewer residents in Lawrence Weston report that their health has been good in the last 12 months or that they are fairly or very happy than anywhere else in Bristol (Bristol City Council, NHS Bristol and Bristol Local Involvement Network, 2009). Young people living in Easton are exercising less than those living in the majority of areas in Bristol and fewer people participated in creative activities in neighbourhood renewal areas. Lawrence Hill and Easton were highlighted as being two of the five areas mentioned.
Project design and delivery

**Inputs**
The project received £153,667 funding through the Big Lottery Well-being fund. Additional inputs into the kitchen £10000 for capital costs from the Community at Heart New Deal for the Communities Health and Wellbeing project at inception and £20000 from for WeHLC for rental, management, utility and office costs. Money is raised from kitchen rental and training delivery including on the Extended School Partnership Working projects locally.

**Activities**
There are a range of activities that have been supported by this project. The ‘Chat café’ is a weekly café open to all residents, users and professionals at lunch time. It offers reasonably priced drinks, sandwiches, as well as soup and a main meal. To attract professionals in the WeHLC to use the café, since their lunchtimes are so varied, they are able to pre-book their lunch and an outside crèche facility supports parents.

The project worker has undertaken considerable outreach work, for example, to an over 50’s group by using a portable cooker top. This has helped the worker to develop cooking skills in a wider range of settings and to also promote activities available at the WeHLC and in the kitchen. During the early stages of the project outreach was undertaken through largely professional networks to promote
the service. However, latterly, demonstrations have been given in children’s centres, care homes, local parks and schools.

The range of activities have included: 50+ Cookery course, Families Cooking Together, Family food on a budget, Festive feast on a Budget, Festive Store Cupboard, Healthy Eating for young people/women/under fives, Somali Elders and others, Men can Cook an d support to lose weight.

There is also a vegetable garden, which can potentially supply fresh produce to the kitchen to complete the cycle of educating people about food.

**Target Beneficiaries**

352 direct beneficiaries, plus
250 indirect beneficiaries
602 total beneficiaries:

The Wellspring Community kitchen used a standard SWWB registration form and questionnaire:

- The modal age range of project beneficiaries: 36-40 years of age (SWWB 30-35 years of age)
- Percentage of males: 36.6% (SWWB 31.4%)
- Percentage of self defined ethnicity of white: 83.9% (SWWB 92.7%)
- Most popular way of hearing about the project: GP, nurse or health practitioner (SWWB Word of mouth)
- Percentage referred by a health professional: 28.4% (SWWB 18.8%)
- The number of beneficiaries in employment: 42.8% (SWWB 33%)
- Number of beneficiaries who own their own home: 37.8% (SWWB 43.5%)
- The number of beneficiaries self defined disabled: 8.1% (SWWB 9.4%)

**Performance**

**Outputs**
- The organisation has successfully managed and delivered a high standard quality capital build that meets the requirements. Staff and service users report being happy with the result.
- Small amounts of funding have been brought in from other sources to pay for specific elements of the kitchen e.g. to fund a special disability work station.

**Outcomes**
- A questionnaire delivered to the project’s key partners revealed that the majority felt that the project was excellent or good at identifying and working with local community needs but less effective in their communication of the project’s progress, linking into other networks or
defining how it fits into other local activities and services. Partners also felt that the project could do more to make the local community aware of the project.

- The development of the Community Kitchen has led to an opportunity for the centre to get rental income to support its activities.
- Hands-on cooking with mixed groups has helped with developing language skills particularly for people who may not necessarily have English as their first language.
- While the number of people reporting that they were smoking prior to and after taking part in the project remained the same six people, 20% (n=31) reported that they no longer drank alcohol.
- The number of people reporting that they had never cycled in the last week had declined by 8.9% to 68% and the number of people reporting that they walked more than three hours in the last week had increased by 17.3% to 62.1%.
- There was also an increase in the number of people reporting that they never felt restless from 17.2% to 35.7%.
- There were similar increases in the number of people reporting that they never or rarely felt optimistic, those who felt useful all of the time and those who felt relaxed all of the time.
- Beneficiaries were more likely to report that they felt they were dealing with their problems all or most of the time, were thinking more clearly, closer to other people and better able to make up their mind.
- 64% (n=16) of beneficiaries who completed before and after questionnaires report increased life satisfaction scores on follow up.

Beneficiary Case Study

Jerry: *It’s something we can do together as a family*

*Families cooking together* is an opportunity for families to learn new culinary skills and enjoy an activity that every member can share. Based in the fully equipped community kitchen, cooking is taught as a fun, sharing and enjoyable activity. The kitchen has been designed for anyone who may need to be seated or access the space using a wheelchair. Most of the courses are based around a specific issue such as: ‘Men cooking with confidence’ or ‘Healthy eating for Single People on a budget’. This particular course offers a family activity for everyone to enjoy. Participants receive a recipe pack and they can take their food home. The costs of courses have varied from £1 to £3.50 a session; which with the food included is seen as a real bargain.

Jerry is a father with a Missus and four young children, some whom are school age. He wanted to find a local activity that would have involved all the family. He has been coming to the Centre for several years and has enjoyed other cooking courses including Festive cooking on a budget: *It was good it meant you could turn out things with very little money, like, if you are on the dole.* Jerry and his friends report that the courses are excellent for their children, it broadens their range of food choices and brings them together as a family. Jerry learnt about the cooking courses available when he attended a Men’s Health Group. Unemployed for over two years and suffering from low level mental health he was recommended the course by another attendee. He decided to join because he wanted to learn more about cooking and discover a new activity to learn as a family.
Life has been difficult for me recently with my depression and that..... so when I found this I thought it would be something really good for us to do because it is about healthy food and that and it is something we can all do when we get home as well. The kids really love it and that is why we have come here over and over again. You also meet other people like you and chat about things and that means you have some new friends to share things with which is important for them as well. They have learnt how to make things and it is something we can also do together when we go home as well, so that cooking isn’t all microwaves and packets. No...we buy things to eat as well that are not in packets and they have learnt a bit about real food.

[The project worker] is so enthusiastic that she really gets them inspired. And she is strict as well...which is good because they learn to be disciplined and work hard and safe and that in the kitchen so I think it is an excellent thing for us to have and I think more people from around here would benefit from it like me.

Wider impact
- There is a good and developing relationship with the adjacent GP practice located in the HLC. Project staff have gradually gained the confidence of beneficiaries and potential participants and partner organisations to use the services and opportunities provided by the community kitchen. Thus the project has started to underpin a range of centre services in line with the organisation’s strategy.
- The outreach work of the project has meant that community groups are increasingly becoming aware that the facility is available.
- Working with local young people has been challenging. In the local area many are not attached to youth centres and are not attending school (Bristol City Council, 2009). But the project has been flexible to develop approaches like impromptu barbecues and linking with youth services to explore opportunities. The project sees that they are helping to provide diversionary activities in the community for young people.

Processes
The funding started later than initially anticipated and therefore the kitchen was only ready to operate in October 2008. Originally it had been planned for January 2008.

The CEO prioritised time to get the capital build up and running. This placed pressures on his wider roles during the early months of the project.

The community kitchen was more expensive than anticipated. Therefore essentials for the kitchen were prioritised to ensure the kitchen was operational as soon as feasible. Groundwork for the recruitment beneficiaries, either directly or through agency networks also took considerable time.
Recruitment to the post of project worker was delayed; nevertheless she was involved in the design of the kitchen and was therefore familiar with the project. This has helped her ensure a good match between the facilities and requirements for the planned activities.

The project made a clear decision to run activities outside of the remit area in order generate additional income to be reinvested in the project.

The Centre’s garden which grows herbs, beans, rhubarb and a variety of vegetables has been run by volunteers. There has been only limited and inconsistent link with the kitchen in terms of ingredient provision. Occasional produce sales occur but the space is largely maintained for demonstration only.

**Conclusions**

**Key lessons**

The funding started later than initially anticipated and therefore the kitchen was only ready to operate in October 2008. Originally it had been planned for January 2008. The Centre Manager prioritised time to get the capital build up and running. This placed pressures on his wider roles.

The project learnt quickly that you need to have the right people involved in the steering group to get the project delivered. Hence they involved local people and cooking professionals to advise on the development of the project and the design of the kitchen space.

It believes it is important to ensure that advisors, supporters and contractors fully understand the ethos and the ways of working within WeHLC is the only way to ensure maximum delivery of their input.

The community kitchen was more expensive than anticipated. Therefore essentials for the kitchen were prioritised to ensure the kitchen was operational as soon as feasible. Groundwork for the recruitment of beneficiaries, either directly or through agency networks, initially took more time than anticipated.

Recruitment to the post of project worker was delayed; nevertheless she was involved in the design of the kitchen and was therefore familiar with the project. This has helped to ensure a good match between the facilities and requirements for the planned activities. The project has learnt through developmental outreach work that different groups in the community have different needs and capacity e.g. working with elderly people the project worker discovered that they were not necessarily interested in cooking having done this all the lives but they did enjoy demo’s on things like quick food, healthier eating and culinary techniques. In developing their outreach work they have been able to recruit beneficiaries onto the longer courses.

Working with local young people has been challenging. In the area many are not attached to youth centres and are not attending school (Bristol City Council, 2009). But the project has been flexible to develop approaches like impromptu barbecues and linking with youth services to explore
opportunities. The project sees that they are helping to provide diversionary activities in the community for young people.

The Centre’s garden which grows herbs, beans and a variety of vegetables has been run by volunteers. There has been only limited and inconsistent links with the kitchen in terms of ingredient provision.

**Opportunities for the future**
The project has been looking at the potential of developing a training package for young NEETS who might be interested in developing skills for employability.

The project is getting increasing enquiries from external organizations to use *Cook for life: cooking from scratch* programmes. In particular Children and Young People Services are looking to support people moving into independent housing and to have this included in an actual care package.

The CEO at WeHLC has been active in seeking links to develop the sustainability of the kitchen. This has included looking to private cooking training providers in the city.

The WeHLC has grown to full capacity and is currently looking to expand its buildings to ensure it can continue to house the services it currently hosts. They have tried to bid to the Social Investment Fund

They are continuing to look to see what health services particularly for BME groups they feel they could offer for the local community and beyond; in particular they are considering and looking to developing a small ops unit.

Capitalising on the broader success of art and health activities provided WeHLC the future Community Kitchen courses and community based activities will be developed and promoted by a generic co-ordinator in the future.

In the future the project is considering a range of new activities including running team building cooking courses, courses that will seek to address key issues of obesity and social isolation and courses for independent living.

**References**
Bristol City Council, NHS Bristol and Bristol Local Involvement Network (2009) *Joint Strategic Needs Assessment...Keeping you informed*.
Westbank New Steps

Location: Exminster, Devon

Host Organisation: Westbank Healthy Living Centre

Introduction
This report provides a profile of the Westbank New Steps project, an initiative funded as part of the South West Well-being programme. This project encourages people to take new steps towards a healthier mind, body and soul and aims to holistically support and help improve mental health, increase physical activity and promote healthier eating.

Background & Host organisation
Westbank is the lead portfolio organisation for the Big Lottery South West Well-being programme. Westbank Healthy Living Centre (WHLC) is managed by Westbank Community Health & Care. It was established in 1986 following a GP inspired, philanthropic, volunteer-led campaign to provide health support to local people. It ran as a registered charity for over 20 years until transferring to a company limited by guarantee in 2007. It benefited from the donation of a site and buildings attached to the former Exminster hospital. Its mission: ‘Providing Care, Promoting Health’ is incorporated in its logo.

Westbank works in partnership with six GP practices, engaging volunteers who provide practical and emotional support to users. It also endeavours to ensure that the volunteer voices are considered in Health and Social Care arrangements locally. As an independent health care provider it also seeks to empower and improve the health of communities and individuals across Devon with the object of the original charity being to relieve sickness and preserve health amongst persons permanently or temporarily resident in the County of Devon and in particular the west bank communities of: Exminster, Kenton, Starcross, Kenn, Kennford, Mamhead, Powderham, Cofton, and Dawlish Warren.

The centre opened 2004. In 2005, the organisation opened an outreach centre in Starcross in the form of a community meeting place and charity shop which is now running as a social enterprise. They provide a busy and oversubscribed day centre service. The work at the HLC and surrounding
communities is supported by a team of more than 80 paid staff. The combination of centre-based and outreach work reflects Westbank’s ‘hub-and-spoke’ model for service delivery.

Its Volunteering Programme includes over 250 volunteers carrying out a wide range of roles both within the HLC and in the community. Volunteers are involved in every aspect of work. During 2009/2010 the volunteers were estimated to have contributed more than 23,000 hours of their free time to support the work of the organisation including: leading health walks, supporting the children’s gymnastic club, serving in the charity shop and drop-in, transporting people to healthcare appointments, visiting and befriending people who are isolated, providing support for carers, supporting our children’s and older people’s activities and giving young carers a break. The Centre has its own minibus. It has a countywide contract to coordinate carer’s services as part of a consortium with East Devon and Exeter CVSs. The HLC hosts a wide range of social, art and fitness events that run into evening hours.

The charity’s main objectives are to:

- Reach socially excluded people,
- Nurture physical, mental, social and emotional well-being,
- Provide early years development and family health services,
- Offer health Intervention for all in smoking, diet and nutrition,
- Provide quality information, advice and guidance,
- Provide care and support to patients and carers,
- Provide quality volunteering opportunities,
- Provide quality day care services.

Project area
The New Steps project serves three local communities which are specified as: Exminster, Rural Teignbridge and Urban Exeter and, in particular, deprived communities in these areas. Within the less urban areas there are higher levels of people over 65 living in isolated communities facing greater barriers for accessing local health and community services.

Health profiles for the local area around Exeter are close to English averages. In fact the Devon Public Health Report acknowledges that in general, the county has ‘a healthy population with very good quality health and social care... But the challenges are largely as a result of our lifestyles’ (Devon PCT, 2008). Amongst the key priorities for the PCT are obesity, the promotion of mental health and well-being (and prevention of suicide), the health of those in socio-economically deprived
communities and the promotion of effective joint working to tackle socio-economic deprivation and thus one of the major causes of ill health and inequality.

The New Steps project aims to meet some of these priorities and in particular target deprived communities in urban Exeter of which the wards of Newtown, Priory and St David’s are amongst the most deprived in the country. Through the LAA the WHLC also seeks to work with its partners to tackle deprivation and the causes of ill health a need highlighted in a Health Needs Assessment undertaken by Devon PCT and Devon County Council. In particular the villages in the Dawlish area on the west bank are recognised as having a rapidly increasing population and it has an over representation in the number of lone pensioner households and those claiming Incapacity Benefit, Severe Disability Allowance and Disability Living Allowance; than in any other Devon area. There is also an over representation of people who feel that their health is generally poor (Devon County Council 2007).

Project design and delivery

Aim & Objectives
Westbank New Steps aims to holistically support and help improve the mental health, physical activity and eating habits of its target communities. It intends to work with people with low level mental ill health, mature (45+) people with sedentary lifestyles and families from deprived communities. The project seeks to help maintain and sustain longer term health behaviour change. As a central focus it aims to retain 80% of participants on a planned programme of physical exercise for six months.

Inputs
The project has received £327,270 of funding from the SWWB portfolio for three years of project delivery. The project started in February 2008 and will end in February 2011. Match funding to support the project also comes in the form of a PCT funded volunteer coordinator and income generated from Westbank self generated income (estimated at £31,000). The project expenditure is largely apportioned to activity and volunteer coordinator staff costs (2.5 FTE). Volunteers play an important role in the project, with an average of over 15 volunteers making a contribution at any one time.

Activities
The New Steps project is based at the WHLC a venue that provides ‘something for everyone’. Project delivery commenced in February 2008 with new opportunities being planned and developed to supplement the very broad range of health and lifestyle activities already available at the HLC. The breadth of activities provided is captured in the activity summary table below. Each project has an action and work plan to pursue. These plans are reviewed with project staff to ensure targets are met.

Referrals to the project can come from local health and community professionals or self refer at the HLC. Through individual support in assisting users to access healthier lifestyles, the project believes it can help build the capacity of local communities to enjoy sustainable, healthy, activities, locally
through encouragement ‘to take new steps towards a healthier mind, body and soul’. The project envisaged providing and developing a broad range of activities from:

- teaching cooking skills to bereaved men who may have limited experience, culinary skills,
- community gardening,
- weight management support and individual support to access the centre’s gym.

The HLC’s gym and fitness centre is a successful key component of the project. It aims to increase its inductions to the fitness suite and will continue to offer support to users through a Lifestyle Assessment. Standard exercise programmes are offered and capital equipment purchases (Sci-fit Pro II) means they are now able to offer more specialised rehabilitation programmes including chronic back pain and acute injury rehabilitation. The GP Referral programme Body Active also offers exercise opportunities to people who may otherwise not have accessed exercise facilities.

Entrance to activities often follows a lifestyle assessment where future participants may be linked with a volunteer motivator. The centre also provides supported volunteering opportunities as another step to well-being.

**Project organisation and services**

![Diagram of project organisation]

**Project activities and services**

- Grow and Cook Sessions
- New Leaf Café
- Food for Mood
- Assertive and Confidence Building course
- Access to physical activities, Walking Group
- Access to exercise classes, Fitness suite, fitness suite with disabled access
- Supported Volunteering and support back to work
- One-off Events
- Development Activities
Target Beneficiaries

Whilst Westbank Healthy Living Centre works with all people across the community, the project primarily seeks to benefit the following groups:

- people at risk of problems associated with their low level mental ill health,
- people over the age of 45 with sedentary lifestyles,
- families from deprived communities.

Over the three years the project has planned to deliver services to 1800 people (600 each year) in these groups. This is in addition to the current 15,000 a year user visits to the organisation’s other services.

Performance

Outputs

Westbank New Steps delivers a wide variety of activities. The majority of these are group based and can be accessed by self referral or via health and social care professionals through existing local partnerships with the NHS. A small fee is collected for some activities to help sustain the project. Almost 70% of beneficiaries hear about the project through word of mouth (source: beneficiary registrations).

Approximately 80% of participants are engaged in group activities and 20% take part in individual activities 2.5 project yrs: 1275 group, 311 individual).

Table 1 Westbank New Steps: Activity Summary

<table>
<thead>
<tr>
<th>Activity</th>
<th>Well being theme*: primary (others)</th>
<th>Providing organisation:</th>
<th>Type of staffing</th>
<th>Status at outset of the project</th>
<th>Individual or group delivery</th>
<th>Type of group, length and size</th>
<th>Targeting and referral details</th>
<th>Fee for service user</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to physical activities with a known impact on anxiety/depression</td>
<td>PA (MH)</td>
<td>Fund holder</td>
<td>Salaried staff, Volunteers</td>
<td>Development of existing activity, new activities</td>
<td>Group &amp; individual</td>
<td>1. Open 2. Varies 3. Varies</td>
<td>Varies</td>
<td>Varies from Free - £4.50 depending on activity</td>
</tr>
<tr>
<td>Supported volunteering and rehab back to work</td>
<td>MH</td>
<td>Fund holder</td>
<td>Salaried staff</td>
<td>Development of existing activity</td>
<td>Individual</td>
<td>1. Closed 2. Continuous 3. Approx 20</td>
<td>Self-referral &amp; referral by professionals</td>
<td>£0.00</td>
</tr>
<tr>
<td>New Leaf Café and mood for food</td>
<td>MH (HE)</td>
<td>Fund holder</td>
<td>Salaried staff and volunteer</td>
<td>Development of existing activity</td>
<td>Group</td>
<td>1. Open 2. Continuous 3. No limit</td>
<td>Open</td>
<td>£1.00 - £4.00</td>
</tr>
<tr>
<td>Assertiveness / Confidence building skills</td>
<td>MH</td>
<td>Fund holder</td>
<td>Sessional staff</td>
<td>Continuation of existing activity, new</td>
<td>Group</td>
<td>1. Open &amp; closed 2. Fixed term &amp;</td>
<td>Self-referral &amp; referral by professionals</td>
<td>Varies</td>
</tr>
<tr>
<td>Walking groups</td>
<td>PA</td>
<td>Fund holder</td>
<td>Volunteers</td>
<td>Development of existing</td>
<td>Group</td>
<td>Open</td>
<td>Targeted</td>
<td>Free</td>
</tr>
</tbody>
</table>
Volunteering
Volunteer support and development has an essential part in the Westbank New Steps project. Table 2 provides an in-depth illustration of volunteering records. This shows the breadth of the contributions by volunteers. These figures are likely to under-record the actual extent of voluntary activity given that it does not reflect, for example, preparation time or informal recruitment through community networks. The project team, therefore, estimates that the actual figure is likely to be more than double those detailed here.

Table 2: Project Weekly Volunteer Hours: Westbank New Steps

<table>
<thead>
<tr>
<th>Activity</th>
<th>No of volunteers are <strong>ACTIVE</strong> in any one week</th>
<th>Combined number of <strong>ACTIVE volunteer</strong> hours PER WEEK</th>
<th>Average no of <strong>ACTIVE</strong> hours PER volunteer</th>
<th>No of adhoc volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Allotment / gardens</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>2 Day centre</td>
<td>14</td>
<td>63</td>
<td>4.5</td>
<td>3</td>
</tr>
<tr>
<td>3 Lunch club</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>4 Family support</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>5 Health &amp; fitness</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>6 Activity groups</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>7 Bereavement support</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>8 Young carers</td>
<td>6</td>
<td>15</td>
<td>2.5</td>
<td>8</td>
</tr>
<tr>
<td>9 Social groups</td>
<td>18</td>
<td>45</td>
<td>2.5</td>
<td>8</td>
</tr>
<tr>
<td>10 Support groups</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>11 Health walks</td>
<td>37</td>
<td>92.5</td>
<td>2.5</td>
<td>8</td>
</tr>
</tbody>
</table>
Volunteer Case Study: Westbank Day Care Centre

Volunteering is an essential element to Westbank’s New Steps project. With an average of 93 people volunteering per week, the support for services has been considerable. Volunteering amounts to 12,690 hours per year, or the equivalent of 6.6 full time staff. As two very different people explain, volunteers often find the work personally very rewarding.

A 73 year old pensioner at Starcoss has been volunteering with Westbank services says:

*I help at the day centre on a Wednesday and also at the charity shop on a Thursday. A friend told me about the day centre. I had just lost my partner and volunteering helped me at a difficult time. [I felt I have been able] to give something back to my community and it is very rewarding because I have met many people I would not have met. I hope I am making other people’s lives happen.*

An 18 year old volunteer studying health and social care at college says:

*I help out at the day centre and after school club at Westbank proving an extra pair of hands for support and supervision. My mum suggested I should do something to broaden my future as it can open new experiences and opportunities, as well as showing how I’m into trying new things when applying to university. It gives me a sense of achievement and I feel I’m giving something back to the community and playing my part in society. I think I help lift a burden and help make the working day easier for those who work [at Westbank].*

Of the approximately 200 volunteers that the project works with, the team estimate that about three quarter this number would be willing to continue to contribute after the close of the Big Lottery funding period. The team see this as an important legacy for the work over the past three years.

Outcomes

General health
Participants rated their health on a five point scale, from 1 for ‘excellent’ to 5 for ‘poor’. There was a significant improvement in self reported health, from a baseline mean of 3.55 to a follow up mean of 2.77.
Table 2 Westbank: Self Reported General Health in the Last Week (n=93)

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>1.1%</td>
<td>10.0%</td>
<td>38.9%</td>
<td>34.4%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Follow-up</td>
<td>9.2%</td>
<td>29.9%</td>
<td>40.2%</td>
<td>17.2%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

Whilst the measures are somewhat different, these data show improvements in comparison to large scale surveys. 50% of Westbank respondents reported their general health to be ‘good’ to ‘excellent’ at baseline. This rose to 79% at follow up. The NWPHO survey (2009) of a cross section of the general adult population found that 72% of respondents reported that they were in ‘good’ or ‘very good’ health.

**Healthy eating**

Respondents were asked to estimate the average number of fruit and vegetable portions they consumed per day. For the 93 respondents there was no overall significant change in mean intake at baseline and follow up (3.47 to 3.42, paired T test p=0.903). Participants taking part in physical activities that included dietary advice were more likely to report an increase in intake (mean: 3.24 to 4.36), however this change was not statistically significant (n=33; paired T test p=0.098). This result suggests the need for a larger sample size in order to further assess the impact of Westbank’s activities on fruit and vegetable consumption.

Other questionnaire measures suggest that Westbank’s activities have had a positive impact on participants’ attitudes towards healthier eating. Using a likert scale, the percentage of participants reporting that they ‘agreed or strongly agreed’ that they put effort and care into preparing meals rose from 69.7% at baseline to 95.4% at follow up (n=85). A paired T test showed that change was statistically significant (p<0.001; t=8.65; SEM=0.11).

**Physical activity**

For general health benefits, adults should achieve a total of at least 30 minutes a day of at least moderate intensity physical activity on 5 or more days of the week (the 5x30 guideline). Participants’ changes in physical activity were measured using the GP Physical Activity Questionnaire (GPPAQ) scale and a 4-week physical activity self report. The findings show that participants who engage in Westank activities are more likely to meet public health guidelines on physical exercise. At baseline 9.1% of participants were following the 5x30 guideline. At follow up this figure rose to 22.7%. This is in the context of national
research that shows 31% of adults were meeting the current guideline (NWPHO, 2009).

Mental ill health

Drawing upon the seven item version of the Centre for Epidemiological Studies Depression Scale (CESD-D), findings from Westbank participants suggested a significant improvement in self reported mental health. There was a statistically significant decrease in reported depression scores demonstrating improved mental health from baseline (M =8.44, SD 5.22) to follow up (M=12.58, SD 4.29) t (88) -7.08. On the shorter CES-D a score of 8 or less is indicative of significant or mild depressive symptoms. The baseline and follow up mean scores here indicate that at baseline beneficiaries reported mild depressive symptoms on the scale but not on follow up.

The data can be put in the context of wider research. The percentages of people reported significant or mild depressive symptoms are:

- 20.8% of the UK population (NWPHO, 2007)
- 36% of respondents in the other BIG Well-being portfolios to date (Sept 2010)
- 49.5% of Westbank respondents at baseline
- 18.9% of Westbank respondents at follow up

These data suggest that Westbank is working with people who have higher than England average levels of mental ill health. For these people, participation in New Steps project activities was associated with a significant improvement in mental health.

Mental well-being: life satisfaction

Participants were asked how satisfied or dissatisfied they were with their life on a scale from 0-10 where 0 was extremely dissatisfied and 10 extremely satisfied. There was a statistically significant increase in reported satisfaction from a baseline (M=6.9, SD 2.29) to follow up (M=8.4, SD 2.02) t (90) -5.74. This measure is a good predictor of wider aspects of psycho-social well-being that can be compared to other survey data. The average scores for the following surveys are

SWWB baseline average = 6.1

BIG Well-being portfolio respondents = 6.6

UK adult population survey (Defra, 2007) = 7.2

A comparison therefore shows that Westbank participants self-reported life satisfaction is below the average for the UK adult population at start of their activities. Following participation in Westbank activities self-reported life satisfaction is higher than the UK average (8.4 compared 7.2).

Mental well-being: positive functioning and feeling

Using measures derived from the Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS), we found a significant improvement in self reported mental well-being. There was a statistically significant mean increase from 22.8 to 26.8 (SDs: 5.0 & 3.9; t-9.82; p<0.001). In the context of other studies, Table 15.2 shows that the percentage of Westbank respondents reporting low mental well-being fell by more than half (53.3-23.5%) over the course of participating in programme activities. By
the end of the evaluation period Westbank participants were reporting mental well-being that approached the English average. It should be noted that the SWEMBS scale need to be interpreted with caution where the number of respondents is under 100.

Table 3 Mental Well-being scores (Short WEMWBS): comparison between national, SWWB and Westbank data.

<table>
<thead>
<tr>
<th></th>
<th>Mean score (out of 35)</th>
<th>Low well-being</th>
<th>Moderate well-being</th>
<th>High well-being</th>
<th>Bases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>England population</strong>*</td>
<td>27.7</td>
<td>16.8%</td>
<td>62.8%</td>
<td>20.4%</td>
<td>18,500</td>
</tr>
<tr>
<td><strong>SWWB baseline</strong></td>
<td>23.3</td>
<td>42.4%</td>
<td>54%</td>
<td>3.4%</td>
<td>671</td>
</tr>
<tr>
<td><strong>SWWB follow up</strong></td>
<td>25.5</td>
<td>26.9%</td>
<td>66.9%</td>
<td>6.2%</td>
<td>671</td>
</tr>
<tr>
<td><strong>Westbank baseline</strong></td>
<td>22.8</td>
<td>53.3%</td>
<td>71.1%</td>
<td>0%</td>
<td>92</td>
</tr>
<tr>
<td><strong>Westbank follow up</strong></td>
<td>26.8</td>
<td>23.5%</td>
<td>71.1%</td>
<td>5.4%</td>
<td>92</td>
</tr>
</tbody>
</table>

* North West Mental Wellbeing Survey 2009

**Social well-being**

The questionnaire used a series of social capital measures to assess changes in participants’ sense of social well-being. Paired T tests showed highly significant (p<0.001) positive changes in social well-being for the following measures:

- Perception of belonging to a community
- Personal help from people who really care
- Social interaction with friends and relatives
- Opportunities to meet people who share similar hobbies or interests
- Help from people in the local area
- Participation on activities in the local area
- Satisfaction with local neighbourhood

Although we have not made direct comparisons with other study results, the findings clearly lend supporting evidence for the wider social benefits of participating in Westbank project activities.

**Beneficiary Case Study**

**Kate:** *I was worried about post natal depression, but through the friends I met on the walk I had all the support I needed to have a happy pregnancy and start to motherhood.* Aged 37

*For years I had been trying for a baby, and over several years have suffered a number of miscarriages and medical problems leading me to believe that I may never be lucky. However when I fell pregnant this time around things felt better. Day by day I was worried about the same problems occurring but as weeks passed and scans were booked I began to realise my time may have come to bring a new baby.*
life into the world. I wasn’t working at the time, and due to my age, I wanted to meet other expectant mothers to ensure I had enough support through the pregnancy and after the birth. I found some groups were unwelcoming and others excluded me because I wasn’t far enough along with my pregnancy, or my ‘bump wasn’t big enough.

It was then that I found the bumps, mums and pushchair walk. I was welcome straight away, and met lots of people who had been through all sorts of different pregnancies, and was able to chat about all of my questions and worries as they occurred with people who weren’t expert but could share their own experiences with me. From buggy choices through to birthing positions and breast feeding!

As my pregnancy progressed my friendships grew stronger and although I had signed up for NCT antenatal classes, I decided not to sign up for post natal classes because I felt like I had all the support I needed. My birth was a month early, and it was at this point that things got slightly worrying. My child had a few weight struggles, and I was feeling very helpless to make things better. The doctors were all conflicting with their advice, so from a suggestion from one of the mothers I contacted the health visitor. Her support has been invaluable to helping to get my child strong and well again. I also had a visit one day from the walk leader after the walk, and her visit was timed just after my baby had been sick her whole feed, at a time when I was terrified she wasn’t getting any nutrition at all. She came through the door and I was so pleased to see a friendly face. I was in tears, but having someone who cared enough to pop in just on the off chance helped me feel so much better that day.

I continued to attend the walks with my baby, and have enjoyed the socialising at a time that can be difficult to get organised to leave the house. Knowing we are just going for a walk, is so much easier than having to get sorted for a baby toddler group or alternative. I never worry about being left in a corner on my own without anyone talking with me, because when you walk you talk!

My most profound success from the walks however has been my recent introduction to a lady who is using the same childcare and rearing techniques that I have adopted. All of my peers on the NCT classes all used conventional methods, which made me feel like my methods were weird and wrong. However meeting another lady whose child was older than my own, who lived just around the corner from me, I instantly felt like I wasn’t the only one rearing their child this way, and that I wasn’t actually weird or alternative. I have met some great friends and wouldn’t be without my weekly walk.

Wider impact
Through the work of the New Steps project the team has been able to further develop links with partners in health and social care. The holistic approach led to the team being asked to develop and deliver a pilot family obesity project in Exeter, the model of which is now rolling out elsewhere in the county. It has also allowed the team to work more closely with GP practices to offer individualised support for their patients (in the form of supported volunteering opportunities, a falls prevention
programme, pulmonary rehab and low-key stimulating activities for people at risk of low-level mental ill health).

The team has been able to offer their expertise to other third sector organisations, thereby stretching the reach of the project. This is highlighted in work with Home Start in Teignbridge with whom the team have jointly delivered healthy eating sessions for families, whilst also equipping and training them up to be able to go on delivering to a wider client group.

The consortium approach has enabled the team to find common ground with other healthy living centres and to work in partnership with them on other pieces of work. An example of this is their work with Upstream Healthy Living Centre, with whom they are now delivering the Walking for Health initiative in Mid Devon.

Part of the project has been about researching and making links with other organisations that the team can refer service users. The staff team have done this in their own areas of expertise and this information has then been shared amongst the team and wider throughout the whole organisation, thereby raising awareness more widely.

Conclusions

Key lessons

- The team have learned that in order for people to make sustained lifestyle changes there needs to be an intense level of support available over a comparatively long period of time and that this is therefore an element which needs adequate resourcing.
- The team has discovered that one of the best ways to engage with GPs is to attend their practice meetings. Attending meetings and outlining services to groups of GPs promoted the most discussion and brought about the highest number of referrals.
- The team have found word of mouth to be one of the best forms of promotion. Getting out into communities and working with people to create the services they need has been the key to the success of the project.

Opportunities for the future

- Through work with the SWWB Programme the team has already been involved in several Well UK pieces of work and are looking to build on this, along with future partnership working opportunities with other healthy living centres.
- The team will be continuing to work with partners in health and social care around the commissioning of services.
- With the community links the team has been building on through the New Steps project will be considering involvement in the Big Society Community Organisers project.
Living Well

Host organisation: West Somerset Sports and Leisure

Location: West Somerset district local authority

Introduction
This report provides a profile of the Living Well project, an initiative funded as part of the South West Well-being programme.

Project aims
West Somerset Sports and Leisure Centre hosts the Living Well project. The project is targeted at deprived communities in the largely rural West Somerset district local authority area. The aims of the project evolved from consultation with local stakeholders and professionals who aspired to:

- Increase physical activity through walking groups and access to exercise classes
- Promote healthier eating through provision of a community training allotment opportunities
- Improve mental health through access to physical activities

All Living Well activities are supported by volunteers who are trained and supported by the project team. Key to the project’s ethos is an active outreach programme to reach and listen to the well being needs of people living in remote communities.

Project rationale and theory base
The project evolved at a time when Somerset County Council was looking to support community health activities external to sports centres. In 2008 the PCT was supporting an Active Life Style Officer to develop work to promote health and physical activities in a community setting. The idea emanated from cross-service conversations developed at a county wide Healthy Communities workshop hosted in June 2008. The public and partners like the Live Well West Somerset project, West Somerset Leisure Trust, West Somerset PCT and West Somerset Community College were asked to explore and think about the development of the health and activity needs of local communities. The partners and services have learnt to identify gaps in local service provision and they felt it was important to expand outreach activities to their large rural community. The approach was seen as a potential method for including remote local communities, building capacity and developing new seeds to give local communities space to be active. Under the Living Well banner partners began working to deliver the West Somerset Sustainable Community Strategy 2007-2010;
particularly the Building Healthier Communities and the Building Stronger Communities elements. Thus they aim to improve the health of all people by:

- Raising awareness of healthy lifestyles
- Ensuring that facilities and services on healthcare are accessible
- Ensuring that facilities and services to promote healthy lifestyles are accessible
- Promoting exercise for all people in West Somerset using the natural environment
- To develop better working relationships between and with health services

The Living Well team at the leisure centre are perhaps not the typical fitness personnel you would find delivering sporting and fitness activities in leisure centres around the country. Instead they perceive themselves as normal people from a broad range of age bands and backgrounds seeking to attract people like themselves into an active lifestyle.

**Host organisation**

Somerset County Council commission the delivery of leisure services from Somerset Leisure Ltd. Somerset Leisure Limited are a charitable trust delivering leisure services at 13 dual school/leisure centre sites around the county. All sites allow school and community access. The West Somerset Sports and Leisure Centre is situated on the West Somerset Community College campus. It provides leisure services to people living in the West Somerset district local authority. The centre offers users an air-conditioned fitness suite with Life Fitness Cardio-Vascular and Sportesse resistance equipment and a free weights area. It has four squash courts, a large sports hall, an activity hall with semi-sprung floor, an artificial outdoor pitch, outdoor floodlit tennis courts, grass pitches and a sports lounge used for meetings, training programmes and light exercise activities.

**Project area**

Approximately 60% of the project’s direct beneficiaries live in the town of Minehead or the immediate vicinity. But the project specifically covers the local authority district of West Somerset an area of 280 square miles inhabited by 35,600 people. Two-thirds of West Somerset is recognised as the Exmoor National Park and a quarter of the population of the district live in the coastal town of Minehead. Almost 30% of the population is older than 65 (England and Wales 16%). Life expectancy is high: 78.9 years for men, 82.1 years for women. 21% of households are pensioners living alone (14% in Somerset). 22.3% of local people have a limiting long-term illness. The number of people defined as being in the lowest quintile of deprivation is smaller in the district than in the South West and England. The health of people in West Somerset is generally better than those of people living in other local authorities in the
country. And over the last 10 years, the death rate from all causes combined and the rate of early
death from heart disease and stroke have fallen. However the rate of malignant melanoma skin
cancer, the rate of people, killed or seriously injured on the roads each year, tooth decay in five year
old children and people diagnosed with diabetes is significantly worse than English average. In
response the Somerset Local Area Agreement has prioritised tackling physical activity, smoking,
obesity, alcohol misuse, teenage pregnancy, fuel poverty and reducing deaths from circulatory
disease over the next 3 years.

Project design and delivery
The Living Well initiative aims to empower local people to discover and adopt a healthier lifestyle by
getting people involved in healthy activities. There are three strands to the project: Health Walks 4
Living, Fit 4 Living and Food 4 Living. These strands are underpinned by the Volunteer 4 Living strand
which seeks to engage willing volunteers with all project activities.

Health Walks 4 Living a programme of regular health walks. The project aims to identify, plan and
ensure the delivery of a range of health walks across the district. The team offers training to
volunteer walk leaders to meet a growing demand.

Fit 4 Living aims to get people to be more active in their community. It seeks to help to establish a
variety of sustainable activity classes for adults and families. Hitherto, these have included things
like: Orienteering, Boot Camp, Women’s football, Tai Chi on the Beach, Yoga and Pilates. Outreach
work has ensured that activities happen in smaller communities beyond the project’s Minehead
base including mountain biking in the villages of Dulverton and Williton and Pilates in a village hall in
Brushford.

Food 4 Living provides vulnerable adults and families on low income and older people with
mentoring and skill development opportunities to grow their own produce by providing a training
allotment and skills training. With matched PCT funding activities like Food For Living and Families
for Living projects have been aiming to address objectives outlined in Department of Health (2004)
Choosing Health approach. Other activities have included Cooking for One, Jam making and support
given to a vibrant food co-operative in Watchet.

The Volunteer 4 Living strand trains and supports volunteers to support the various Living Well
projects. The project has established a bank of volunteers for the Living Well programme. They train
and provide ongoing support to volunteers. They are always developing new volunteering
opportunities and aim to provide opportunities to suit individual volunteer’ needs. In the long term
they aim to transfer the management of the bank of volunteers to local partners.

Additionally, the project has supported a range of one-off events and activities like Seed Swap, Apple
Juicing and Potato Days etc. Clients of the project and the public are invited to suggest potential
courses and activities on line through the project website. Application forms for activities can also be
completed on line. And the website serves as a useful source of information on the range and
variety of activities such as Gardening for Pleasure delivered by Somerset Skills and Learning.
Currently, the site receives between 50 and 180 hits a day. The project team have also developed
and printed individual leaflets on each activity which specify and outline the health benefits of pursuing any of its local activities.

**Inputs**

In addition to the Big Lottery funding of £104,994 NHS Somerset is supporting the project with £80,000. Somerset Leisure have provided benefits in kind including office space and equipment at the leisure centre. West Somerset Local Authority has part funded member of staff.

**Target Beneficiaries**

The project’s beneficiary numbers for each of the strands were:

- Health Walks for Living (150 Beneficiaries)
- Fit 4 Living (160 Beneficiaries)
- Food 4 Living (300 Beneficiaries)
- Volunteer 4 Living (100 Beneficiaries)

Total beneficiaries: 710

The Living Well project uses a standard SWWB programme registration form to collect details of core beneficiaries. Analysis of this registration information from their database provides the following project beneficiary profile statistics:
• The modal age range of project beneficiaries: 30-35 years of age (SWWB 30-35 years of age)
• Percentage of males: 32.1% (SWWB 31.4%)
• Percentage of self defined ethnicity of white: 98.6% (SWWB 92.7%)
• Most popular way of hearing about the project: Word of mouth (SWWB Word of mouth)
• Percentage referred by a health professional: 5.2% (SWWB 18.8%)
• The number of beneficiaries in employment: 50% (SWWB 33%)
• Number of beneficiaries who own their own home: 66.6% (SWWB 43.5%)
• The number of beneficiaries self defined disabled: 5.3% (SWWB 9.4%)

Performance

Outputs

• This project has uniquely provided the sports centre staff with an opportunity of reaching new communities to discover and learn about the health needs of new clients. Hitherto, sports centres have relied on service users to find them.
• Great efforts have been made to develop links into rural communities including advertising activities in parish magazines and GP surgeries and Active Living Centres for the elderly.
• Innovatively they have used the opportunity provided by the Big Lottery funding to break new ground in developing new activities including Tai Chi by the Beach, Family Orienteering and a Women only gym.
• The team has expanded their knowledge about the community’s needs, feasible activities, the capacity of providers and the options of what is available in terms of venues for activities.
• The project is proud to have planted a legacy in supporting individual practitioners to establish new businesses to independently deliver activities developed by the project.
• Local professionals report on the value added they have discovered by working with direct beneficiaries e.g. single parents who have lacked the confidence to develop a social life outside of their daily routine.
• New users are coming to the sports centre who had not accessed their services before.
• The project has enabled the Living Well project to develop a new model of working within the county. In particular it is about community development, outreach, experimenting and learning. Project team staff have disseminated their community development approach through presentations to other service providers across the county. Other leisure centre staff consider the West Somerset model an example of good practice.
• Sports centres have an image that is largely youthful, athletic and energised. In many ways this is an ideal. The project team take a more down to earth approach and pride themselves on being normal people and being able to present a customer face that suggests that normal people can engage with leisure activities.
The project has worked hard to find new service deliverers to provide activities. It has worked with a private provider of a swimming pool to give local people an opportunity to swim by covering the community transport costs.

Outcomes
Using the standard questionnaire developed as part of the SWWB programme Living Well collected baseline and follow up health and well-being evidence from 54 people. Records were collected at the point of enrolling with the project and then on completion. The findings from this study show considerable improvements in health and well-being across a number of measures. The number of people reporting that their health was either very good or excellent over the previous week increased from 51.9% at the start of their involvement in this project to 67.9% at the end. Three participants report giving up smoking and the remaining smokers had cut down significantly with no one reporting that they smoked more than 20 a day. One participant reported giving up alcohol.

The questionnaire asks several questions on beneficiaries’ physical activity. Our assessment of physical activity draws upon the GP Physical Activity Questionnaire (GPPAQ) scale. We found that there is a very significant improvement in self reported physical activity using conservative values to rate activities reported. There was a statistically significant (p<0.001) increase in reported activity scores from baseline to follow up t (49) =-7.919. The mean increase in scores was 2.17 with a 95% confidence level of -1.612 to -0.959. The eta squared statistic (0.7) indicated a moderate effect size. Beneficiaries also report increased cycling, walking and gardening activity.

These beneficiaries also report a significant (p=0.001) increase in their enjoyment in physical activity. At baseline (M=4.23, SD 0.657) to follow up (M=4.83, SD 0.778) t (53) =-1.29. The mean increase in scores was 0.6 with a 95% confidence level of -441 to 0.98. The eta squared statistic (0.04) indicated a small effect size.

The number of beneficiaries reporting that they feel happy most days also increased by 18%, the number of people reporting that they never feel depressed increased 12.5%, those that feel engaged everyday increased by 6% and those reporting that they never feel lonely fell by 33% after experiencing their activity.

Wider impact
The project team has worked hard to ensure that they have reached deep into West Somerset hinterland to build a health activity infrastructure for this largely rural district. Several communities have received activities that they never had before.

The volunteer programme has gone well and they now have x volunteers on their database and these are training up to deliver and lead activities for the future.

Some activities are now self sustaining including the Dunster walking group who organise and maintain themselves and also develop additional social activities outside their walking programme for members to share and enjoy.
They have made new and unique connections to organisations they have never worked with before like Natural England. This has included gaining advice and support for volunteer projects to deliver activities like the Porlock Community Orchard.

There are 13 Sports and Leisure the county of Somerset. The project team believe they have developed a successful model of developing outreach work for the other centres in the county to embrace. Including new communities in healthy activities is potential model for sustaining centres in more economically stringent times. As a model they are beginning to make other centres think about how to get more people involved with their activities.

**Processes**

- The project has welcomed the support that Westbank has provided. In particular; as a seedcorn project, they have enjoyed the knowledge exchange and support offered.

- Since the election of the coalition government all local authorities are facing cost constraints. The extent to which the project can be supported beyond the project end remains unclear. Somerset is actively seeking continuation funding.

- They feel that they have not been as successful in attracting men to the project as they had hoped. Certain activities like Boot Camp has not been as yet attracted sufficient interest to improve their male beneficiary profile. However the number of male beneficiaries attracted remains above the SWWB average.

- Transport is a particular problem. There is insufficient public transport links to the district’s rural hinterland of Exmoor National Park. This not only isolates communities but poses challenges for vital outreach work. However the project has been able to fund transport on some occasions to provide access to activities like swimming.

- One of the issues that continues to challenge the team is trying to identify an appropriate activity charge to ensure that those facing barriers to participation (e.g. because of affordability, transport or child care) can be included in the activities that they provide.

**Conclusions**

**Opportunities for the future**

In order to prepare for the future they are preparing a Consultation event in November to respond and build on the conclusions of the Joint Needs Assessment.

The project has always had a view to encourage sustainability of activities identified as popular by service users. They have started to supported people setting up an independent business from a successful activity. An instructor is now delivering Dance Fitness having started delivering opportunities from the programme.
Engaging volunteers in the process of activity delivery has ensured that the legacy of the Living Well approach will continue. The growing projects will carry on have been established by a very enthusiastic co-ordinator.

The project has been sensitive to the needs of service users and has been flexible in their plans to ensure that the ethos of Living Well is continued. Identifying that their location on school premises might not be ideal location to engage new clients they are considering the possibility of getting a shop front to promote their services in the future, particularly if they are forced to adapt to the changing funding environment.

**Beneficiary Case Study**

**Carol: Learning to run again after twenty years**

Carol is 37 years old. She is married with two children: a boy aged 11 and a girl aged 8. She puts a lot of time into raising her family and she works part time. From Monday morning to late Friday night her husband works away from home. Three years ago she was persuaded by a friend to participate in the *Race for Life* charity run at Barnstaple: a four mile run. She was ‘really shocked’ to find that she could only run a small way before getting out of breath. After a quick burst of running she completed the course by walking most of the way. Another shock was to see people in their fifties and sixties completing the course quicker than her. She realised she had not done any sport or fitness activity since leaving school twenty years ago. A few weeks later she saw a Living Well advertisement for a Running Group for Beginners and decided to give it a go. Finding a regular and reliable babysitter was difficult so was overcoming her initial anxiety around potential breathlessness as an asthma sufferer. These were allayed by the Living Well adviser when she signed up for the group.

Her first lesson saw her doing warm-up and stretching exercises with thirteen other beginners. This led to an instructor led jog of a mile. Running in groups helps Carol to pace herself to an appropriate speed for the course. Since starting in September 2009 the group have been extending their distances and they now run 4.5 miles in the follow on Running for Fun group. Carol has progressed into the new group which involves varied runs of up to five miles across different terrains. She has all the appropriate gear drawing upon the experience of her fellow participants. She learnt simple things like how to tie laces properly for running to avoid blood circulatory problems in the feet. In the week prior to meeting her she had joined a relay team to complete a 7.5 mile competitive Beacon to Beach run. Their team was the second fastest adult group. Her husband and family cheered her across the finishing line and now her ambition is to train to do a half marathon in either Taunton or Bath. In September she hopes to support the Beginners group as well as participate in the Fun group and act as peer support for those taking a similar step into running like she did only a year ago.

*It’s always a great experience and I feel so much better now, more energised than before. Even when I feel I am not up for a run, just doing it with my friends makes me feel so much better in myself. More alert. I can take on anything then. It’s a great thing to do and it helps to build your confidence to be active.*
5 x 30 More Active More Often

Location: Exminster, Devon

Host Organisation: Westbank Healthy Living Centre

Introduction
This report provides a profile of three district council areas of the 5 x 30 More Active, More Often Devonwide project, funded as part of the South West Well-being programme. These areas are within North and West Devon.

Project Aims
The project aims to provide support to initiate and encourage community-led sports activities and to increase active participation across all of Devon. The Well-being programme supports the work undertaken in North and West Devon. The objectives of the project are to:

- initiate an increase in participation in more rural areas,
- increase access to sporting and physical activity opportunities with greater focus on building pathways to sport,
- make improved links with other sports, health and well-being initiatives,
- bring together sports and activity providers in a collaborative and community-driven approach to participation.

Background & Rationale
Sports and active recreation can have an important role in helping adults achieve the guideline recommendation to engage in moderate aerobic exercise for 30 minutes a day, 5 days a week. Given
evidence of highly unequal take up, Sport England has identified that there is a need to increase participation in sport by 1% per year. This has been reflected in the Devon Local Area Agreement that has sought to *maintain and increase levels of participation in physical activity and sport to improve the quality of life within local communities*.

Given the evidence of low engagement in physical activity in Devon, Westbank sought to develop a project that would address this issue – especially in rural settings. Initially Mid Devon District Council and later included West Devon Borough Council both piloted the first 5X30 project with an overall aim to increase participation in physical activity by 1% year on year leading to an overall increase of 3%. Evaluation of the pilot showed evidence of increased participation across all target areas. In the areas where 5X30 has operated, Active People showed that participation in physical activity is greater than expected for these locations according to national averages and demographic projections, achieving more than 1% increase in physical activity.

Work with local partners also created a strong buy-in to the pilot scheme and the role of 5X30 as a lead organisation to deliver more physical activity outcomes across Devon. The project was used by Sport England to show best practice in delivering physical activity, reducing obesity and in motivating people to engage in sport. Building on this success 5X30 Devonwide sought to take the good practice established in the initial pilot over a wider more diverse geography across Devon.

**Host organisation**

Westbank is the host organisation for 5X30 Devonwide and is also the lead portfolio organisation for the Big Lottery South West Well-being programme. Westbank HLC is managed by Westbank Community Health & Care. It was established in 1986 it ran as a registered charity for over 20 years until transferring to a company limited by guarantee in 2007. As an independent health care provider it also seeks to empower and improve the health of communities and individuals across Devon with the object of the original charity being to relieve sickness and preserve health amongst persons permanently or temporarily resident in the County of Devon. Westbank is a combination of centre-based and outreach work that reflects the organisation’s ‘hub-and-spoke’ model for service delivery.

**Project area**

Devon has 93% of its land area defined as rural (settlements of fewer than 10,000 people) 33% of Devon’s estimated 1,110,000 residents live in rural areas. (Devon Strategic Partnership, Rural Devon Profile 2006) In Devon, 12.3% to 28.8% of adults are classified as obese. Active People shows that participation in sport and physical activity in the rural areas of Devon is variable ranging from 19.5% in Torridge to 26.2% in West Devon compared with a national average of 21%. This project covers 3 district council areas, Torridge, North Devon and West Devon whilst the 5X30 Devonwide project overall covers 6 district areas across the county.

**Project Design and Delivery**

**Inputs**

5x30 North and West Districts, have been funded £51,600 through the SWWB programme. This contribution is just over 20% of the total budget required for delivering the 5X30 scheme in these
areas. Further funding has been contributed from a wide range of other organisations including Sport England, local district councils, primary care trust, and In-kind support from organisations such as Active Devon, Devon County Council, District Councils, Devon Health Authority and voluntary providers.

The North and West areas are supported by the Devonwide Co-ordinator (0.6fte), an administrator and 3 geographically-focused part-time community activators working in North Devon, Torridge and West Devon.

**Activities**

5X30 Community Activators are primarily based within the community they are working with. They are also required to have extensive local knowledge that enables them to quickly develop networks amongst community leaders. The role of Community Activators has been to:

- raise awareness of the benefits of sport and physical activity for health and well-being
- help people, groups and organisations identify new physical activity opportunities and transfer the knowledge Skills and training that enables them to deliver locally
- support and sustain local facilities and create a network of organisations to strengthen the delivery of physical activities for sport and health benefits
- create new physical activity opportunities in sport and recreation
- increase participation in existing and new sport activities and moderate intensity physical activities within targeted communities and specifically with people most at risk of not engaging or who would benefit most
- work with stakeholders to deliver a joined up approach to physical activity delivery that links with and strengthens Community Sports Networks

Community Activators have had small budgets to help activities become established. These grants have been used to support activity costs, hire of facilities, publicity, training and travel. The project also offered loan of sports equipment and free basic equipment. The range of activities includes:

- Dance, aerobics and seated exercise groups
- Walking, cycling and running groups
- Mind and body groups such as tai chi classes
- Team sport groups such as football or rugby teams
- Conservation and gardening groups
- Event days such as sports or fitness festivals

Activators use a range of facilities including public sports and leisure centres, schools, village halls and open spaces. District Councils, schools and voluntary organisations work with 5X30 Devonwide to provide subsidised taster sessions and low or no-cost events. Community Activators often seek to establish intergenerational groups and have had a particular focus on ‘lads and dads’ groups. The 5X30 Devonwide co-ordinator works with partners to ensure events and activities are advertised and
celebrated both before and after they take place. This has been an important element to strengthen partnerships and contributes to the long term sustainability of the project.

**Target Beneficiaries**

Between October 2008 and February 2010 the project has sought to work with:

- People living in the most deprived areas of Devon and people on low incomes
- Families, children and young people
- People living sedentary lifestyles
- Over 45’s, people who are obese or overweight
- People with low self-esteem or low level mental health symptoms

The project also supports and encourages the wider population to be more active; through awareness raising and publicity that promotes health and well-being.

The 5x30 project uses a shortened standard SWWB programme registration form to collect details of core beneficiaries. They collected registration information from 58 direct beneficiaries. Analysis of this registration information provides the following project statistics:

- Percentage of males: 12.1% (SWWB 31.4%)
- Most popular way of hearing about the project: Word of mouth (SWWB Word of mouth)
- Percentage referred by a health professional: 1.7% (SWWB 18.8%)
- The number of beneficiaries in employment: 15.5% (SWWB 33%)
- Number of beneficiaries who own their own home: 3.4% (SWWB 43.5%)
- The number of beneficiaries self-defined disabled: 5.2% (SWWB 9.4%)

**Outcomes**

For the communities taking part there has been very positive engagement that has lead to the identification of Community leaders, the training and development of community members and a strong sense of community ownership of the new activities. All these points are significant in ensuring best fit with community needs and choices which in turn are key to long term sustainability. The data collected to date (with a further 6 months to go) identifies the real increased numbers of people who have taken up a physical activity during this current 2 year programme.

For North Devon – within this current 2 years of 5x30 intervention there have been 2875 new participants. This is equivalent to 1.8% of population.

For West Devon – with this current 2 years of 5x30 intervention (these results demonstrates the value of longer term intervention in change readiness, as this area received a previous 3 year intervention) there have been 3503 new participants. This is equivalent to 6.6% of population.

The baseline and follow-up questionnaire survey shows there has been significant increases in cycling activity from baseline \((M=1.20, \text{SD}=0.462)\) to follow up \((M=2.09, \text{SD}=1.007)\) \(t(43)=5.32, p=\)
<0.000 (two-tailed); and activity around the house (M=2.67, SD=1.116) to follow up (M=3.42, SD=0.812) t(43)=4.09, p= <0.000 (two-tailed).

**Wider impact**

5X30 has developed a low cost, locally led approach that serves as model for sports development. In addition to new and increased participation in a physical activity this approach has provided educational and skills development outcomes by increasing opportunities for adults and young people and development of volunteer skills. Activators have worked with coaches, community, health and sports professionals to increase training in community settings, providing motivation and inspiration for individuals to participate and learn about sports and physical activity.

The project has increased demand for sports coaches, use of local facilities and has added to wider economic impacts by increasing participation and sports events which attract investment, tourism opportunities and local hospitality business.

The project has also worked with the local Crime and Disorder Partnership to develop community and safety and play initiatives to help young people to increase self-motivation and to engage in positive sports-based activities and exercise. The project has therefore sought to address community cohesion agendas at the local level.

**Conclusion**

**Key lessons**

The following lessons are based on the direct work carried out by the activators in the following areas:

- The personal approach of activators in local communities has been very effective.
- Local knowledge and using personal contacts proved invaluable. Activators were appointed on their depth of local knowledge.
- Success is based on providing what the group community wants. Community engagement ensured ownership and direction to a new group’s progress.
- The seasons affects activity engagement this being more difficult during the winter months
- Activators had collectively a breadth of skill sets which were pooled and shared through team meetings
- Flexibility of working hours is key for community
- Activators were out-reach workers from home bases – reducing travel time and increasing contact with community.
- Because Activators worked remotely team meetings were key to ensuring team cohesion.
- Launch and network events raised the profile and attracted more community groups and potential trainees in the sports sector
- Attending local events such as School Sports days was effective in engaging new groups
- Support from Sports development units and local CSPANS
- Social Networking work well for brand awareness and youth
Development of GP referral schemes have created links to health initiatives

**Opportunities for the future**

5x30 Devonwide has conducted a review of its services and has identified a wide range of opportunities for the development of project work. These include:

- Kit bag development is a cheap and effective way of empowering small village groups (e.g. youth Clubs) to mobilise their attendees.
- Links with weight management groups/franchises who do not offer physical activity as part of their remit. E.g. Slimmers’ World.
- Investigate external business partnerships for events and activities, such as Garmin, Orange, Speedminton and Aerobie.
- Engage with School colleges and Universities via SSCO’s FESCO’s.
- Development of Chair aerobics in schools (Take Five Chair Aerobics).
- Accreditation of NEW chair aerobics CPD courses.
- Engage with the PCT to work with obese families.
- Link to Health Promotions Events, such as non smoking day.
- Engage with Devon Youth Services.
- Cycle –Recycle links with YISP, YOT, Devon Constabulary & DCC recycling centres.
- Treasure trails, Look at commissioning specifically health/social walks relating to each locality across Devon.
- Develop partnership with Sports Unlimited project – possible funding opportunities.
- 5 X 30 Business Games – This has its own website and is an extension to the physical activity work carried out in the workplace by Ken Ross. It has local Devon Business’s competing in sports and physical activities while raising money for charity.
- Green Travel Plan group – joined to help promote healthier alternatives to travelling to work. Cycle Project for staff.
- To use the Kitbags that Mid Devon have passed onto 5 x 30, by offering them out to local community groups etc for a donation, thus helping create some more funding for the project.
- Writing CPD courses for specific exercise regimes.
- Work with Age Concern/Help the Aged – to be part of and to help set up a community calendar of local activities.
Be Healthy, Be Happy

Host organisation: Gloucester City Council-lead authority

Location: The six district authorities across Gloucestershire

Introduction

Be Healthy, Be Happy Gloucestershire project is as unique as is the county’s diversity, with a population of 601,405 it is mainly rural, with two major urban centres of Gloucester and Cheltenham at its heart. Gloucestershire already has a greater proportion of people aged 65 and over than England and Wales, this age group makes up 18.2% of the total population compared with 16.1% nationally, this has implications and need to be considered at a local level. All six of the counties local authorities, Gloucester City Council, Cheltenham Borough Council, Stroud District Council, Forest of Dean District Council, Cotswold District Council and Tewkesbury Borough Council manage and deliver a variety of Healthy Lifestyles programmes that regenerate people lives that help people to make healthier choices.

Background and Rationale

Gloucestershire Healthy Living Alliance is a county networking group that was formed in 2006 bringing together representatives from all six district Health & Well-being Partnerships that are themed strands of the Local Strategic Partnerships to enable and encourage a co-ordinated and cohesive approach to developing health and physical activity in the county.

- Gloucester City Council-lead authority
- Cheltenham Borough Council
- Forest of Dean District Council
- Stroud District Council
- Cotswold District Council
- Tewkesbury Borough Council

This group has grown with interested members now including NHS trusts, community and neighbourhood partnerships and the voluntary sector.
Project area

- **Gloucester City Council** covers 1.5% of the county’s total area and has a population of 114,900 people, which equates to 19.6% of the total county population. Gloucester is predominately an urban area with only 0.3% of people living in rural areas, the population is evenly spread across all five quintiles, however it has the highest percentage of residence living in the most deprived quintile [25.1%] based on national quintiles of the index of multiple deprivation 2007 [IMD] by lower super output area [LSOA]. LSOAs are small geographical units [neighbourhoods] with 1,000 to 3,000 residents.

- **Cheltenham Borough Council** covers 1.4% of the county and has a population of 112,600 people, which equates to 19.2% of the total county population. Cheltenham is a predominately urban area. Compared with the county as a whole it has a higher proportion of people living in the most deprived quintile [12.2% v 7.5%] as well as a higher proportion living in the least deprived quintile [37.5% v 29.7%] based on national quintiles of the IMD 2007.

- **Cotswold District Council** covers 43.1% of the county and has a population of 84,600 people, which equates to 14.4% of the total county population. Cotswold is a rural area with only 20.25% of people living in urban areas in the district compared to the county average of 67%. 46.7% live in either a village or hamlet. The majority of people [37.2%] live in the least deprived quintile based on the IMD 2007.

- **Forest of Dean District Council** covers an area of 20.8% of the county and has a population of 82,500 people, which equates to 14.1% of the total county population. The Forest is a predominately rural area with only 30.5% of people living in urban area of the district. The majority of people live in quintiles 2-4 with no one living in an area ranked as the least deprived based on the IMD 2007.

- **Stroud District Council** covers 17.6% of the county’s total area and has a population of 111,700 people, which equates to 19.1% of the total county population. Stroud is a predominately rural area with no residents living in the most deprived quintile. One third of residents live in the least deprived quintile with the majority of residents living in quintiles 2-4, based on the IMD 2007.

- **Tewkesbury Borough Council** covers 15.3% of the county’s total area and has a population of 79,900 people, which equates to 13.6% of the total county population. Tewkesbury is predominately an urban area with only 34.2% of people living in rural areas. The majority of people live in the two least deprived quintiles of deprivation with only one lower super output area ranked in the most deprived quintile based on the IMD 2007.

Project aims

The aim of the Be Healthy, Be Happy Gloucestershire project is the unique opportunity through the strong regeneration drive underpinning the delivery of Health and Physical Activity programmes throughout Gloucestershire. We aim to use this opportunity to regenerate people’s lives that will enable them to make healthier choices.
The well-being services are delivered in areas of high deprivation and hard to reach groups in each of the six Gloucestershire local authority districts using local community facilities and engagement with voluntary organisations that have ensured community ownership and a high level of engagement.

The project is used as a vehicle to signpost to community based exercise sessions, health workshops for healthy eating, stress, depressions, drug/alcohol related illnesses and health MOT’s, walking, cycling, green gyms and community gardens.

Project outcomes

- Improved mental health through increased levels of physical activity and social interaction
- Primary and secondary prevention of long term chronic conditions
- Falls prevention-link into later life
- Referrals from the Healthy Lifestyles programmes [exercise referral]
- Community cohesion brought together by the participation in physical activity sessions
- Keeping people well and living longer, which means:

  Not only adding life to years, but years to life and will require preventing and promoting health and well-being by tackling some of the biggest health issues of the 21st century such as our aging population, increasing levels of migration and the rising level of childhood obesity.

Project overview

The Be Healthy, Be Happy Gloucestershire project delivers a wide range of programmes and services that include:

- Community based exercise and physical activity sessions
- Sheltered housing active and able sessions
- Health workshops
- Walks for Health programmes
- County wide annual Walks for Health event
- Green Gym/Community gardens programmes

The people that have mostly benefited from the project are:

- People over the age of 45yrs with sedentary lifestyles
- Children under the age of 16yrs who have ‘opted’ out of physical activity
- People who experience poor health or particular medical conditions i.e. obesity, high blood pressure, arthritis and mental health
- BME populations
- Individuals and families from deprived communities
- Immigrant/migrant population
- People at risk of developing a chronic/long term illness associated with a sedentary lifestyle
Performance

Outputs
The Be Happy Be Healthy used a shortened standard SWWB programme registration form to collect details of core beneficiaries. Analysis of this registration information provides the following project statistics:

- The modal age range of project beneficiaries is 41-45 years of age (SWWB 30-35 years of age)
- Percentage of males: 28.1% (SWWB 31.4%)
- Percentage of self-defined ethnicity of white: 98.5% (SWWB 92.7%)
- Most popular way of hearing about the project: GP Nurse or Practitioner (SWWB Word of mouth)
- Percentage referred by a health professional: 39.2% (SWWB 18.8%)
- The number of beneficiaries in employment: 10.8% (SWWB 33%)
- Number of beneficiaries who own their own home: 55% (SWWB 43.5%)

Good Practice Case Study- Cheltenham

The Stable Company: Physical Activity – encouraging and promoting the outdoors as a way of increasing participation specifically through projects focussed around gardening and allotment work

The Project
The Stable Company is a social enterprise set in one of Cheltenham’s most deprived areas – Hesters Way. They have been working with a range of local partners to help promote the activities and initiatives which they run to enable as many disadvantaged people to take part. Although not their
sole focus, the group aim to reach vulnerable and disabled people living across Cheltenham, promoting healthy living as part of their work.

**Target Beneficiaries**

- Working with the disabled, vulnerable groups, those with learning difficulties, from under privileged backgrounds and children
- Giving disadvantaged people confidence and purpose
- Ensure the scheme is open to all and that it provides activities which benefit all those who show an interest
- Working with schools to provide educational facilities to promote health and wellbeing
- Create a programme of garden maintenance for vulnerable groups and the elderly in the local proximity
- Create a programme of training for the long term unemployed with in a volunteering environment, boosting employment possibilities

Currently, the group are able to offer allotment based activities – gardening, weeding, planting and maintenance, growing their own produce such as vegetables and herbs which are then used as part of their very own fruit and vegetable box scheme. Volunteers help to source local fruit (which they are unable to grow themselves), pack the boxes (which are often decorated as part of their arts and crafts activities) and deliver them using the van which they have had funded through other sources.

The group run a coffee morning from their local church – this facility is provided for them by the church for free – and local people are able to come along, buy various produce that the Stable have grown, have a cup of tea and join in with the arts and crafts activities which they offer. This has been a vital part of local people’s lives – helping to get people out of the house and encouraging them into a social environment where they can break their day up. A home cooked meal is provided for lunch to those that attend - healthy eating being the main theme – helping those who live in very deprived circumstances to get some healthy food within their day.

The group now have 4 allotment sites and have since bought chickens which are looked after by the volunteers in the scheme. This has brought about the production of eggs which they are now also able to sell.

As with a number of SWWB initiatives, this project has received funding from both SWWB and other sources including Cheltenham Borough Council NHS Gloucestershire and Extended Services (Gloucestershire County Council). The funding from SWWB has been used towards helping them to raise awareness around the town – promoting the work that they do. Leaflets and flyers have been bought as well as uniform and graphics for their van. They have also been able to attend events with families and children in Cheltenham to help encourage people to get involved with their projects and to showcase the work that they do.
As a result, they have now received further funding to develop an allotment based project at one of our local primary schools. This is going to be maintained and led by the Stable Company and utilised in the day by the school children and then after school by families and adults.

We have received lots of feedback from the group and the beneficiaries including adults and children. One of the most common themes is around the social opportunities that getting involved with the group allows (Due to many of the group having learning difficulties, feedback may be provided on behalf of the person and is taken by a carer);

**Added Value**

‘When asked, Stephen loves what he does with the Stable as it gives him the chance to get out of the house, get some exercise and the best bit is meeting new people and making new friends’ (On behalf of Male, 52 yrs)

‘I really enjoy growing all types of veg and working on the soil. It gives me a real sense of achievement and plenty of fresh air and relaxation. I have also made a few good like-minded friends’ (Females, 66 yrs)

People have also commented on how relaxing it can be;

‘Working on the allotment is very enjoyable and relaxing. I enjoy feeding my family with produce I have grown myself. I have also met some very nice people’ (Female, 41 yrs)

‘I like having an allotment where I can grow vegetables. My sister and I have a small patch where we grow carrots. We also like to run and play’ (Female, 14 yrs)

The growing of foods is also helping to encourage people into cooking with these products;

‘Tim enjoys the chance to use his skills to grow vegetables and he loves growing his own herbs. He uses these when he is doing his own cooking’ (On behalf of Male, 30 yrs)

‘I use the allotment for fresh air and exercise. It is a great way to relieve stress and unwind. A bonus is having fresh, organically grown vegetables to eat and fresh eggs’ (Female, 30 yrs)

**Conclusions**

The group have now developed their own website which is another way of them promoting the work that they do and also to try and encourage people to volunteer with them.

Mike who heads up this group really feels that as a result of this funding, they now have a strong message which people are becoming much more aware of. The uniform, van and promotional leaflets have allowed them to set themselves up as a professional group and as a result they have been able to encourage many more people to get involved in the many different types of activities that they run; helping those people become more aware of the healthy eating and physical activity messages.
Case Study-Gloucester

Active and Able falls prevention classes have been introduced into community-based venues in Gloucester City in order to reduce injury through falls and prolong quality of life in the older populations through a social and fun activity. The scheme is run in partnership between Sports Development, Gloucester City Council and Gloucester City Homes.

What is the Active and Able Scheme

Active and Able has been set up in Gloucester to provide a tailored service to the over 60s population. The sessions focus on providing appropriate exercises to contribute to long term health and in particular, falls prevention. The intervention is targeted to reach those who cannot, for whatever reason, access this service easily in their community.

The scheme links into the LAA under the theme Healthier Communities and Older People, is detailed on the Healthy Gloucestershire Locality Delivery Plan for Gloucester under section 2, Active and Healthy Ageing and works towards achieving several points under Aim 3 under the Sustainable Community Strategy.

The Project

The objective of the project is to provide a weekly session to the age 60+ population aimed at improving core balance and strength with an overall goal of improving health and reducing incidences of falls in this population. 4 classes currently run in Podsmead, White City, Abbeydale and Tuffley with a view to expanding provision across the City in the future. The classes are all based at a sheltered housing scheme and are also aimed at the local population as they are open to anyone external to the scheme.

An instructor specialising in activities for this age group has been employed to deliver these sessions whilst incorporating a fun and sociable aspect to the scheme, and giving people the knowledge and confidence to be able to carry out some basic exercises in their own home. The classes are around 45 minutes in duration and incorporate mild aerobic, balance and strength exercises. The group are encouraged to socialise and enjoy the session. All activities can be adapted to be done from a chair-based position. The class is done to music and some basic hand held equipment is available for those who wish to use it.

The project developed from discussions between Gloucester City Homes and the Sports Development Service with regards increasing physical activity levels of the older population residing within the sheltered schemes. Funding was awarded from NHS Gloucestershire to develop and run
these classes at a spread of venues over the City. The initiative was well received by both scheme managers and residents keen to take part in the sessions. Managers played a key role in marketing the scheme to potential participants. Local external populations from this age group were also targeted through a mailing list and through awareness campaigns at local events.

The scheme has proved popular and Gloucester City Homes are keen to support the sessions financially to ensure that they continue in the future and expand to service a wider audience.

**Target Beneficiaries**

They aim for classes to reach an ideal capacity of 15 - 20 participants per scheme (75% internal, 25% from external)

Beneficiaries should be over the age of 60 and usually fairly inactive. The initiative has been concentrated in areas of deprivation where access to such sessions externally is problematic or impossible.

**Performance**

Outputs: Improvement in health of participants (mental and physical)

Outcomes: Increased levels of the 60+ population taking part in a physical activity on a regular basis.

- Podsmead – 14 regular participants
- White City – 11 regular participants
- Abbeydale – 13 regular participants
- Tuffley – 16 regular participants

Wider impact: Reduced levels of falls in this population across the county

**Conclusions**

The target audience has responded well to services being brought to them. Access to external services is often limited or difficult to manage. The feedback gained from participants and managers alike has all been positive, many appreciating the social aspect of the class as well as the physical benefits to be gained.

With support from Gloucester City Homes and further funding opportunities, we aim to expand the project to more venues across the city and open these opportunities to a wider market.

**Case Study—Forest of Dean**

The Forest of Dean has approximately 84,000 residents with only 21% of them being physically active enough to benefit health. The demographics of the district are that there are very rurally isolated areas and various pockets of deprivation. Transport is a real issue and provides a barrier to access physical activity. The district council manages an exercise referral scheme, which tackles those in need and health inequalities but this does require support and resource from other agencies. However, the referral scheme was unable to accept those patients who had previously
experienced an MI due to lack of trained personnel in this area and the lack of funding to set this initiative up.

The Forest is also highlighted as an area where CHD (coronary heart disease) is a long-term problem. Patients had to travel in excess of 20 miles to access a suitable class for their condition, which often meant that these patients did not take up the necessary program of exercise that they could sustain to maintain health and prevent a further heart attack. With this information to hand, phase IV cardiac rehabilitation was highlighted as a need for the district. These classes also need to be ‘community’ based so that there is no barrier to participation.

**What is phase IV Cardiac Rehabilitation?**

The early stages after a heart attack are often frightening, and leave patients bewildered and anxious. At these times, they need the support and supervision of clinical and medical professionals. Once the initial crisis has been dealt with, there is then an ongoing programme aimed at helping them gradually return to normal activities. Throughout the process, patients and their families have access to individual and/or group counselling and education sessions on lifestyle and behaviour change. The final part of this process is the phase IV program. This is an open ended phase which supports and encourages the participants to continue exercising in a safe and professional environment, allowing the maintenance of individual goals and reinforcing all the messages from the previous phases of the program. These ‘exercise’ sessions consist of low intensity workouts whilst deriving benefits to ‘heart health’. Participants are monitored throughout the class through the use of heart monitors and are shown how to look at their own intensity levels and to self-monitor. The class is intended to enable patients to recover as quickly as possible from their condition and to offer support and advice towards healthy living, thus reducing the risks to further heart disease. After the class everyone stays for a cup of tea as this gives time for the instructor to check for any complications or arrhythmias caused by exercise, and provides a valuable opportunity for class members to chat. It has resulted in an informal ‘buddy’ scheme being developed – yet another support network for those recovering from a heart attack. After completing 12 weeks at Phase Four they are reassessed and a decision is made as to whether they are safe to move into exercising in the community. The Phase Four class, however, will stay open to them to attend for as long as they wish.

**The Project**

The start of the project began with identifying a need for Cardiac rehabilitation within the district and to finding a trainer who could deliver the program. An individual was employed but training for the qualification had to be gained. This was enabled with the funding. Once training had completed and the qualification achieved, work began by approaching all the surgeries within the district about the ‘new’ scheme and to highlight the fact that they can now refer clients who have experienced a heart attack.

The objective of the project is to provide phase IV community sessions to anyone who has had a heart attack with a goal of improving overall health and fitness to those with coronary heart disease. Presently we have been able to set up three classes. One class takes place in a leisure centre studio and is a ‘circuit’ type class, another is based at a gym, where gym equipment is used and the third class is located at a village hall, adjacent to a surgery and is again a circuit type class. Each
participant onto the scheme has an assessment with the Cardiac advisor where lifestyles are discussed and present activity levels noted. These assessments can now take place at either of the 2 listed surgeries or at any of 3 leisure centre sites. A buddy scheme has also been added into one of the gyms to allow participants to access physical activity whilst the Cardiac advisor is in attendance. This session is only open to these clients and to clients who have participated in the exercise referral scheme, which is another initiative, also managed by the District Council. There is also a monthly ‘heart walk’ which is to encourage individuals to walk more and be more active through everyday activity. The scheme has also leased a mobile defibrillator which is with the trainer at all times should an incident occur.

Each class lasts about an hour, with half an hour at the end to drink tea and discuss any concerns. This is an ideal time for health messages to be delivered and feedback to be gathered. The classes are fun and sociable but at the same time there is a real purpose behind why they are taking part and the importance of keeping activity as a priority in their lives. Many of the participants attend all three classes a week, despite transport issues! Many have expressed that they feel healthier and fitter now than they have in 10 years or more.

**Target Beneficiaries**
We aim for classes to reach an ideal capacity of 8 - 15 participants

Beneficiaries can be of any age but need to have experienced a Myocardial Infarction. However, there is strong encouragement for partners to also be involved in the class and to take part so that there is encouragement at home to stay active! The sessions take place in areas of the Forest where there ‘appears’ to be a high rate of coronary heart disease.

**Added Value**
‘Coming to the Cardiac classes and starting exercising was the best thing I’ve ever done’. Tony Roberts, Lydney

‘Cardiac classes have made me realise I can push myself a bit without worrying what might happen. George Eden, Newent

‘I really like Cardiac classes, the people are lovely and the exercise isn’t bad either!’ Clive Hill, Drybrook

‘I can do so much more in my garden since starting cardiac classes’ Valerie Gardiner, Drybrook

‘I’ve lost weight, got fitter and made some good friends. I’ll keep coming to cardiac class for as long as you’ll have me’ Mike Morgan, Drybrook

‘I feel so much better in myself and love having a laugh at cardiac class’ John Goodsell, Lydney
Performance

Outputs: Improvement in health of participants (mentally and physically)
Outcomes: To achieve sustainable classes within community settings so that access is made easy for individuals.

Wider impact: To reinforce the messages of healthy lifestyles amongst our communities.

Conclusions
Those who have accessed this opportunity have really expressed gratitude for the service and have responded well in their support of the service. However, I do feel that take up has been slower than was anticipated and that more referrals could be made from surgeries. The social aspect of the class has been excellent and many have made new friends.

With continued support from the Forest of Dean District Council and possible future funding opportunities it is hoped that this opportunity can be developed further and more classes can be available in phase IV cardiac rehabilitation.

Case Study-Tewkesbury
Play Gloucestershire is a charitable company established to develop playful communities with active children. Our overall aim is that all children and young people in Gloucestershire should have regular and easy access to high quality, free and inclusive spaces and places for play and recreation. We combine play delivery with strategic representation and support for new and existing open access play and recreation projects.

Play Gloucestershire’s Play Rangers deliver mobile outreach play activities in parks sited in the Tewkesbury Borough in areas of rural and social disadvantage. Qualified Playworkers deliver a varied programme of play, sports, arts, environmental and adventurous activities to school aged children. We target sessions at 7-16 year olds with the aim of enabling children and young people to reclaim their parks and green spaces for play.

Play Rangers sessions in other areas encourage...

- More children out playing (research tells us it’s good for them and society)
- Children to learn to be active and healthy with Play Rangers (ECM: Be Healthy)
- Children to feel safer in their parks when Play Rangers are present (ECM: Stay Safe)
- Children to have fun (ECM: Enjoy and Achieve)
- Children to enhance their sense of community through volunteering (ECM: Positive Contribution)
- Free, accessible play activities to support low income families & mitigate effects of poverty
- Children to be more connected to the natural environment by playing outdoors all year round

The Project
Within Tewkesbury town, Priors Park was highlighted as an area that would benefit from year round play ranger service. With the scheme running throughout the borough, residents and local project workers had highlighted the need for this service within their community as there was no such facility for children and a high level of need.

In order to reach the children and young people of Priors Park, sessions were to be run in their estate with their approval. Play Rangers ran 2 sessions in order to engage with local children, young people and members of the community, after which a location and day was chosen. Full day session delivery started in July 2009 on the Vineyards and the full year delivery continued in the Priors Park estate in the evenings to run after school sessions, returning to Vineyards for the larger school holidays of Easter and Summer.

Full year delivery includes 10 full day school holiday sessions which run 10am-4pm and 32 after school sessions which run 4-6pm. Sessions run all year round in all weather promoting active play. Play Ranger sessions encourage children to take responsibility for their own actions and to resolve disagreements amongst themselves, staff will intervene if absolutely necessary. Play Gloucestershire believe that children need and want to take risks when they play, our Play Rangers aim to respond to these needs by offering children stimulating, challenging environments for exploring and developing their abilities. In doing this, we aim to manage the level of risk so that children are not exposed to unacceptable risks. We encourage children to play freely and choose what they do.

Our Play Rangers promote healthy eating by providing free fruit and drinking water at all sessions. We also promote this through our Get Out and Cook sessions where users can learn to prepare and cook healthy meals and snacks at our sessions.

**Target Beneficiaries**
Play Gloucestershire’s Play Ranger service targets delivery at 7-16 year olds; under 7’s are welcome and we recommend that they are accompanied by a parent or carer.

Our Play Ranger activities are open access which means there is no registration and that children and families can come and go as they please. Sessions take place in areas of social disadvantage but are open to all. Play Gloucestershire love families to join us at sessions as enabling families to feel confident in using their parks and green spaces will encourage them to meet more regularly to play.

**Added Value**

‘I think play rangers is fantastic. If it weren’t for play rangers I would go completely mad with boredom…’ Michaela, aged 13

‘I like play rangers, its my best place ever.’ Alana, aged 7

‘I look forward to Thursdays and I know it is play rangers.’ Rhys
‘I think play rangers is good for kids because instead of staying at home, being bored, they can just come to play rangers! Danielle B, aged 10

Performance

Outputs: Children, young people and families getting out to play

Outcomes: Playful children and communities: an improvement in physical and mental wellbeing of users

Wider impact: Playful and active communities leading to improved community cohesion

Conclusions

Children and young people are enjoying sessions and thrive on the consistence of the play ranger team being on site each week in all weathers; if users return when you are running an open access scheme, you know it is because they want to be there. Parents have been involved with full day sessions since the start, but are beginning to become involved in evening sessions, and the support of the local community is growing.

This positive activity for children and young people in the area has made a difference to the lives of individual children as well as that of more sporadic users. The support in providing a playful space in an area where you are brought up to grow up and look after yourself is appreciated by the wider community and not just the children and young people attending each week; they hope that this support will continue.
Children’s Activities and Support Programme

Host Organisation: The Healthy Living Project
Location: Barnstaple, North Devon and Torridge

Introduction
The report provides a profile of the Healthy Living Project, Barnstaple: a project funded by Big Lottery and local partner agencies.

Project aims
The Healthy Living Project is a collaborative project hosted by two organisations. Children’s Activities and Support Programme (CASP) is funded by Devon County Council and Community Action North Devon (CAND) is a voluntary sector organisation. It aimed to deliver gardening and cookery activities to young people in community settings following referrals from both lead organisations and other professionals working with vulnerable young people in need.

The project specifically aimed to provide cookery sessions using community facilities in targeted areas in the two districts of North Devon and Torridge. Skills taught would include finance and meal planning and practical cooking skills with the objectives to improve young people’s confidence and deliver positive healthy eating messages. Structured sessions were planned to be targeted at:

- Young people at risk of entry into the criminal justice system
- Families from deprived communities
- Children and young people with low levels of confidence and self esteem and high levels of low mental ill health

The project hosts have an extensive track record of linking with other local partner agencies who work with young people and they anticipated and received referrals from:

- Local Children’ Centres
- The Youth Offending Team
At its inception it also aimed to develop activities on an identified allotment and sought to discover additional available plots within the targeted communities, to promote food awareness and physical activity. The project was to be delivered on an outreach basis to best fit the needs of an extremely rural community where services are very limited.

**Project rationale**
The ethos of the project was to develop and reinforce young people’s self confidence and competence through the provision of positive activities and specifically here around food and cooking. Over time Community Action North Devon had noted and documented that many young people were growing up lacking basic cooking skills. It therefore devised a project aiming to reach young people in need. A subsidiary aim was to assist their families who may not necessarily have access to basic cooking facilities, training and opportunities. The project envisaged having food professionals engage young people in cooking and encourage them to try new foods and learn new culinary techniques which they may not have encountered before so that their culinary skills and nutritional understanding could be improved. An additional belief was a hope that such skills would transfer back home helping young people to engage with their family to improve their diets. Issues around budgeting, where possible, would also be addressed. At the project design phase the project’s original aim was to deliver activities on an outreach basis to best fit the needs of two local authority districts which host considerable numbers of remote communities in a largely rural area.

**Host organisation**
This project is managed through a partnership between Community Action North Devon who work with young people aged 8-25, largely on two social housing estates in Barnstaple and the wider community and Children’s Activities and Support Programme. CASP is an early intervention family support programme for vulnerable children aged 5-13 who are at risk of social exclusion. Community Action North Devon was originally named as North Devon Volunteers and were formed in 1967. In 1980 it adopted its current name and in March 1997 the charity became an incorporated limited company. CAND have acted over the years as a host for a range of projects all of which aim to benefit the wider community and young people at risk of exclusion in particular. This has included the GOYA project which was part of the Positive Futures National Programme; Junior GOYA – a project funded by the Children’s Fund, the Constructive Leisure Programme in partnership with the Youth Offending Team and Positive Activities for Young People in Partnership with Connexions. Additionally, CAND has been supporting young people as part of an alternative curriculum for young people referred by the Pupil Referral Units, Schools and the Youth Offending Team. It also has been contracted to deliver the Football Foundation funded Youth Inclusion Programme in the Forches area of Barnstaple and runs a Young offender Training mentoring scheme and My Life courses.
CASP is a Children’s Fund project, which runs an early intervention service for 5 – 13 year olds and their families throughout the districts of North Devon and Torridge. Prior to the start of this project it had three years of experience of working with CAND. Referrals are received from education, social care, voluntary sector and health. CASP uses the Common Assessment Framework with the Healthy Living Project as identification of action.

**Project area**
The geographical remit of the project is the North Devon and Torridge district authorities. An area with a population of 158,000 living across 900 square miles. Most of the project work was targeted in the market town of Barnstaple (50%). However other principle communities targeted were North Devon and rural Torridge (30%), Ilfracombe (10%) and East of the Water, Bideford (10%). The health of people in North Devon is similar to the English average. Life expectancy for women is significantly better than the English average. However the incidence of malignant melanoma, adult obesity, people diagnosed with diabetes is worse than the English average. In Torridge health indicators are generally better however the number of adults with obesity and the number of people diagnosed with diabetes is worse than the English average. In terms of young people’s health and well-being health indicators suggest that children and young people are close to the English average on all health indicators. In fact North Devon has significantly fewer children living in poverty, higher levels of breast feeding initiation and lower levels of teenage pregnancies; but the district endures lower rates of children achieving A*-C GCSE in English and Mathematics. In Torridge health indicators suggest that children and young people are also close to the English average however with significantly fewer children living in poverty, higher levels of breast feeding initiation, lower levels of teenage pregnancies and higher levels of physical activity. North Devon has average median incomes of £16k which is 401st out of 408 districts. Three wards in North Devon fall within the top 5 most deprived areas in Devon. North Devon also has ten areas of the worst 25% nationally.

**Project design and delivery**

**Inputs**
The grant of £118,825 paid for the project co-ordinator, rental of community facilities, project management, resources to ensure a good quality kitchen standard, publicity, travel and overheads. This included capital costs of £3000 to supply the portable kitchen equipment required to ensure of an appropriate standard and specification to be transported to community kitchen spaces around the two districts. An additional £2000 of (in-kind) support has come from CASP to cover admin’ support.

**Activities**
This project was designed to deliver structured cooking sessions to young people. Most sessions last between one and three hours depending on the age of the young people and the number in a group. Between the three staff on average between 4 and 5 individual sessions are delivered in a week. Most groups have on average between 3 and 6 direct beneficiaries in attendance and the session can require at least two adults to deliver and supervise depending on the young people involved and their stage of development. The project co-ordinator and sessional workers pre-plan and arrange the
initial session but young people are encouraged to plan onward sessions. Ingredients are frequently bought at retail outlets close to the beneficiary groups to ensure that the recipes are easily replicable by beneficiaries locally. Sessions are usually run in community facilities identified by the co-ordinator or the sessional staff in the targeted areas. These are often in venues like community centres, children centres, youth centres and schools. They do not deliver activities in beneficiary homes. Sessions are bespoke to suit the individual and group needs of those referred e.g. for young people leaving care who need to know how to cook for independent living. The culinary skills learnt are variable depending on need, age and time available. For young people experiencing a series of session’s staff start cooking familiar food that beneficiaries know or like e.g. pizza or a fresh burger before moving into unfamiliar recipes. Basic implements are used because the project has learnt that beneficiaries may not have expensive equipment like food processors or mixers to prepare their meals. All young people are awarded a cooking certificate at the end of the course to verify their involvement and boost confidence by reinforcing a sense of achievement.

In addition to practical culinary skills project staff attempt to deliver education around finance and meal planning, nutritional information and food awareness. Again this depends on the beneficiaries and it is usually bespoke. Food is often taken home for friends and families to share. The aim is always to improve confidence and deliver positive healthy eating messages so considerable time is spent talking and engaging with the participants.

At the beginning of the project it was hoped that the cooking sessions targeting young people and families would be linked to the project’s intended allotment and that additional available plots within the targeted communities would have been sought to help promote food awareness and physical activity. This was seen as helping the project to meet its targets under the physical activity strands of the SWWB programme.

Project Organisations and Services

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<tr>
<th>Community Action North Devon</th>
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<td>Manager</td>
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<td>HLP Project coordinator</td>
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Target Beneficiaries

The initial project plan sought to work with 720 ‘direct’ beneficiaries and 2880 indirect beneficiaries from 600 community sessions.

To date there have been 336 direct and 1248 indirect beneficiaries (1584 total). Activities include cooking & nutritional awareness with groups and individuals, linked visits to a working smallholding, community cooking sessions and promotion at events.

The direct beneficiaries on the project are vulnerable young people. Those referred by CAND are sometimes seen as being at risk of offending and may have already done some physical activities provided by CAND. CASP tend to refer families and young people who maybe having difficulties around parenting or managing young children. These may have a multiplicity of problems that need to be addressed including violence, bereavement and debt. Link Ed refer young people who may not be in school and the Youth Inclusion and Support Panel (YISP) refer young offenders. The beneficiaries on the project are often characterised as being low educational achievers and the project aims to provide them with an opportunity to achieve.

The South West Well-Being (SWWB) database has little demographic information on the direct beneficiaries. There are only 25 completed SWWB registration forms entered. For most of the young people the project has been working with, the forms were seen as inappropriate by the project for their beneficiaries. The original application stated that all information would be recorded using SUBSTANCE and that this was accepted as an alternative. These forms reveal that all the direct beneficiaries were less than 20 years of age. There was an equal gender split indicating that this project has the highest level of male participation in the SWWB portfolio. The majority said that they heard about the project through a project worker with most saying they were referred on to the project either by the project worker or by another non-health professional. The majority of beneficiaries said they were at school. No one reported a disability.

- The modal age range of project beneficiaries: 11-15 years of age (SWWB 30-35 years of age)
- Percentage of males: 50% (SWWB 29.8%)
- Percentage of self defined ethnicity of white: 100% (SWWB 95.9%)
- Most popular way of hearing about the project: Project Worker (SWWB Word of mouth)
- Percentage referred by a health and social care professional: 0% (SWWB 23.3%)
- The number of beneficiaries in employment: 0% (SWWB 29.8%)
- The number of beneficiaries self defined disabled: 0% (SWWB 10.3%)

The direct beneficiaries on this project describe their health to be similar to those as other direct beneficiaries across the SWWB portfolio. They also drink similar amounts of alcohol. However Healthy Living Project direct beneficiaries report higher levels of smoking (48% compared to SWWB for 15%). In terms of attitudes towards food direct beneficiaries report lower levels of fruit and vegetable consumption (2.92 pieces daily compared to 3.87 pieces daily for SWWB). At the start of the project they report lower levels of eating meals from basic ingredients (4.12 days a week compared to 4.87 days a week). The direct beneficiaries also report similar levels of enjoyment of
putting effort and care into the food they eat but they were less likely to enjoy eating healthy food (43.5% compared to 81.5% SWWB).

Performance

Outputs
The project has really opened children’ and young people’ eyes to their own potential for cooking and provided some young people with their first experience of working with real food. Some young people have learnt that healthy food can actually be nice and cooking is fun!

For some young people it has been an opportunity to learn a new skill at what is a very difficult and challenging time in their life.

The need for support with young people’s cooking skills remains high with the project developing an extensive waiting list of new referrals. Demand is high but there is insufficient staff time to currently meet this need.

The project has discovered that there are a large number of families who do not cook at home. This is sometimes traceable back two generations to relatives who have opted for processed food and who believe that healthy eating and cooking is expensive.

The sessional staff and the project co-ordinator have expanded their skill sets. The Project Co-ordinator enrolled on and completed an Open University short course on human nutrition. This was supported by the partner agencies but the project co-ordinator undertook the study in her own time giving great value added for the project. She is also training on a Royal Society for Public Health (RSPH) L4 Food Hygiene course to be able to deliver a broader range of skills to future beneficiaries. This was in response to anticipating where demand would be in the future.

The Project Co-ordinator has also set up a certified Food Hygiene course for a specific group of girls who wanted to expand on their interests and develop more skills.

CASP has sustained their child protection procedures. All staff have enhanced CRB checks in place and are trained in First Aid, child protection and mental health awareness. HLP staff also hold current Food Hygiene certificates.

Most of the work has been with groups but they sometimes work on a one to one basis simply to start to develop direct beneficiary confidence. Additionally they work with whole families or several families according to need.

The project prides itself on teaching young people achievable social skills which can be achieved by young people working together or in groups on a common task of cooking.

Outcomes
The project used a young people’s questionnaire to collect health and well-being information from 25 direct beneficiaries. There is only baseline information available.
Wider impact

The predominant aim of the project was to develop positive activities for young people. In developing skills around food the project hopes that young people will take key skills home with and share these with their family and friends.

Demand for the cooking sessions provided by the project has grown as the profile of the project has increased and referring agencies have learnt about the beneficiary experiences.

Processes

Key lessons

The project was quick to learn that non-attendance necessitated closer work and involvement of the direct beneficiaries’ case or support worker. These vulnerable young people often needed more time and support than was envisaged and planned for at the start of the project.

The most disappointing developmental problem faced by the project was that it was unable to fulfil its gardening plans. It faced real challenges in trying to access and run their identified plot and they were also unable to find any additional plots. Realistically the project would have required another member of staff to deliver and manage a garden plot given that the majority of the young people’s engagement with the cooking element of the project rarely extended beyond four weeks.

Like other projects in the portfolio this project had a large geographical remit which presented transport challenges. Nevertheless the project co-ordinator took a strong lead in organising its delivery in an environmentally sustainable and a time efficient way. Activities planned with families or individuals in close proximity were planned to be delivered on the same day to maximise impact and minimise time lost in travel and use of resources.

The project has also faced challenges in meeting their target number of direct beneficiaries. Initial projections of direct beneficiary numbers in community groups underestimated the extent of support required to deliver the sessions. Nevertheless the challenges faced in working with excluded young people meant they were able to offer more quality time to begin to address their often complex needs.

Bringing a county council service together with a voluntary organisation having very different cultures is not easy. However, regular open dialogues about: programme planning, budgeting and staff sharing along with a high degree of flexibility allowed the management of staff to respond flexibly to the project’s development.

Sessional staff have been required to be flexible in the hours worked on the project with some week’s demanding more of their time than others. This ability to be flexible has served the project well.

The success and demand for the project services’ has meant that there has been little time to continue to develop outreach work. However although successful outreach links were developed at the start of the project to raise its profile amongst local professionals who work with vulnerable
young people e.g. extended school officers, probation officers. This has proved sufficient to generate demand for the project’s work.

Having such a large geographical area (900 square miles) can pose challenges to any project. Transport between venues can take over an hour so a considerable amount of time was spent just travelling.

Working with older young people meant they were often aware of broader agendas and problems that these young people face.

The project co-ordinator has noted some real improvement in young people’s disposition towards fruit over time and believes the five-a-day message is beginning to make an impact on some young people. The project believes the impact of the work they deliver can only be effectively documented over a much longer time. It is therefore felt that this project has hopefully laid the foundations for improved and sustained attitudes to opt for healthier food and eating in the future.

**Opportunities for the future**

CAND are looking for new funding to sustain this work that has proved popular both with young people and with referring agencies whose enthusiasm for cooking skills training has necessitated the development of a waiting list.

In the future the project is looking to try and work with other groups including schools to help deliver culinary training to all young people.

The Project team has taken seriously the skill base they need to develop in order to sustain delivery of their work in the future. Taking on additional training and planning to adapt curricula to young people’s needs in the future is testament to the experience they have developed about direct beneficiary needs and demands. It is also hoped that they will be able to offer paid courses to their groups in the future.

CAND has a well developed profile in Devon and beyond having worked for 40 years in the area. This has included attending organised police events and going to smaller villages. It has developed links regionally with the Youth Justice Board and nationally with charities and the national funding programmes.

The project has made links and contacts to develop the gardening side of the project including talking to the police about a community plot that could be used to offer visits for young people to engage with gardening activities. In addition to culinary skills they could learn and develop insight into the growing cycle.

**Beneficiary Case Study**

**Hannah and her father**

Hannah and her father were referred to the project by their Key Family Support Worker from CASP in February 2009. They moved to Barnstaple only a few years ago. They originally visited the area on a family holiday and fallen in love with the town. They waited three years to get a council house
exchange with a local tenant who needed to move back to Birmingham. They moved down together as a family but Hannah’s mother now spends a lot of her time back in Birmingham where Hannah grew up as a child. Hannah is now 14 years of age and her older brother Bret were having problems at their new school. As a newcomer Hannah endured bullying. They weren’t attending and even now Hannah still doesn’t attend school. Initially she wouldn’t even leave the house and instead preferred to spend a lot of her time playing computer games, e-mailing and chatting to her friends from Birmingham on Facebook and just hanging around at home. The family have difficulty getting up in the morning. Hannah and her father first came to the cooking project with another family who were dealing with loneliness issues after suffering a recent bereavement. Sharing friendship and being with others is an important part of the project’s ethos. Sessions usually start and end with a reflection on what they have cooked during the week and what they are planning to cook in the near future. Hannah now really enjoys cooking and has enjoyed learning new cooking techniques and skills with her Dad. They cook in a small community hall near their house. A place they walked by everyday without realising it was an open community resource. There is a working kitchen containing tools and utensils that they are likely to have in their own kitchen. There are no fancy food processors or electric mixers as the project sticks to the principle of replicating what is most likely to be in beneficiary kitchens. When they moved from Birmingham they didn’t have a working cooker for several months. They have learnt how to make their own bread, burgers, pizza, pies and sorbet. Their most popular dish is curry which all family members cook together; even Bret, who usually eats only pizza. She can’t recall ever cooking at school or even helping out at home with food preparation but since being with the project she has learnt to get involved with all food preparation.

Hannah: *We thought it would be hard to bake bread but they have made it easy for us to learn.*

Their eating habits have now changed entirely. Hannah reports being *pickier* about the food she chooses to eat. She now only wants fresh produce and dislikes processed food:

Dad: *We eat a lot more fresh food now. We used to shop at Iceland or Hargreaves but it is now very rare we go there now. It has to be fresh food all the time and we have to cook it from scratch.*

They are also considering growing their own food and brought some seeds to plant:

Hannah: *We were going to dig our garden but there isn’t enough room. We have a patch of ground but it is all full of rubble and stuff.*

Hannah is now venturing outside the home to be with other people. She has joined an art class at a local community hall. She has won a bronze award for her work and contributed to the design and development of a charity Christmas card. Her confidence has grown and she now acts as a volunteer to assist other young people aged 8 to 11 who enjoy art as well. This gives her a bit of responsibility which helps her to think about other things. She has also helped with a young person’s camp.

Hannah: *This project does give you a lot of skills in the kitchen and it is a lot of fun and you do get to socialise with other people. I have made friends with Maggie and Sophie since I joined and that is good.*
## 8 Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>APHO</td>
<td>Association of Public Health Observatories</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>BTCV</td>
<td>British Trust for Conservation Volunteers</td>
</tr>
<tr>
<td>CAB</td>
<td>Citizen Advice Bureau</td>
</tr>
<tr>
<td>CAND</td>
<td>Community Action North Devon</td>
</tr>
<tr>
<td>CASP</td>
<td>Children’s Activities and Support Programme</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
</tr>
<tr>
<td>CES-D</td>
<td>Centre for Epidemiologic Studies Depression Scale</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CHDW</td>
<td>Community Health Development Worker</td>
</tr>
<tr>
<td>CHLC</td>
<td>Cornwall Healthy Living Centre</td>
</tr>
<tr>
<td>CIOSHPS</td>
<td>Cornwall and Isles of Scilly Healthy Living Centre</td>
</tr>
<tr>
<td>CLASP</td>
<td>Cornwall Leisure Activities and Sports</td>
</tr>
<tr>
<td>CLES</td>
<td>Centre for Local Economic Strategies</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CSP</td>
<td>Cornwall Strategic Partnership</td>
</tr>
<tr>
<td>CVS</td>
<td>Community &amp; voluntary sector</td>
</tr>
<tr>
<td>DCC</td>
<td>Devon County Council</td>
</tr>
<tr>
<td>Defra</td>
<td>Department for Environment, Food and Rural Affairs</td>
</tr>
<tr>
<td>FAHLC</td>
<td>For All Healthy Living Centre</td>
</tr>
<tr>
<td>GP</td>
<td>General Practice/Practitioner</td>
</tr>
<tr>
<td>GPPAQ</td>
<td>General Practice Physical Activity Questionnaire</td>
</tr>
<tr>
<td>HE</td>
<td>Healthy Eating</td>
</tr>
<tr>
<td>HLC</td>
<td>Healthy Living Centre</td>
</tr>
<tr>
<td>HLW</td>
<td>Healthy living Wessex</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>HSE</td>
<td>Health and Safety Executive</td>
</tr>
<tr>
<td>HT</td>
<td>Health Trainer</td>
</tr>
<tr>
<td>ILCM</td>
<td>Inter-link Capability Model</td>
</tr>
<tr>
<td>IMD</td>
<td>Index of Multiple Deprivation</td>
</tr>
<tr>
<td>IVR</td>
<td>Institute for Volunteering Research</td>
</tr>
<tr>
<td>LAA</td>
<td>Local Area Agreement</td>
</tr>
<tr>
<td>KWHP</td>
<td>Knowle West Health Park</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Nef</td>
<td>new economics foundation</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Clinical Excellence</td>
</tr>
<tr>
<td>NVQ</td>
<td>National Vocational Qualification</td>
</tr>
<tr>
<td>NWPHO</td>
<td>North West Public Health Observatory</td>
</tr>
<tr>
<td>P2H</td>
<td>Pathways 2 Health</td>
</tr>
<tr>
<td>PA</td>
<td>Physical Activity</td>
</tr>
<tr>
<td>PARC</td>
<td>Physical Activity Referral Coordinator</td>
</tr>
<tr>
<td>PARQ</td>
<td>Physical Assessment Readiness Questionnaire</td>
</tr>
<tr>
<td>PCDT</td>
<td>Penwith Community Development Trust</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PQASSO</td>
<td>Practical Quality Assurance System for Small Organizations</td>
</tr>
<tr>
<td>PSSRU</td>
<td>Personal Social Services Research Unit PSSRU</td>
</tr>
<tr>
<td>PVB</td>
<td>Penwith Volunteer Bureau</td>
</tr>
<tr>
<td>PWP</td>
<td>Positive Well-being Project</td>
</tr>
<tr>
<td>SMART</td>
<td>Specific, measurable, agreed upon, realistic and time-based</td>
</tr>
<tr>
<td>SOA</td>
<td>Super output Areas</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>SSDC</td>
<td>South Somerset District Council</td>
</tr>
</tbody>
</table>
9 References

http://www.biglotteryfund.org.uk/wellbeing_evaluation_tools.pdf
Accessed 20Feb09


Bristol City Council, NHS Bristol and Bristol Local Involvement Network (2009) Joint Strategic Needs Assessment...Keeping you informed.


Accessed 29th November 2010.
Devon County Council (2007) Joint Strategic Needs Assessments; Local profiles.

Accessed 29th November 2010


Jones, M., SWWB programme (South West Well-being programme: First year evaluation

Jones, M., South West Well-being programme: Adding Value Judge 2004


Plymouth PCT/City Council 2008 Joint Strategic Needs Assessment


### Appendix 1: Sources for the SWWB Questionnaire

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question Area</th>
<th>Question Sources</th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>General health</td>
<td>Health Survey for England</td>
</tr>
<tr>
<td>3-6</td>
<td>Alcohol and smoking behaviour</td>
<td>Health Survey for England</td>
</tr>
<tr>
<td>7</td>
<td>Nutritional intake</td>
<td>NWPHO Lifestyle Survey</td>
</tr>
<tr>
<td>8</td>
<td>Food habits</td>
<td>Bespoke: nef</td>
</tr>
<tr>
<td>9</td>
<td>Enjoyment of healthy food and preparation</td>
<td>Bespoke: nef</td>
</tr>
<tr>
<td>10</td>
<td>General physical activity</td>
<td>Sport England</td>
</tr>
<tr>
<td>11, 12</td>
<td>Physical activity</td>
<td>GPPAQ (2006)</td>
</tr>
<tr>
<td>13</td>
<td>Enjoyment of physical activity</td>
<td>Bespoke: nef</td>
</tr>
<tr>
<td>14</td>
<td>General well-being</td>
<td>DEFRA Survey of Public Attitudes and Behaviours</td>
</tr>
<tr>
<td>15</td>
<td>General mental health</td>
<td>DEFRA Survey of Public Attitudes and Behaviours. CESD plus (nef adaptions)</td>
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<tr>
<td>16</td>
<td>Personal well-being</td>
<td>Short Warwick Edinburgh Well-being Scale. 7item version &amp; nef questions</td>
</tr>
<tr>
<td>17-20</td>
<td>Social Well-being</td>
<td>ESS Round 3 Neighbourhood Belonging Place Survey</td>
</tr>
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</table>
Appendix 2 & 3: South West Well-Being Registration Form

<table>
<thead>
<tr>
<th>YOUR PROJECT NAME</th>
<th>YOUR LOGO</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID NUMBER:__/____</td>
<td>START DATE:<strong>/</strong>/__</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AME:</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ADDRESS:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER</td>
<td>Home Tel</td>
</tr>
<tr>
<td>STREET</td>
<td>Mobile</td>
</tr>
<tr>
<td>TOWN</td>
<td>Work Tel</td>
</tr>
<tr>
<td>POSTCODE</td>
<td>E-mail</td>
</tr>
</tbody>
</table>

How did you hear about us?

- Word of mouth or through a friend
- GP/ Nurse/ NHS Practitioner
- School/ Children’s Centre/ Nursery
- Website
- Newspaper/ Newsletter/ Poster/ Leaflet
- Project Worker or Volunteer
At a project event / open day

Other (Please say):

<table>
<thead>
<tr>
<th>Who referred or recommended you to this activity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I referred myself</td>
</tr>
<tr>
<td>A local community group</td>
</tr>
<tr>
<td>A GP or other health professional</td>
</tr>
<tr>
<td>Someone working for this project</td>
</tr>
<tr>
<td>Another professional e.g. youth or community worker</td>
</tr>
<tr>
<td>Other (Please say):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race / ethnicity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
</tr>
<tr>
<td>Black or Black British</td>
</tr>
<tr>
<td>Other (Please say):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your first language:</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
</tr>
<tr>
<td>Other (Please say):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you consider yourself a disabled person?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

Please give details if you wish:
<table>
<thead>
<tr>
<th>Are you receiving benefits because of a health problem or disability?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which of the following best describes your current situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live alone</td>
</tr>
<tr>
<td>Live with partner and children</td>
</tr>
<tr>
<td>Other (Please say):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you a carer for someone with disability or health needs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>If Yes please give details:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accommodation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own home</td>
</tr>
<tr>
<td>Council or housing association</td>
</tr>
<tr>
<td>Other (Please say):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which of the following best describes your current situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>At school</td>
</tr>
<tr>
<td>Retired</td>
</tr>
<tr>
<td>Seeking to work</td>
</tr>
<tr>
<td>Full time looking after home or family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
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<table>
<thead>
<tr>
<th>GP Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
</tbody>
</table>

OFFICE USE
We operate a secure system of holding information. The personal details on this form will not be passed to any other organization. Anonymised information in this form will be used in summary monitoring and evaluation reports. These reports enable us to be accountable to our funders and the communities we serve. Further details on our Data Protection Policy are available from xxxxxxx.

I consent to xxxxxxxxxxxxx holding information in accordance with the Confidentiality and Protection statement.

Signature ___________________________  Date ________________
Appendix: South West Well-Being Questionnaire (SWWBQ)

This form will ask you questions about your health, your diet, your community and your lifestyle. Please answer all questions.

1) Please tell us your postcode and date of birth.

<table>
<thead>
<tr>
<th>Your Postcode</th>
<th>Your Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2) How would you describe your health generally over the last week?

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3) Do you smoke?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Go to question 5)

4) How many cigarettes per day do you usually smoke?

<table>
<thead>
<tr>
<th>cigarettes per day.</th>
<th>I don't smoke daily.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5) Do you drink alcohol?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

(Go to question 7)

6) How many units do you drink in an average week?

_____ units per average week

A unit of alcohol is half a pint of beer, lager or cider; a pub measure of spirit, a small glass of wine.

7) On average how many portions of fruit and vegetables do you eat a day?

_____ per day on average

A portion is e.g. an apple, a glass of fruit juice, 3 handfuls of carrots. Do not include potatoes.

8) In a normal week, how often do you eat a meal that has been prepared and cooked from basic ingredients, either by yourself or someone else?

<table>
<thead>
<tr>
<th>Never</th>
<th>Less than once a week</th>
<th>Once a week</th>
<th>2-3 times a week</th>
<th>4-6 times a week</th>
<th>Daily</th>
</tr>
</thead>
</table>

For example Shepherd’s Pie made with raw mince and potatoes, or curry made with fresh vegetables and boiled rice?
9) Please indicate how much you agree with the following statements.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I enjoy putting effort and care into the food I eat.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) I enjoy eating healthy food.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10) Please tell us the type and amount of physical activity involved in your work.

I am not in employment
  e.g. retired, retired for health reasons, unemployed, full time carer

I spend most of my time at work sitting
  e.g. in an office

I spend most of my time at work standing or walking
  However, my work does not require much intense physical effort
  (e.g. shop assistant, hair dresser, childminder etc).

My work involves definite physical activity
  Including handling heavy objects and use of tools
  (e.g. plumber, electrician, carpenter, cleaner, nurse etc).

My work involves vigorous physical activity
  - including handling of heavy objects
  - (e.g. scaffolder, construction worker, refuse collector etc).
11) During the last week, how many hours did you spend on each of the following activities?

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Some but less than 1 hour</th>
<th>More than 1 hour, but less than 3 hours</th>
<th>3 hours or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td>Cycling, including cycling to work and during leisure time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c)</td>
<td>Walking, including walking to work, shopping, for pleasure, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d)</td>
<td>Housework / Childcare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e)</td>
<td>Gardening / DIY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12) In the past 4 weeks, on how many days have you done 30 minutes of physical activity such as brisk walking, cycling, sport, exercise, active recreation, sufficient to cause you to breathe more deeply? Please do not include physical activity as part of your job.

<table>
<thead>
<tr>
<th></th>
<th>0 days</th>
<th>1-3 days</th>
<th>4-6 days</th>
<th>7-12 days</th>
<th>13-19 days</th>
<th>20+ days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13) Now read the following statements and indicate on the sliding scale the point that best describes your feelings around physical activity.

<table>
<thead>
<tr>
<th>I wish I didn't have to do physical activity, but I know it's important for my health</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>As well as being important for my health, physical activity is something I enjoy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14) All things considered, how satisfied are you with your life as a whole nowadays?

<table>
<thead>
<tr>
<th>Extremely Dissatisfied</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Extremely Satisfied</th>
</tr>
</thead>
</table>

15) Below are a number of things people might say that they feel. Please tick the box that best describes how often during the past week each description would have applied to you?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>At least once</th>
<th>On a few days</th>
<th>Most days</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) You felt happy or contented</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) You felt depressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) You felt engaged or focused in what you were doing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>d) You felt energised or lively</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>e) You felt lonely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) You felt everything you did was an effort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Your sleep was restless</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
16) Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the past four weeks.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>None of the time</th>
<th>Rarely</th>
<th>Some of the time</th>
<th>Often</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>I've been feeling optimistic about the future</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b)</td>
<td>I've been feeling useful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c)</td>
<td>I've been feeling relaxed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d)</td>
<td>I've been dealing with problems well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>e)</td>
<td>I've been thinking clearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>f)</td>
<td>I've been feeling close to other people</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>g)</td>
<td>I've been able to make up my own mind about things</td>
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<tr>
<td>h)</td>
<td>I've been feeling like a failure</td>
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<tr>
<td>i)</td>
<td>I've felt like I belong to something I would call a community</td>
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<tr>
<td>j)</td>
<td>I've been feeling good about myself</td>
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</tbody>
</table>

17) Please indicate how much you agree with the following statements by ticking the appropriate box on each line.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>There are people in my life who really care about me</td>
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<td></td>
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<tr>
<td>b)</td>
<td>I regularly meet socially with friends and relatives</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>c)</td>
<td>I find it difficult to meet with people who share my</td>
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</tbody>
</table>
### 18) How often in the last twelve months did you help with or attend activities organised in your local area?

<table>
<thead>
<tr>
<th></th>
<th>At least once a week</th>
<th>At least once a month</th>
<th>At least once every three months</th>
<th>At least once every six months</th>
<th>Less often</th>
<th>Never</th>
<th>Don’t know</th>
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<tbody>
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</table>

### 19) How strongly do you feel you belong to your immediate neighbourhood?

<table>
<thead>
<tr>
<th></th>
<th>Very strongly</th>
<th>Fairly strongly</th>
<th>Not very strongly</th>
<th>Not at all strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### 20) Overall, how satisfied or dissatisfied are you with your neighbourhood as a place to live?

<table>
<thead>
<tr>
<th>Extremely Dissatisfied</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Extremely Satisfied</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

### 21) Is there anything else you would like to tell us about yourself or the activity you are doing?

### 22) What are your health goals? What would you like to get out of this activity?