GHK

Evaluation of Living Well: Final Report

Living Well West Midlands

13th January 2011

Living Well West Midlands

WEST MIDLANDS COUNCILS

LOTTERY FUNDED

GHK

Evaluation of Living Well: Final Report

Living Well West Midlands

Submitted by GHK Consulting Ltd

13th January 2011

Queries relating to this report should be directed to:

Fraser Battye

GHK Consulting,
30 St Paul's Square
Birmingham
B3 1QZ

0121 233 8900
fraser.battye@ghkint.com

www.ghkint.com

GHK

Document Control

Document Title	Evaluation of Living Well – Final Report
Prepared by	Fraser Battye, Daljeet Johal, Aidan Moss, Dr Nahid Ahmad, Rakhee Patel, Leighton Mitchell, David Salisbury, Dr David Scott
Checked by	Fraser Battye
Date	13th January 2011

Contents

1 What was Living Well & how was it evaluated? 1
1.1 Living Well was part of the BIG Lottery's 'Wellbeing Fund' 1
1.2 The evaluation was commissioned at regional level, but was designed 'from the projects up' 5
1.3 This report presents a summary of all the evidence gathered during the evaluation 8

2 What is the context for Living Well? Why is 'wellbeing' a policy concern? 9
2.1 'Wellbeing' is a very broad concept with contested definitions 9
2.2 Policy interest in wellbeing is often related to criticisms of a model of human development that is seen as being too concerned with economic growth 10
2.3 There have been several recent policy developments in relation to wellbeing 13

3 What resources did Living Well use & what outputs were created? 15
3.1 Living Well projects used around £7.6 million of resources 15
3.2 A wide range of activities were delivered by projects and just over 36,000 people in the region were beneficiaries of the services 17
3.3 Activity under Living Well was very largely 'additional' 22

4 How well was Living Well implemented? 24
4.1 Monitoring returns suggest a gradual improvement in implementation 24
4.2 Projects faced a range of challenges in delivering their services; they evolved a range of strategies to address them 24

5 What difference did Living Well make? 33
5.1 Quantifying projects' outcomes is challenging for a variety of reasons 33
5.2 The qualitative evidence shows a range of outcomes for beneficiaries 36
5.3 There have also been improvements in organisational capacity 47
5.4 From the projects' perspective, the value of the local and regional level support structures varied 49

6 Have Living Well Projects been Sustained? 51
6.1 'Sustainability' is a subtle concept; most projects will not continue in their current form, but their work will continue in some respect 51
6.2 Projects have taken a range of routes to sustainability 52
6.3 Accepting substantive challenges in terms of structural reform and funding cuts, the policy agenda is very favourable to Living Well 56

7 Did Living Well suggest any broader lessons: a) for this type of programme, & b) for changing behaviour to promote 'wellbeing'? 59
7.1 Living Well has highlighted four key issues that are likely to be generic to this type of fund 59
7.2 Living Well provides examples for promoting behaviour change 61

8 Final Conclusions & Recommendations 68

Annex 1 Interviewees 71

Annex 2 Topic Guides 72

GHK

Acknowledgements

This report is the final output from the evaluation of Living Well. Very many people across the West Midlands have given their time to make important contributions to this study.

GHK extends particular thanks to the:

- programme management team;
- steering group and regional stakeholders;
- project managers and staff; and,
- beneficiaries of the projects.

The information and support provided has been invaluable. GHK is very grateful for their participation and the study team offer their thanks for the enthusiasm and engagement shown. Any errors remain ours.

Key Points in this Report

In November 2007, GHK was commissioned to evaluate the Living Well Portfolio. This document is the final report from the evaluation and this summary presents the report's key points. They are that:

1. Living Well was part of the BIG Lottery's 'Wellbeing Fund'. It covered the West Midlands region and addressed three main themes: mental health, physical activity and healthy eating. Services were delivered by a diverse range of projects in each of the region's Local Authority areas.
2. The programme used around £8.6 million of resources – around £2.1 million of which was 'levered in' by projects in the form of in-kind and other cash funding.
3. Projects delivered a wide range of services – including mentoring, volunteer-led walks, wellbeing workshops, support for employers, allotments in schools and community-based exercise classes. These services were almost entirely 'additional' – they would not have been provided in the absence of BIG Lottery funding.
4. The demographic profile of the 'typical' beneficiary was young, female and 'White British'. This was partly an artefact of the profile of people accessing 'high throughput services, such as exercise classes. The costs per beneficiary under Living Well compare well with those of analogous services.
5. Projects encountered a range of challenges in delivering services to beneficiaries. These included: staff recruitment and retention problems; difficulties attracting, retaining and assessing beneficiaries; recruiting and supporting volunteers; engaging with employers; and working with GPs and other parts of the NHS.
6. A range of approaches were developed to address these challenges and projects were, with few exceptions, successful in delivering their services. A key point of learning here was the need for simple project designs, especially given the relatively short timescales involved.
7. There are methodological and practical problems associated with quantifying Living Well's outcomes. While noting these limitations, projects reported that around 6,500 people increased their levels of physical activity; 6,000 improved their mental wellbeing; and 3,000 improved their diet. There were also a series of significant labour market / workforce related outcomes.
8. The holistic and broad approach to promoting 'wellbeing' was central to achieving these outcomes. Other successful elements in this respect included: the use of interventions based upon providing opportunities to socialise and have fun; approaches based upon targeting families and groups, rather than individuals; and, the extensive use of volunteers.
9. The question of projects' 'sustainability' is complex. Very few projects will continue in the form established under Living Well, yet most activities will continue in some guise. Accepting the substantive challenges posed by cuts in public spending and the re-organisation of the NHS, the policy climate is favourable to Living Well projects. In particular, the recent Public Health White Paper, and the notion of the 'Big Society' present an agenda that fits with that of Living Well.
10. Living Well highlighted a set of issues and challenges generic to delivering 'this type' of programme. These included: the need for better guidance in target setting; questions of when BIG Lottery or government funding ought to be used; the monitoring and evaluation of projects; and, possible improvements to the bid process. Each of these issues offers an opportunity for BIG Lottery and other funders to develop their approaches.
11. Lastly, Living Well should be seen as part of a broad set of developments to incorporate 'wellbeing' into public policy. It therefore offers practical examples of services and models that can be used to further these developments. In particular, projects have tested a range of approaches to promoting behavioural change to achieve better health and wellbeing. Many of these approaches fit with emerging government thinking; they can therefore be disseminated and learnt from.

Executive Summary: what were the main findings from the evaluation of Living Well?

In December 2007, GHK Consulting Ltd (GHK) was commissioned by the West Midlands Regional Assembly – now 'West Midlands Councils' - to provide monitoring and evaluation services to the Living Well in the West Midlands Portfolio. This is a summary of the Final Report from the evaluation.

What was Living Well and how was it evaluated?

Living Well was part of BIG Lottery's £165 million 'Wellbeing Fund'. The Wellbeing Fund was established in support of existing policy goals and, more specifically, to further policy developments on the issue of wellbeing. It was designed to improve outcomes in three areas: mental health, physical activity and healthy eating.

Living Well services were delivered in each of the Local Authority areas of the West Midlands. The projects providing these services varied in both nature and scale. Activities included volunteer-led walks, community exercise classes, work to change employers' approaches to wellbeing, supported volunteering and social marketing. Across the projects there was a focus on mental wellbeing, and the links between physical activity and mental wellbeing. In general, projects took a broad and holistic approach.

The evaluation was commissioned to provide an assessment of implementation and outcomes at regional level. This required an understanding of the diversity of local projects, balanced with the need to gain enough common information to provide a programme-wide assessment. GHK's approach to doing so was to use project-level monitoring and evaluation plans, defined around a series of common elements (inputs, outputs and outcomes). We also supported projects in self-evaluation, and conducted around 450 qualitative interviews with beneficiaries, project staff and regional level stakeholders.

What is 'Wellbeing'? Why is it a policy concern?

As noted above, Living Well should be considered against the background of the development of wellbeing as a concept and – more latterly – a subject of public policy. In doing so, it is important to note that the concept of wellbeing has long historical and broad philosophical roots. It has been examined by philosophers, economists, psychologists, sociologists and theologians. This has left the definition broad.

More recently, wellbeing has become a policy concern – partly because there is evidence (albeit contested evidence) to suggest that, beyond a certain point of development, greater material wealth does not lead to higher levels of self-reported wellbeing. This has led to various efforts to re-define the ways we aim for and measure human development – principally to have a more balanced approach than a more narrow focus on GDP allows.

What resources were used by Living Well? How many people accessed services?

Over the three years of the programme, projects used around £8.6 million of resources. Significantly, around £2.1 million of this was 'levered in' by projects in the form of in-kind and other cash funding. Resources provided in-kind were important to many projects – especially in terms of volunteer time. Living Well activities were almost entirely 'additional' – meaning that services would not have been provided but for BIG Lottery funding.

People accessing Living Well services were from a range of backgrounds. Some projects specifically targeted certain groups – such as older people, people with learning disabilities or primary school children; other projects were 'open access'. By the end of the programme, over 36,000 people had accessed a service and nearly all projects either met or exceeded targets in this respect. The 'typical' beneficiary was young, female and 'White British'; this profile is largely an artefact of a few high throughput projects.

How well was Living Well implemented?

While some projects were able to 'get up and running' from the start of the programme, many took much of the first year to establish themselves and start delivering services to beneficiaries. Implementation improved greatly in Year 2, as reflected in data showing expenditure and uptake of services over time. By the end of Year 3, many projects considered themselves to be 'ahead of schedule'.

A range of common issues emerged relating to implementation; these included:

- *Staffing*. Many projects reported problems recruiting suitable staff at the start of projects. This was for a range of reasons including apparent skills shortages, conditions of near full employment (and a buoyant public sector), and some inflexibility in statutory organisations relative to the voluntary sector. There were also some problems in retaining staff at the end of projects, but this was largely overcome – through the use of sessional staff for example;
- *Attracting, retaining and motivating beneficiaries*. As noted above, nearly all projects met targets for recruitment and Living Well offered some examples of good practice in this respect. Success factors here included: tailoring services to specific groups' needs; working to make services 'demand led'; making services practical and fun; and, using community development approaches;
- *Assessing beneficiary progress*. Some projects worked with a stable cohort of beneficiaries and delivered a standard programme. They could therefore undertake initial and follow-up assessments of progress comparatively easily. Conversely, where projects were open access and had high levels of throughput (community exercise classes for example), tracking change was more difficult;
- *Recruiting and supporting volunteers*. The use of volunteers was a feature of many projects. In the main, projects were successful at recruiting, training and retaining volunteers. This was despite some increases in the requirements of volunteers – notably in terms of the qualifications needed to lead exercise classes. Successful approaches here included: tailoring experiences to suit the motivations of volunteers (some of which were work-related); working hard to ensure a high quality placement – including some use of formal agreements; and, providing clear and appropriate support to volunteers;
- *Engaging with employers*. Living Well was implemented as the economy entered recession; engaging with private sector employers therefore proved difficult. Most projects addressing workplace wellbeing therefore concentrated on the public sector. There was one notable exception to this, where a voluntary sector organisation took a flexible approach to engaging private sector employers. They successfully used human resources legislation as a means of framing the issue of wellbeing; and,
- *Engaging with primary care services*. Several projects set out with a design based upon receiving referrals from GPs and other parts of primary care services. In the main, this did not work as planned. These projects therefore typically revised their approach to include alternative sources of referrals. In cases where projects did successfully engage with primary care services, the key factor seemed to be simple persistence.

Lastly, and in more general terms, implementation was aided by effective local partnerships and simple project designs.

What difference did Living Well make?

There are methodological and practical challenges inherent in quantifying Living Well's outcomes. Accepting the limitations that these challenges provide, Living Well increased around 6,500 people's levels of physical activity; improved the mental wellbeing of around 6,000 people; and, improved 3,000 people's diet.

Qualitative evidence showed that:

- Improvements in mental wellbeing, physical activity and healthy eating were often related. The broad approach taken by projects meant that many beneficiaries experienced improvements on all three dimensions;

- Offering the opportunity to socialise and have fun was central to many projects' approach. Very often, the 'active ingredient' in Living Well services was the chance to participate in group activities and make friends. Providing tailored interventions that promoted choice and control were also cited as being effective;
- Improvements in physical activity were seen in a range of target groups. Again, tailored and fun approaches worked well here. One project also overcame barriers of price and access to childcare to promote improved physical activity amongst women in deprived neighbourhoods;
- Projects that worked with whole families seemed to be more effective at changing diet than projects that targeted individuals (and especially individual children). Practical approaches – demonstrating recipes and physically showing salt / fat content in foods for example – also worked well here; and,
- Projects working with volunteers were notable for achieving labour market related outcomes. There were several examples of projects achieving 'soft' outcomes, such as gains in confidence and self-esteem, as well as 'harder' outcomes such as employment or improved qualifications.

There were other, less common, outcomes - such as: beneficiaries reducing their use of treatment services; and, beneficiaries having better access to other services and opportunities. Moreover, at the organisational level, there were some gains in capability – in part arising from the programme of support put in place by the programme management team.

Have Living Well projects been sustained?

'Sustainability' is a somewhat complex notion here. Few projects gained funding for their work to continue in the form established under Living Well. Yet, through a variety of approaches – including changing mainstream services; making wellbeing a core offer of the organisation that delivered the project; training volunteers; and gaining funding for part of the service established under Living Well – the majority of services will continue in some guise.

There have been a range of barriers facing projects in approaching mainstream (i.e. Primary Care Trust / Local Authority) commissioners. Principally, the substantive cuts in these organisations' funding, and the re-organisation of the NHS, have hampered efforts here. On a more positive note, the policy agenda set out in the recent Public Health White Paper, and the notion of the 'Big Society', represent favourable developments for Living Well projects.

What general lessons can be taken from Living Well?

Living Well highlighted two main types of lesson. The first relates to the design and implementation of programmes of 'this type'. Issues highlighted here included: ways that BIG Lottery funding might best add value to government funding; the relative merits of different local models of combining sectors and organisations to deliver services; issues relating to the bid process and definitional guidance in target setting / performance management; and, methods for the monitoring and evaluation of diverse projects. Living Well also highlighted the value of providing structured support to projects (e.g. in bid writing or undertaking economic analysis).

The second type of lesson relates to behavioural change. Many of the approaches tested under Living Well fit with emerging thinking on this issue – notably in relation to the 'MINDSPACE' framework currently being developed by Cabinet Office. Living Well thereby provides some practical examples, showing how this framework might be implemented in practice.

Finally, and thinking in terms of more general learning from the programme, the concept of wellbeing has proved useful. Accepting some of the definitional 'fuzziness' noted above, wellbeing allows for a broad range of health issues to be addressed in a positive way. More specifically, Living Well demonstrated that framing services as addressing 'wellbeing' enabled many projects to approach mental health problems in a way that talking about 'mental health' does not.

1 What was Living Well & how was it evaluated?

In December 2007, GHK Consulting Ltd (GHK) was commissioned by the West Midlands Regional Assembly (WMRA) – now 'West Midlands Councils' - to provide monitoring and evaluation services to the Living Well in the West Midlands Portfolio. This document is the Final Report from the evaluation.

This first section provides a brief summary of Living Well and the evaluation. It begins by outlining the origins of Living Well and the BIG Lottery Fund's 'Wellbeing Fund'.

1.1 Living Well was part of the BIG Lottery's 'Wellbeing Fund'

In April 2006, the BIG Lottery Fund (BIG) launched their Wellbeing Fund, making £165 million available to support portfolios of projects. In part, the Fund was established to support existing policy goals in public health and growing interest in the concept of 'wellbeing'.

The overall aim of the Fund was to support communities in need to live healthier lifestyles and improve their wellbeing; it focused on three themes[1]:

1. **Healthy Eating**: children, parents and the wider community eat more healthily.
2. **Physical Activity**: people being more physically active.
3. **Mental Health**: people and communities have improved mental wellbeing.

The table below shows the nine outcomes of the Fund associated with these themes:

Table 1.1 The three themes and nine outcomes of the Wellbeing Fund

Theme	Outcome
Healthy Eating	Promote healthy eating for children, parents and the wider community
	Build greater access to healthy foods to encourage increased consumption and healthier choices for everyone
	Increase children's knowledge of healthy foods, food skills and improve their eating habits
Physical Activity	Encourage those who have the most sedentary lifestyles to increase their activity levels
	Promote increased physical activity in daily life and encourage individuals to incorporate more activity into their daily lives and routines
	Improve the ability of communities to organise and run projects that provide opportunities for local people to become more active
Mental Health	Increase user involvement in the design, development and running of the project
	Improve mental wellbeing by developing preventative approaches to common mental health problems
	Contribute towards changing perspectives on mental health by tackling stigma within communities and positively promoting mental health

Bids had to demonstrate that they fulfilled the following general principles:

[1] Big Lottery Fund (April 2006) *The Wellbeing Programme Guidance notes*

- Portfolios should ideally cross over more than one theme;
- Partnership working across health and other sectors;
- Providing support to those 'in need';
- Adding value to existing provision to build on 'what works'; and,
- Encourage innovation and piloting of new approaches.

BIG designed the Fund such that fewer, larger awards were made - and that they had to be of regional or national scale. As the guidance notes state:

> *"This application process has been designed for programmes where we want to make grants for strategic projects consisting of a portfolio of more than one project. In this way, we can make sure our funding is used most effectively to tackle needs strategically."*

In the West Midlands, the Regional Health Partnership and West Midlands Regional Assembly (as was) coordinated a regional bid. It was successful and £6.79 million of Lottery funding was secured to run the 'Living Well' Portfolio.

The main part of the bid comprised a series of project proposals from the 14 top-tier Local Authority (LA) areas in the region - each addressing one or more of the outcomes set out above. The final set of projects that formed Living Well is shown in the table below.

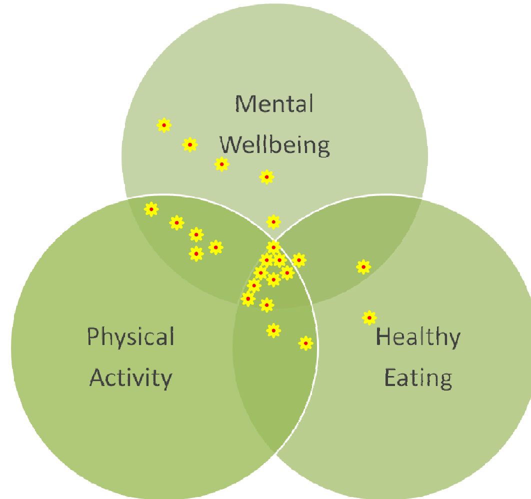
Table 1.2 Projects were varied in nature and scale

Area	Project(s)	Summary
Birmingham	bWell Birmingham	Services were commissioned by the Birmingham Health and Wellbeing Partnership to address two themes: Communities and Employers. 'Communities' services were largely delivered by the third sector and a range of target groups were covered, e.g. survivors of sexual violence. 'Employers' included training, consultancy and the Mindful Employer charter; the aim was to improve wellbeing at work.
Coventry	Body and Mind	Delivered by a voluntary sector organisation with close relationships with statutory services, this project offered one-to-one and group-based sessions as part of a holistic mental and physical health programme.
Dudley	Healthy Retail	This project took a social marketing approach to increasing the consumption of fruit and vegetables in a deprived neighbourhood, based around a school. Activities included the provision of cook-and-taste style sessions, food vouchers and a mobile food stall.
	Priority Care	Delivered by a housing association and providing older people who were referred by their GP / associated professionals with a 'friendly neighbour' to provide a range of social support services.
	Workmate	Supported employers to promote the employment of adults with learning disabilities.
	Healthy You!	Supported a group of minority ethnic adults with learning disabilities, and their carers, to access mainstream leisure services.
	Park Life	Provided an officer to support volunteers to lead a variety of different walks in parks.
Herefordshire	Living Well Herefordshire	Range of services targeted young people and their families, including counselling, physical activity and woodland-based sessions. Delivered largely by the voluntary sector.
Sandwell	Being Well in Sandwell	Wide range of interventions (e.g. light therapy, yoga) and addressed each of the three themes. Delivered by the YMCA to both their existing client group, but also to others (e.g. working with nurseries to make their food healthier).
Shropshire	Shropshire Outdoors	Green-gym activities to improve the wellbeing of adults with learning disabilities and / or mental health problems; also to improve the support offered to this group by mainstream countryside services. Delivered by the County Council in partnership with local voluntary groups.
	Shropshire Indoors	Provided a range of physical activities in community-based settings. Delivered by a voluntary organisation.
Solihull	SHINE	Targeted obese children and their families in Solihull and based around a structured programme of weekly healthy eating / physical activity sessions. Run as a partnership between statutory and voluntary organisations.

Area	Project(s)	Summary
Staffordshire	Dove Mentoring	Supported volunteers to mentor minority ethnic adults with mental health problems. Delivered by a voluntary organisation.
	Wellbeing Workshops	Provided a structured series of workshops for people to improve their own mental wellbeing, and that of their organisation (through a 'train the trainer' approach).
	Volunteering 4 Health	Supported people referred from health services / voluntary sector organisations into volunteering opportunities.
	Sharing Spaces	Provided funding, guidance and materials to support the improvement of school grounds.
Stoke-on-Trent	Living Well in Stoke-on-Trent	Delivered as a partnership between statutory and voluntary organisations, activities included healthy eating workshops and large-scale community events to raise awareness of mental health issues.
Telford and Wrekin	Women in Motion	Recruited and supported volunteers to deliver physical activity classes in local communities.
Walsall	Feeling Good!	Offered a range of services, such as a schools-based counselling sessions, physical activity and creative arts sessions. Some focus on South Asian communities.
Warwickshire	Action for Wellbeing	Led by a local Age UK and delivered a wide range of services, including physical activity sessions (e.g. line dancing) and community development work.
Wolverhampton	Wellbeing for Life	Recruited and supported volunteers to deliver physical activity sessions to older people.
	Nutrition Training	Provided training for schools and professionals (e.g. health professionals / Children's Centre staff) to promote better nutritional intake amongst users of these services.
	Farm to Fork	Worked with local schools to deliver workshops to improve knowledge of food / healthy eating and developing growing areas.
Worcestershire	Wellness Works	Worked with employers to assess and improve organisational wellbeing. Delivered by a voluntary organisation.

The Figure below maps the projects against the three themes of the Wellbeing Fund using a Venn diagram. It shows that most projects addressed more than one theme - and that mental wellbeing was the priority theme within the Portfolio. In terms of linkages between themes, several projects addressed all three, but there were a significant number of projects that looked specifically at the links between physical activity and mental wellbeing.

Figure 1.1 Projects typically addressed more than one theme of the Fund



Projects were supported and overseen by an infrastructure which comprised:

- Local Communication Leads (LCLs) at the Local Authority level, whose role was to oversee and coordinate projects locally. The exact role varied and some LCLs were directly involved in project delivery, whereas others were representatives of the local accountable body but had no involvement in direct delivery;
- The Portfolio Management Team (Programme Director, Programme Manager, backed by administrative and financial support);
- A Steering Group at regional level; and,
- Other regional level support including:
  - this evaluation;
  - a website (www.livingwellwestmidlands.org);
  - newsletters;
  - annual conferences; and,
  - Public Relations support.

1.2 The evaluation was commissioned at regional level, but was designed 'from the projects up'

The overall aim of the evaluation, as set out in the Invitation to Tender, was:

> *"…to monitor and evaluate the outcomes, impacts and successes of the portfolio including producing generic methods for data capture at a local level, and methodologies for assimilating and analysing information at a regional level."*

Significantly within this aim, there was a requirement to collect monitoring and evaluation (M&E) data at local level such that it could be aggregated to regional / Portfolio level. The diversity described in Table 1.1 above presented a significant challenge to achieving this. Moreover, there was a challenge in designing M&E systems that were meaningful at project level (so that information gathered was relevant to the services delivered and took account of

practical, organisational constraints), but that also contained enough commonality to allow the evaluation to aggregate results.

The approach adopted attempted to address these trade-offs. It was based upon **individual project-level M&E plans**, which were produced and agreed in consultation with project managers early in 2008. These plans set the requirements for projects' quarterly and annual reporting; they were backed by tools, guidance and ongoing support[2]. In order to support the aggregation of information gathered, some indicators and tools were common to most projects.

In addition to the system of self-evaluation and monitoring returns, the evaluation team undertook annual visits to each project. These visits comprised semi-structured interviews with project staff, beneficiaries and stakeholders; interviews were predominantly undertaken face-to-face, supplemented by telephone interviews. Interviews were also undertaken with regional stakeholders in the first and third years of the evaluation.

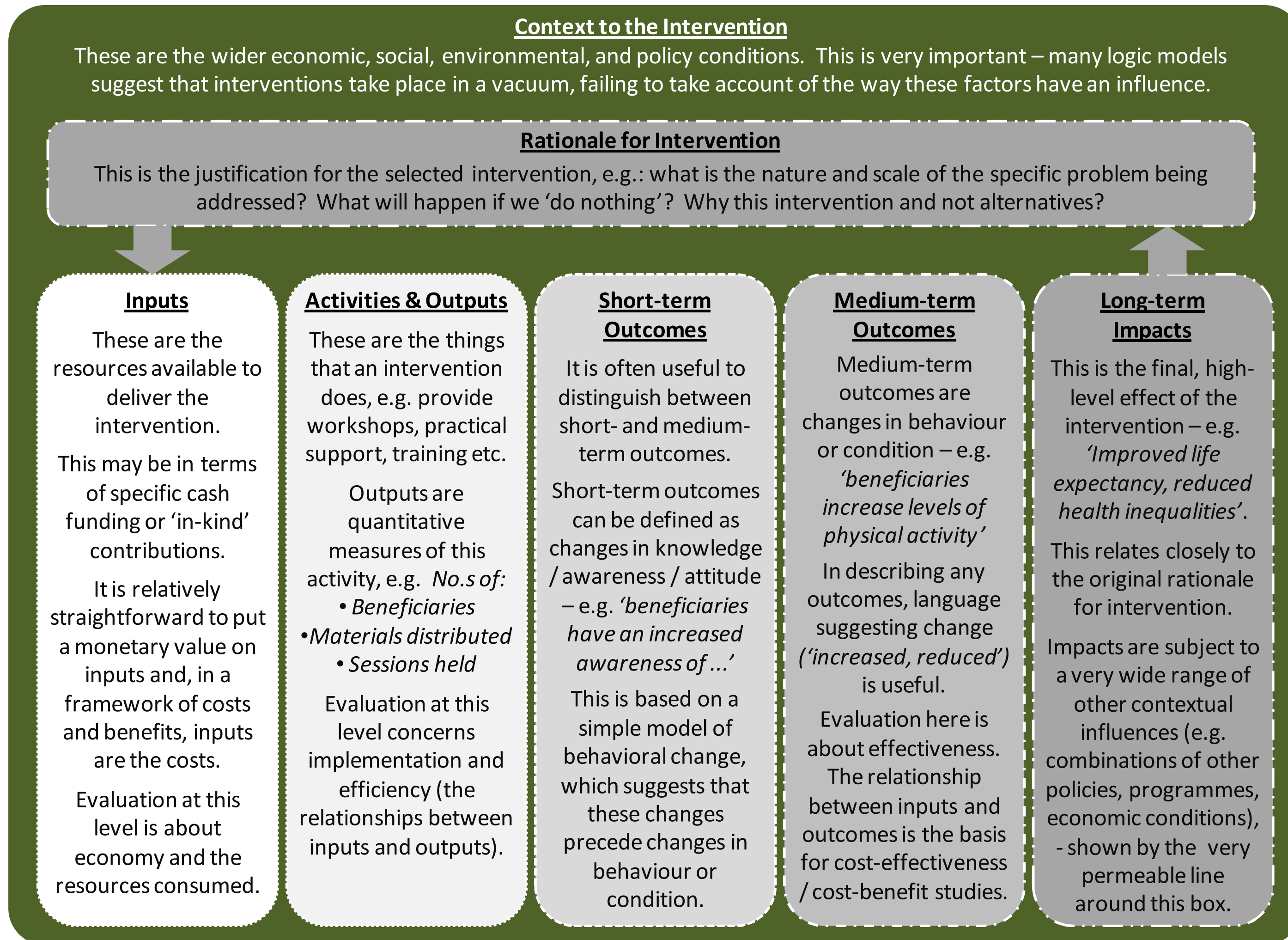
In total, around 450 interviews were conducted across the three years of the study. Over 70 staff and stakeholders, and nearly 80 beneficiaries were interviewed specifically for this report. A list of people staff and stakeholders interviewed is included at Annex 1 and the topic guides used are at Annex 2.

1.2.1 The evaluation was based upon a simple conceptual model of an intervention

In order to provide some conceptual clarity to projects' plans, and to support the aggregation of information, we used a common model of an intervention - shown in Figure 1.2 below. The model also forms the basis for the structure of this report.

[2] For example, we widely recommended the use of the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) to measure changes in mental wellbeing. We also provided training sessions and guidance in economic analysis.

Figure 1.2 The model used to structure the evaluation



GHK defined each project in the terms shown in the model and designed M&E requirements around each element. This provided a basis upon which aggregation to regional level could take place; we were therefore able to sum inputs, outputs and outcomes across projects to form a view at Portfolio level.

1.3 This report presents a summary of all the evidence gathered during the evaluation

This report contains the following:

- Section 2 describes the context to Living Well in terms of the development of the idea of 'Wellbeing';
- Section 3 shows the resources consumed by Living Well (inputs) and the associated activities (outputs);
- Section 4 describes the main issues in relation to implementation;
- Section 5 summarises the outcomes achieved;
- Section 6 discusses the main issues in relation to sustaining services established under Living Well;
- Section 7 provides a discussion of lessons learnt in relation to programme design / management, and also in terms of promoting behavioural change; and,
- Section 8 brings together evidence presented into a set of conclusions and recommendations.

2 What is the context for Living Well? Why is 'wellbeing' a policy concern?

This section provides a brief summary of issues, debates and policy developments surrounding the concept of 'wellbeing'. It begins by outlining what we might mean by 'wellbeing', before setting out some of the key debates surrounding it. The section concludes with a discussion of the most wellbeing policy developments in this area.

2.1 'Wellbeing' is a very broad concept with contested definitions

The concept that we refer to as wellbeing has long historical and broad philosophical roots. For example, it was a subject of the ancient Greek philosophers Aristotle and Epicurus. Aristotle wrote that 'eudaimonia' - which has been translated variously as 'living well', 'happiness' or 'human flourishing' - was the ultimate goal of human activity.

In the 1800s, wellbeing was also a concern of the utilitarian thinkers Bentham and Mill. They were concerned with question of how human 'utility' - again variously defined, but normally taken to mean happiness or welfare - could be maximised. In doing so, and with a clear focus on public policy, Bentham used the formulation of 'the greatest happiness of the greatest number' as a means of judging the worth of actions.

The linage of the concept is therefore long. Moreover, wellbeing has been considered from a wide range of perspectives – including economics, psychology, sociology, physiology, theology, philosophy and political economy. This has rendered the definition broad.

Nevertheless, it is possible to demarcate the parameters of the definition by reference to some of the main debates over what we mean by wellbeing. Briefly, these relate to:

- Distinctions between 'higher' and reflective pleasures - such as those gained from intellectual and personal development, intimate relationships or contemplation of art - and 'lower' more immediate pleasures, such as those gained from eating or sex[3]. These distinctions relate closely to those drawn between the concepts of 'life satisfaction' - which would encompass a broad, overall and reflective sense of one's life - and 'happiness', which would be an impermanent, but perhaps more intense and pleasurable, state. In the literature, these distinctions are often described as being between 'hedonic' and 'eudaimonic' accounts of wellbeing - where a hedonic perspective is concerned with the experience of pleasure and a eudaimonic perspective concerns the development of human potential and functioning in a broader sense (even recognising that the pursuit of pleasure *per se* may be damaging); and,
- Related distinctions between 'subjective' and 'objective' accounts of wellbeing. Questions here concern the extent to which an individual's perception of their wellbeing compares to a set of norms – e.g. relating to the fulfilment of basic material needs / political freedoms / education etc[4].

Despite these substantive conceptual difficulties, wellbeing is often given as an aim of policy and various attempts have been made to provide working definitions of it for this purpose. (As we shall see later in this section, these definitional problems feed directly into the problem of measurement).

---

[3] Mill summarised his position in this debate as follows: *"It is better to be a human being dissatisfied than a pig satisfied; better to be Socrates dissatisfied than a fool satisfied".*

[4] As an example of this debate, one economist - Carol Graham – has highlighted some of the problems around self-reported wellbeing, describing what she sees as the paradox of 'happy peasants and miserable millionaires'. She notes that Kenyans are as satisfied with their healthcare as Americans – when, by any objective standard, they ought not to be. See: http://www.stwr.org/economic-sharing-alternatives/the-paradox-of-happy-peasants-and-miserable-millionaires.html.

Definitions of wellbeing are typically linked to the concept of health; for example, the Cambridge (online) dictionary provides the following definition:

> *"The state of feeling healthy and happy"*

The World Health Organisation (WHO) also includes 'wellbeing' in its definitions of both health and mental health; the latter of which goes some way to providing a definition of wellbeing itself (see box to the right).

WHO definitions of 'health' and 'mental health'

Health: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Mental Health: a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

Other broader and more socially-orientated attempts at providing a working definition include a briefing paper to the Department of Education, published in August 2010, which defined wellbeing as:

> *"...generally understood as the quality of people's lives. It is a dynamic state that is enhanced when people can fulfil their personal and social goals. It is understood both in relation to objective measures, such as household income, educational resources and health status; and subjective indicators such as happiness, perceptions of quality of life and life satisfaction."*[5]

And the cross-departmental Sustainable Development strategy (2007), which defines wellbeing as:

> *"...a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It requires that basic needs are met, that individuals have a sense of purpose, that they feel able to achieve important personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, strong and inclusive communities, good health, financial and personal security, rewarding employment, and a healthy and attractive environment."* [6]

A further definition was provided by Stiglitz, Sen and Fitoussi in their report to the French President Nicolas Sarkozy (discussed further below) on the measurement of economic performance and social progress:

> *"...wellbeing has to do with both economic resources such as income, and with non-economic aspects of people's life (what they do and what they can do, how they feel, and the natural environment they live in)."*

2.2 Policy interest in wellbeing is often related to criticisms of a model of human development that is seen as being too concerned with economic growth

In large part, the concept of wellbeing has (re)entered policy discourse because of a view that the dominant goal of post-war western economies - pursuing economic growth and enhancing material prosperity[7] (typically measured by GDP) – is:

- not the best way to promote human development in its roundest sense; and,
- is likely to be environmentally unsustainable.

One of the most widely cited pieces of evidence in support of the first of these points is provided by the economist Richard Easterlin, who showed that self-reported happiness does

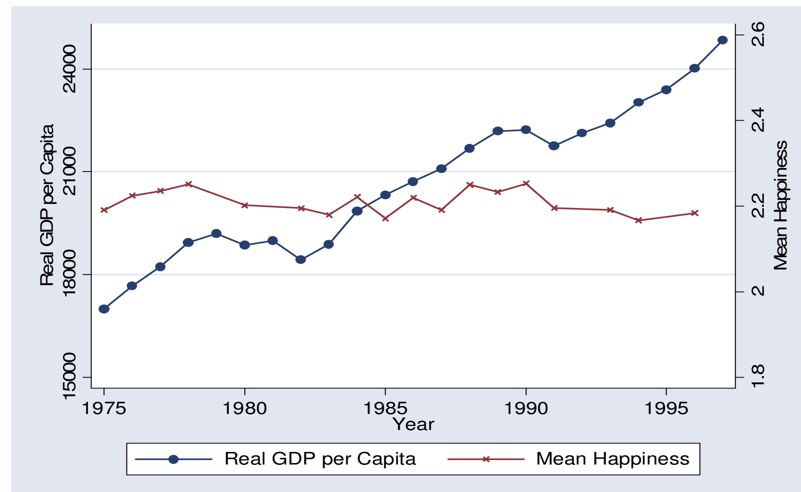
[5] http://www.education.gov.uk/research/data/uploadfiles/FinalChildDFEwebsite.pdf p. 2

[6] Defra website, Sustainable Development pages: http://www.defra.gov.uk/sustainable/government/progress/national/68.htm

[7] There have been notable criticisms of this characterisation of government policy by those who argue (Paul Ormerod for example) that governments have always maintained a balance of policy aims and have not typically pursued growth at the exclusion of all else.

not increase in line with GDP (as shown in Figure 2.1). This seemed to suggest that, beyond a certain point of development, the relationship between greater material wealth and happiness breaks.

Figure 2.1 Money doesn't make you happy (beyond a certain point) – the 'Easterlin Paradox'[8] [9]



Moreover, as the economist Andrew Oswald notes, there is also the risk of confusing means and ends:

> *"The relevance of economic performance is that it may be a means to an end. That end is not consumption of beef burgers, nor the accumulation of television sets, nor the vanquishing of some high level of interest rates, but rather the enrichment of mankind's feeling of wellbeing. Economic things matter in so far as they make people happy"*[10]

Furthermore, as noted above, even if GDP were a good measure of wellbeing, it does not seem to take sufficient account of environmental sustainability – meaning that it does not properly reflect trade-offs between the wellbeing of generations. This work has been developed partly by environmental economists, such as Professor Tim Jackson, in the search for measures of progress that go 'beyond GDP'. Insights from this work, alongside evidence that a good natural environment is a contributor to wellbeing[11], has meant that wellbeing is increasingly included in sustainable development models (see Defra definition above).

[8] Available at http://www2.warwick.ac.uk/fac/soc/economics/staff/academic/oswald/ - Presentations *"Emotional Prosperity"*

[9] It is again important to note that this finding – and the policy implications of it – has been the subject of debate. For example, in the 2007 book 'Happiness, Economics and Public Policy' Helen Johns and Paul Ormerod argue that one interpretation of the paradox is that measurements of GDP are not bounded (and so can keep increasing), whereas wellbeing is typically measured using scaled questions (and so reach a limit as a feature of the means of measurement). Johns and Ormerod also cite problems with the paternalistic nature of the policy implications of much wellbeing / happiness research – that that the state / scientists know what is better for the individual than they do. For a useful summary of the arguments on the Easterlin paradox, see HM Treasury (2008) *Developments in the economics of wellbeing*

[10] Oswald (1997) "Happiness and Economic Performance" in *The Economic Journal, 107(November)* p.1815

[11] Newton, J (2007) *Wellbeing and the Natural Environment: A brief overview of the evidence*. Defra

2.2.2 'Measuring what matters' is a related concern

If we choose to pursue a broader agenda based more on wellbeing (or, at least, a rounder definition of human development) and less on economic growth, how would we measure progress towards these revised goals? There have been various attempts to address this question; for example:

- The United Nations Development Programme's Human Development Index (HDI), which built on the work of economist / philosopher Amartya Sen – who looked at human capability in a broad sense - takes into account a fuller definition of 'wellbeing', but excludes self-reported measures.
- Sen also worked with economists Stiglitz and Fitoussi[12], on a 'Commission on the Measurement of Economic Performance and Social Progress' - established by President Sarkozy - to examine alternatives to the goal of increased GDP. Their report argued that GDP is an inadequate measure of human wellbeing - and that this is important as what we measure affects how policy perceives and responds to problems. They assert that GDP is often inaccurate, not trusted by the public[13], and that there are trade-offs between growth in GDP and protection of the environment. The report identifies eight dimensions of wellbeing (shown in the box to the right) and provides twelve recommendations for improving the measurement of wellbeing. In the UK, the 2010 'Marmot Review' into health inequalities supported the work of this commission, noting that: *"Wellbeing should be a more important societal goal than simply more economic growth"*.

Eight Dimensions of Wellbeing

1. Material living standards
2. Health
3. Education
4. Personal activities (including work)
5. Political voice and governance
6. Social connections and relationships
7. Environment (present and future conditions)
8. Insecurity, of an economic as well as physical nature

- New economics foundation (nef) has attempted to measure wellbeing in their Happy Planet Index (HPI), which aims to represent: *"...the efficiency with which countries convert the earth's finite resources into wellbeing experienced by their citizens."*[14] Items included cover ecological resources, subjective measures of wellbeing and measures of health. This can lead to some counter-intuitive results, as countries usually ranked highly when measuring GDP (for example the UK) are much less successful in the HPI. For example, in 2009 the UK was ranked 74th, while Pakistan was 24th.
- There has been interest in the experience of the Himalayan kingdom of Bhutan who have been working on an appropriate measurement system for Gross National Happiness[15] (GNH) for some years and have recently begun to measure their progress in this way. Bhutan is one of the few low-income countries with high levels of self-reported happiness (although is should be noted that this result is problematic and contested).
- The European Commission led a 'Beyond GDP' project to produce indicator sets that take account of poverty, resource depletion, and issues associated with climate change.
- Two prominent economists - Lord Layard and Paul Dolan – have promoted the role of self-reported measures of wellbeing. Layard argues that economics ought to concern itself with utility (see Bentham / Mill above) and subjective happiness. He views GDP as a proxy for utility, and argues that it has become less relevant as better measures of

[12] http://www.stiglitz-sen-fitoussi.fr/documents/rapport_anglais.pdf

[13] According to the report only one third of the UK public trust government figures on economic growth, inflation and unemployment.

[14] NEF Happy Planet Index (2006) p.8

[15] http://www.grossnationalhappiness.com/default.aspx

subjective wellbeing have been developed. For Dolan, objective lists – such as those used in the HDI - can become prescriptive accounts of wellbeing in which those measuring tell others what makes them happy. Further, the weighting of items in an objective list is difficult – what makes us happier: better healthcare or better housing? Dolan proposes that subjective measures of wellbeing should not replace other ways of looking at wellbeing but should be used to provide a fuller picture and make up for shortcomings of other types of measurement.

- The Children's Society has developed an 'Index of Children's Wellbeing', which is based on self-reported measures of overall happiness, as well as domain-specific measures covering issues such as family situation and satisfaction with appearance.

Finally, another important development in the measurement of mental wellbeing is the use of the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) in population surveys. WEMWBS has been used in population surveys by NHS Grampian and the North West Public Health Observatory as well as being included in the core modules of the British Social Attitudes Survey in 2007. It is described further in the box:

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

WEMWBS was designed by a team from the Warwick and Edinburgh Universities. It comprises 14 statements covering key aspects of mental wellbeing such as mood, energy, coping, cognitive ability and relationships. It covers both 'hedonic' and 'eudaimonic' accounts of wellbeing. There is also now a short WEMWBS, with seven items. Both have been used in population level surveys; they have also been used as part of this evaluation.

2.3 There have been several recent policy developments in relation to wellbeing

In England, the issue of wellbeing has recently become a mainstream policy concern – although it is important to note that the definitional problems described at the beginning of this section remain. Notable points in relation to policy development include:

- The 2000 Local Government Act, which gave Local Authorities the duty to: *"promote the general wellbeing of a community and its citizens"*;
- In 2005, Defra established the cross-departmental Whitehall Wellbeing Working Group. Defra also led work showing the importance of wellbeing within the framework of sustainable development, which was contained within the 2007 Sustainable Development strategy;
- The 2008 Foresight Project on Mental Capital and Wellbeing, which provided a summary of the best evidence available in this area and provided recommendations to government for improvements in this area. One output of this review was nef's 'Five Ways to Wellbeing'[16], which sought an equivalent of the '5-a-day' message for mental health;
- The mission statement of the Department of Health is to *"improve the health and wellbeing of people in England"* and one of the key themes in health policy development[17] has been a reorientation away from treating ill-health and towards prevention and promotion of better health. Policy development here has tended to emphasise the links between better physical / mental health and a sense of 'wellbeing';
- One of the two HM Treasury departmental strategic objectives for 2008-2011 is: *"Ensuring high and sustainable levels of economic growth, well being and prosperity for all"*;

[16] http://www.neweconomics.org/projects/five-ways-wellbeing

[17] For example see the 2004 report 'Securing Good Health for the Whole Population' (the 'Wanless report'), which recommended this reorientation for the NHS – away from being a 'National Sickness Service', which focuses on treating problems once they arise.

- In January 2009, the Department for Communities and Local Government put together the first Child Wellbeing Index (CWI)[18], which takes a similar approach to the index of multiple deprivation;
- The 2003 Every Child Matters (ECM) agenda has been the key driver for policy in children's services and which includes 'Achieving Economic Well Being' as one of its five outcomes. ECM prompted the Social and Emotional Aspects of Learning (SEAL) programme to run in 80% of primary schools and 30% of secondary schools across England. NICE also issued guidance on the promotion of wellbeing in primary and secondary schools; and,
- In December 2009 the New Horizons Mental Health strategy was published. The strategy established that the government departments which were engaged in the agenda[19] would form a Ministerial board to ensure high level oversight. The strategy set out that all policies should consider wellbeing and contained a strong focus on children, early intervention and promotion of wellbeing during childhood.

Finally and most recently, the concept of wellbeing has also been a feature of the coalition government's policy development. Wellbeing is mentioned three times in the 'Programme for Government' and David Cameron has long expressed interest in the concept – for example, in a 2007 speech at the London School of Economics, he stated that:

> *"Abstract national wealth – a high rate of GDP – is necessary, but not sufficient, to deliver higher GWB, or general wellbeing."*[20]

Cameron went on to argue that three things that consistently correlate with wellbeing are: trust in society; health; and strength of marriage. For Cameron, *"wellbeing is simply the opposite of social breakdown."*[21] In November 2010, Cameron asked national statistician Jil Matheson to examine ways that wellbeing could be measured and tracked over time – with a view to incorporating this information into policy making. In doing so, the measures will balance objective data (such as levels of recycling) with subjective, self-reported data.

We return to the policy context for Living Well in Section 6, when we examine the scope for lessons from the Portfolio to be applied more broadly. Before doing so, it is first necessary to present the detailed findings from the evaluation, which we now do – starting with a description of the resources used and outputs created.

---

[18] http://www.communities.gov.uk/documents/communities/pdf/1126232.pdf

[19] At the time this included the Department of Health and the Department for Children, Schools and Families, the Cabinet Office, the Department for Work and Pensions, the Department for Communities and Local Government, the Ministry of Justice and the Home Office. This strategy is due to be re-launched under the new public health agenda (described later in this report).

[20] http://www2.lse.ac.uk/PublicEvents/pdf/20071009t1634zoo1.pdf p.8

[21] Ibid p.2

3 What resources did Living Well use & what outputs were created?

This section addresses the first two elements of the model shown in Figure 1.2, namely 'inputs' (resources consumed) and 'outputs' (quantitative measures of activity). As such, it draws mainly on the quarterly monitoring returns provided by the projects, which concentrated on these elements.

The section begins by setting out caveats in relation to the data presented, before moving on to describe Living Well's inputs (cash and in-kind) and outputs (primarily in terms of sessions held and beneficiary numbers). It concludes by presenting some limited analysis of a combination of inputs and outputs – looking at costs per beneficiary – and considering the extent to which Living Well activity was 'additional'.

Caveats in relation to the data

Before presenting any results, it is first important to note that the data derived from the monitoring returns are aggregated across projects. They should therefore be treated with some caution. While summing inputs is comparatively straightforward, since they are all monetised, aggregating outputs is an inexact undertaking that relies upon the use of assumptions and judgements. For example, one of the main outputs – the number of beneficiaries – faces a definitional challenge, since projects engaged in very different ways with their service users[22] . Data presented here should therefore be used with this caveat in mind.

3.1 Living Well projects used around £7.6 million of resources

The Figure below shows the final total level of resources used by Living Well projects, broken down by the 'type' of input. These types are 'BIG Lottery funding', 'Other cash funding' and 'In-kind'[23] support. The results show that:

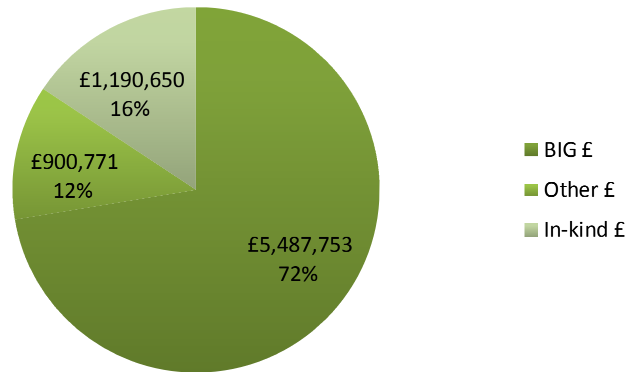
- A total of £ £7,579,170 worth of resources were used;
- BIG Lottery funding accounted for over 70% of these inputs (£5,487,753) and 'other cash' for over 10% (£900,771); and,
- In-kind funding was worth nearly £1.2 million.

These figures can be added to the (part projected) management budget, which includes staffing costs, the PR and evaluation contracts, legal and financial advice to give a **grand total for Living Well of a little over £8.6 million**.

[22] The problems relating to this definition became apparent early in Year 1. GHK therefore issued a working definition for projects to use, defining a 'beneficiary' as: *"An individual who receives an intervention, where a plausible link can be made between this and some improvement in their life"*. We included the test of a 'plausible link' between intervention and outcome in order to leave aside those who had received minimal levels of intervention – e.g. had visited a website or been given a leaflet.

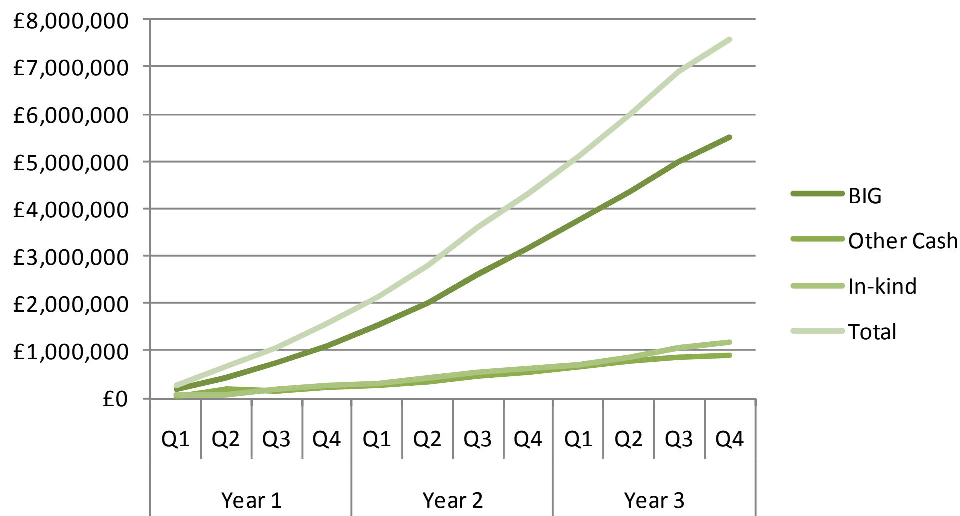
[23] We asked projects to keep a record of in-kind support, following guidance based upon the estimated value of people's time for specific tasks and / or estimates of what they would have had to pay in the absence of the resource being provided for 'free'.

Figure 3.1 Living Well projects used a range of different inputs – 'in-kind' resources were significant



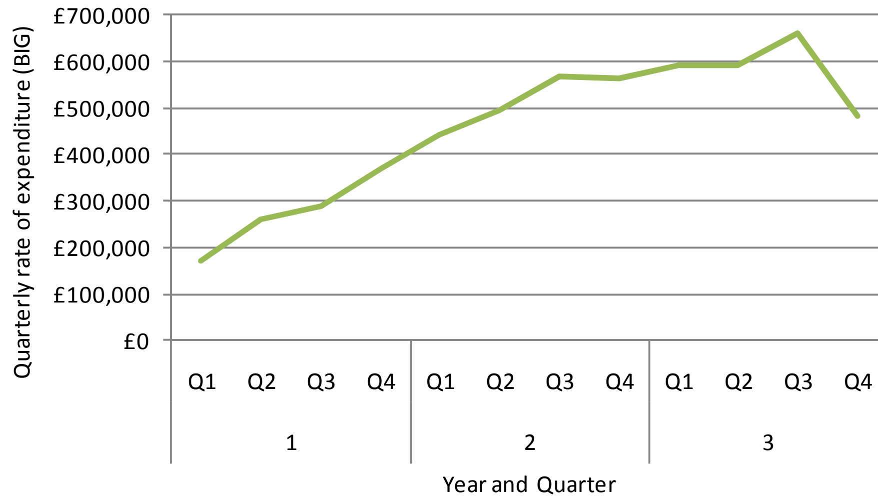
The Figure below shows the way in which these different types of input varied over time. It shows that the most significant change in the rate of use was in relation to BIG Lottery funding, which began to increase rapidly from the end of Year 1.

Figure 3.2 Levels and types of input have varied over time



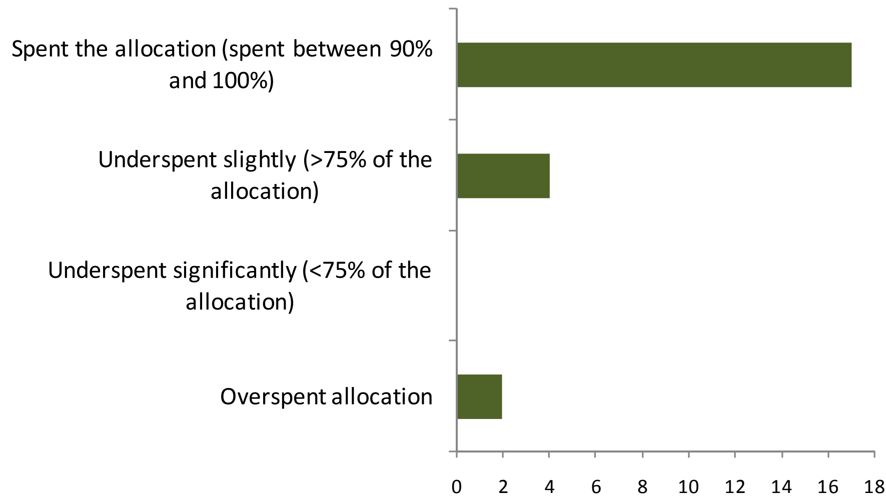
Looking in more detail at the change in rates of BIG Lottery funding over time, we see from the Figure below that the rate of expenditure grew most between the third quarter of Years 1 and 2. It then stabilised, before a slight rise and fall at the end of Year 3. The average quarterly rate grew each year from £272,595 in Year 1, to £516,797 in Year 2, to £582,547 in the final year.

Figure 3.3 The quarterly rate of BIG Lottery expenditure grew steadily until mid-way through Year 2



As a means of estimating possible 'under-spend' at the end of each quarter, GHK provided estimates of the likelihood of projects using their full allocation of BIG funding. This exercise showed a progressive decline in the likelihood of substantive under-spend as project activities reached full delivery - and as the programme team and Steering Group emphasised the importance of monitoring expenditure (alongside developing strategies for the potential use of such funds). In combination, these factors led to a situation where nearly all projects used between 90%-100% of their allocated funding, as shown in the Figure below, which is taken from a project survey in the final quarterly monitoring return:

Figure 3.4 Nearly all projects spent their allocated funding



3.2 A wide range of activities were delivered by projects

As noted at the start of this section, the task of aggregating projects' outputs faces a number of conceptual and practical challenges. Nevertheless, using data returned through the monitoring system, it is possible to provide good estimates of the scale of activities undertaken; this is shown in the Table below.

The key points of note are that:

- physical activity sessions were the most common output, followed by mental wellbeing and healthy eating sessions;
- nearly 1,000 professionals were engaged in some form of training;
- nearly 700 volunteers were recruited / trained;
- there have been high levels of partnership working / engaging with partner organisations; and,
- over 50 sites have had some form of physical improvement made to them.

Table 3.1 There have been a wide-ranging set of outputs across the Portfolio[24]

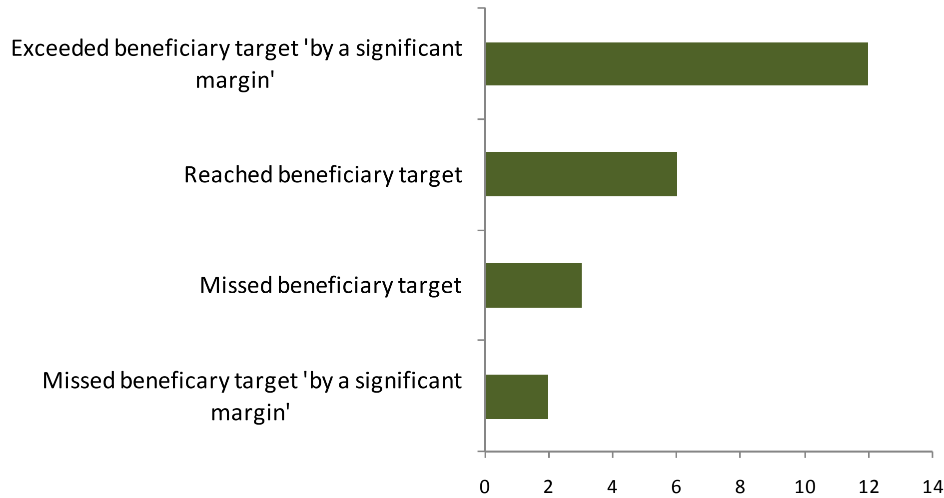
Output type	No.
Physical activity sessions	7,250
Mental wellbeing sessions	5,860
Healthy eating sessions	2,710
Professionals engaged in training activity	980
Partner organisations engaged with	790
Volunteers recruited and / or trained	680
People consulted	370
Sessions relating to consultation / research and scoping activities	120
Sites improved	53

The First Annual report from the evaluation addressed the question of the very significant disparity between the targets set for Living Well and the actual numbers achieved (targets were far higher than the actual results). The report noted that this disparity was a function of a number of over-optimistic assumptions, perhaps combining with the incentives of bidder and appraiser to be optimistic at the bid stage.

Targets for projects were therefore revised during the first quarters of Year 2; as part of the final monitoring return projects were asked whether they had met these targets. The Figure below shows the results reported by projects; it suggests that the targets were either met or exceeded by nearly all projects.

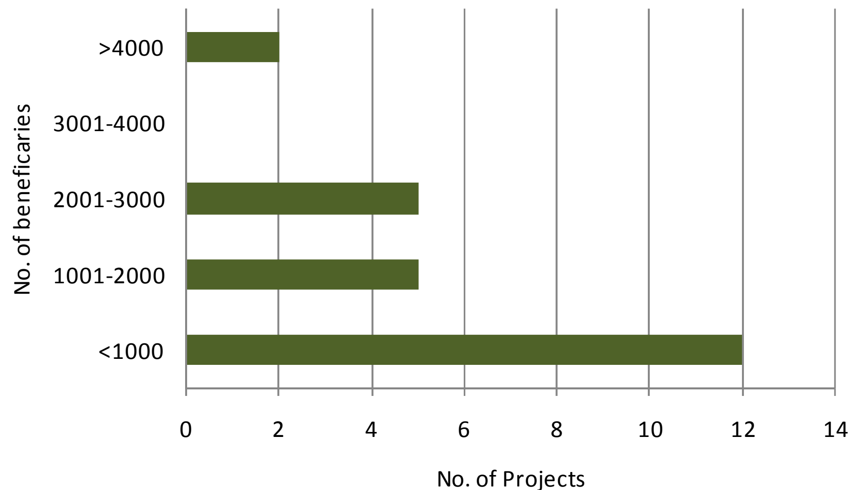
[24] Outputs rounded to the nearest 10 with the exception of 'sites improved'.

Figure 3.5 Nearly all projects reached or exceed their targets for beneficiaries reached



Looking across Living Well, the mean number of beneficiaries per project was a little over 1,500 and the median was a little below 860. The project with the fewest beneficiaries was Priority Care (a little under 100) and the project with the most was Living Well in Sandwell (slightly over 8,050). The Figure below shows this distribution across the projects; it shows that projects most commonly had fewer than 1,000 beneficiaries.

Figure 3.6 Projects typically had fewer than 1,000 beneficiaries



The characteristics of these beneficiaries remained broadly constant from the end of Year 1; they are that:

- Nearly 70% of beneficiaries were female;
- Over 40% were aged under 16, those over 55 accounted for around 20%;
- Over 65% were 'White British', with 'Asian' groups accounting for 18%; and,
- Around 4% considered themselves to have a disability - although qualitative information gained during project visits suggested that this is likely to be higher since some beneficiaries with disabilities did not identify themselves as such.

This profile is largely an artefact of a few high throughput projects, such as Sharing Spaces and Being Well in Sandwell. More detailed results are shown in the Figures below.

Figure 3.7 Around 2/3rds of the beneficiaries were female

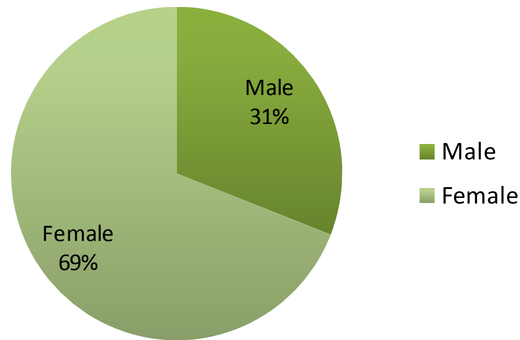


Figure 3.8 Over 40% of beneficiaries were under 16

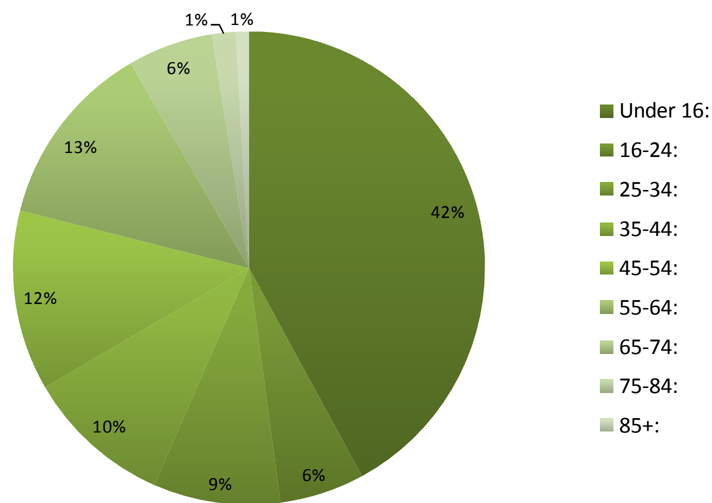
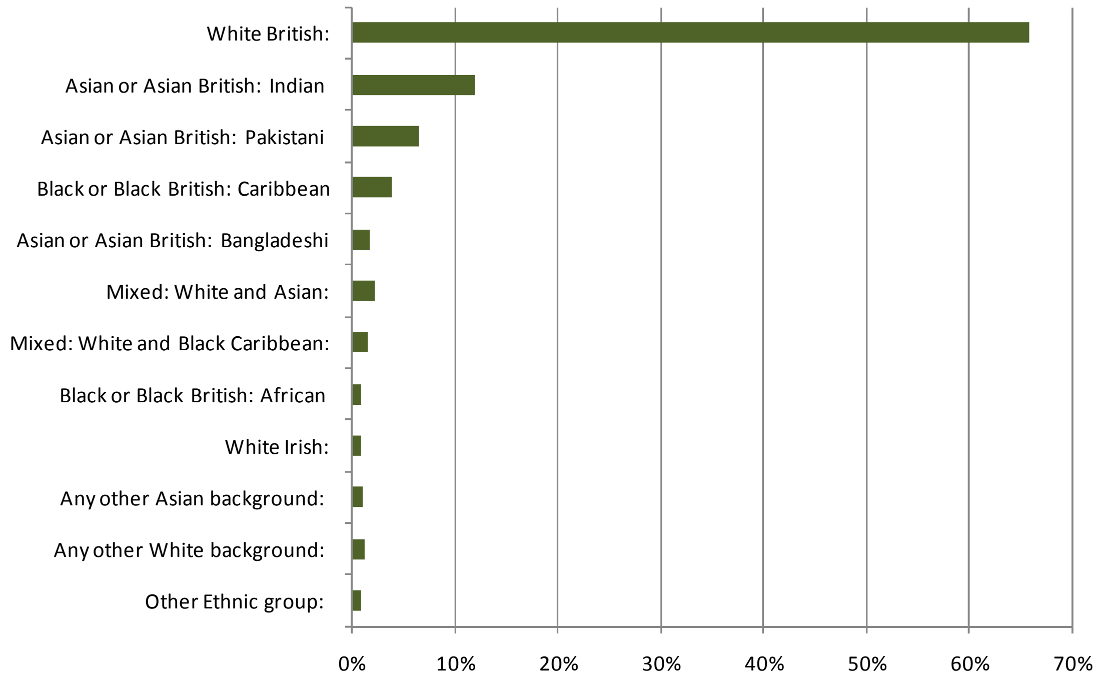


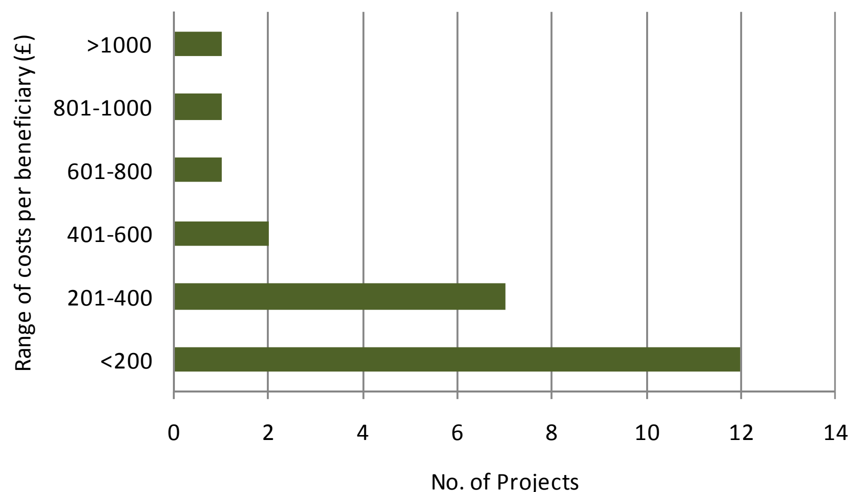
Figure 3.9 Over 65% of beneficiaries were 'White British'



3.2.2 Projects' costs per beneficiary are comparable to available benchmarks

We can compare Living Well's inputs and outputs to generate a series of per beneficiary costs. Using the BIG Lottery element of the funding and the total number of beneficiaries shows that the median[25] per beneficiary cost across the projects was a little over £190, with a range from £20 (Sharing Spaces) to nearly £1,020 (Dove Mentoring). The Figure below shows the distribution of costs per beneficiary; it shows that projects most typically had a per beneficiary cost of less than £200.

Figure 3.10 Per beneficiary costs were typically under £200



[25] We use the median figure given the skewed nature of the distribution. The mean was a little under £290.

These costs can be benchmarked against 'similar' services to see how Living Well compares. Care must be taken in doing so. While this analysis is more sophisticated than simply assuming that lower per beneficiary costs are better, it is still limited – notably in this case by the challenge of finding 'similar' services. There are also problems in the way that different figures are produced. Nevertheless, it seems that Living Well compares either similarly or broadly favourably with:

- The Watch It! programme, which ranged from around £460 to £2,450 per participant;
- LEAP interventions, which ranged from £50 to £3,400;
- The Well@Work programme, which had a figure of £150 per participant[26]; and
- Health projects within the New Deal for Communities programme[27], which showed an average figure of a little under £300.

Finally on this issue, last year's Annual Report noted that there was some tendency for 'harder to reach' beneficiaries to cost more to support.

3.3 Activity under Living Well was very largely 'additional'

Lastly in this section, we consider the extent to which activity under Living Well was 'additional'. Additionality is: *"...the extent to which something happens as a result of an intervention that would not have occurred in the absence of the intervention"*[28]. We investigate this partly as a means of addressing the methodological problem of not having any comparator or control groups within the evaluation; in doing so, we accept that this does not substantively answer the question of what would otherwise have happened (see Section 5 for a fuller discussion of this issue).

Assessment of additionality requires judgements on a number of key dimensions. In our assessment we have assumed:

- No *leakage* (benefits falling outside the target area), since the programme was regional and no projects raised this as an issue for them;
- No *displacement* (where the project leads to reduced activity elsewhere), since the services are very largely in the voluntary sector and the primary concern here would be state action 'crowding out' private / voluntary action; and,
- No *multiplier effect* (where benefits 'ripple out' to those other than beneficiaries), because the causal chains to make such claims are too long and indirect. It is however worth noting that these effects could be significant – for example, the Action for Wellbeing in Warwickshire project led to 19 employers developing a mental health policy, covering an estimated 37,000 employees; we also know that cascade training has taken place under several projects – Nutrition Training, Wellness Works and the Wellbeing Workshops for example. There may well therefore have been benefits for some people involved as 'secondary' beneficiaries. Nevertheless, we leave these hypothesised benefits outside of our analysis. The main reason for doing so is that there is not a good conceptual means of stopping this line of thought: the *reductio ad absurdum* is that insofar as any project has led to a reduction in the use of NHS services then all UK taxpayers would be 'beneficiaries' of Living Well. We have therefore taken a slightly conservative position on this issue in order to maintain a defensible set of figures.

The assessment of additionality therefore focuses on the narrow issue of estimating the extent to which projects' activities would have taken place in the absence of Living Well

[26] Figures for these three programmes taken from Policy Exchange (November 2008) *Weighing in Dealing with the challenge of obesity.* No adjustments made for inflation.

[27] Cambridge Economic Associates Ltd (2005) *National Evaluation of New Deal for Communities: Value for Money Strand, Final Report* (figure taken from Figure 10.7, p.68).

[28] Definition taken from (the excellent) 2004 English Partnerships *'Additionality Guide'*

funding[29]. To assess this, we asked the following question as part of the first quarterly monitoring return of the final year:

What do you think would have happened to your project if Living Well funding had not been available? (Assume that you could not have accessed another funding stream)

Our project…

…would have gone ahead without any changes

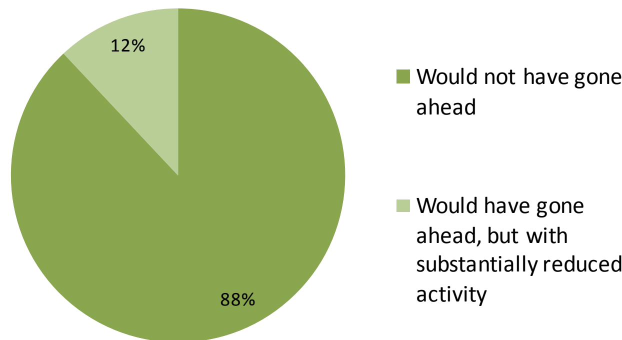
…would have gone ahead, but slightly reduced level of activity

…would have gone ahead, but substantially reduced level of activity

…would not have gone ahead

The Figure below shows the results; it suggests that only a minority of projects would have delivered any activity without Living Well funding.

Figure 3.11 Nearly all projects would not have gone ahead in the absence of Living Well



We can then apply these results to the results achieved in order to estimate the scale of additionality across the portfolio. Three projects (Parklife, SHINE and Women in Motion) stated that that would have gone ahead but with 'substantially reduced' levels of activity would. This means that, in the absence of Living Well, these projects would have had some beneficiaries and would thereby have achieved some outcomes. We can use assumptions about the degree to which they would have gone ahead to examine the effect on results achieved.

This exercise suggests that very little would change at Portfolio level. If we assume that these three projects would have reduced their activities by two-thirds, then would have expected around 850 beneficiaries to have received an intervention in the absence of Living Well funding. Even if we assume that half of the three projects' activities would have taken place anyway, then the figure is still only around 1,200 - less than 0.05% of the Portfolio total. The conclusion therefore is that Living Well activity was almost entirely additional.

Having described the nature and scale of Living Well's inputs and outputs, we now turn to the issue of implementation.

[29] Our method for doing so draws upon the approach used in Cambridge Economic Associates Ltd (2005) *National Evaluation Of New Deal For Communities Value For Money Strand: Final Report*

4 How well was Living Well implemented?

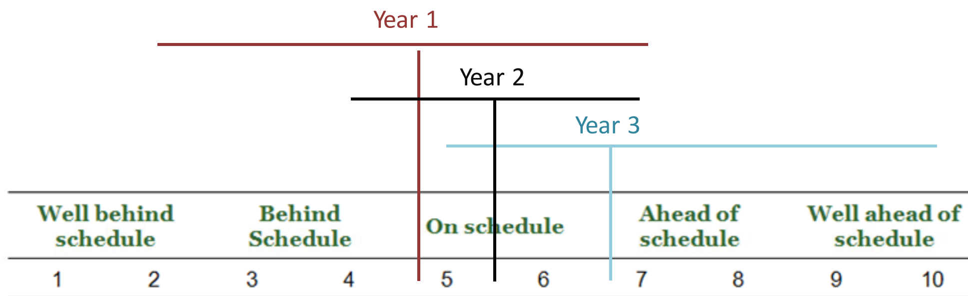
This section addresses the question of implementation; it follows the model set out in Figure 1.2, by looking at the issues faced by projects in converting funding into activities. It begins by providing a short quantitative description, before moving on to a more in-depth qualitative examination of the main themes arising from the research.

4.1 Monitoring returns suggest a gradual improvement in implementation

As part of the quarterly returns, projects were asked to rank the state of their implementation relative to their planned timescales. They were asked to respond on a scale from 1-10: a score of 10 representing being 'Well Ahead of Schedule' and a 1 being 'Well Behind Schedule'; a score of 5-6 would therefore indicate being broadly on-track.

Over time, the results showed a consistent increase in the rating; there was also a reduction in the variation between Year 1 and 2, although this re-emerged at the end of Year 3 as four projects rated themselves as being 'well ahead' of schedule. The range and the mean at the end of each year[30] are shown in the Figure below:

Figure 4.1 Projects rated their implementation as improving over the lifetime of the programme



There is a significant degree of subtlety underneath these headline figures; this is set out in the remainder of this section.

4.2 Projects faced a range of challenges in delivering their services; they evolved a range of strategies to address them

The main themes relating to implementation, as highlighted through the project visits, are described in detail below.

4.2.1 There were slow starts, but some projects were able to deliver quickly

The First Annual Report noted that, whilst some projects were able to get up and running early in the first year, some took more than a year to begin full delivery. At the end of the first quarter of the second year, three projects were still not delivering services to beneficiaries. There were a range of reasons for this, including: over-optimism in terms of the length of time needed to recruit; trying to do so during a period or near full employment; the re-organising of PCTs; CRB checks for staff and volunteers; and the inflexibility of public bodies relative to the voluntary sector.

In a small number of cases, this related to the need for substantive revisions to the original service. For example, the Solihull project was originally conceived as a 'Watch it!' service, but this had to be revised when the main partners for the service were unable to fulfil their roles in the project. This entailed re-designing the project substantively, before then recruiting staff and a project manager. These delays meant that the Solihull service took over a year to become operational.

[30] The figure for Year 2 is taken from the Q3 return as the question was not asked at Q4.

But the most common reason for delays related to staff recruitment. For example, Dudley's Healthy Retail project also found it difficult to recruit a project lead from the PCT; in part, this was a feature of the time-limited nature of the funding being relatively unattractive to existing PCT staff. Similarly, Being Well in Sandwell experienced delays in implementing some of the interventions (e.g. Social Skills training) due to various problems with recruitment and retention in the specialist roles required. Training also created delays for the 'mindfulness' intervention as accreditation of tutors took some time.

As projects neared the end, some found that staffing problems re-emerged as staff left before the end of fixed-term contracts. There were examples where projects were creative in addressing this problem - allowing services to continue. These included Action for Wellbeing in Warwickshire, which made use of sessional workers to ensure that their healthy eating and physical activity work could be maintained without having to recruit staff (which would have delayed, and may have even stopped, delivery). Similarly, Shropshire Outdoors was able to retain its project manager on a consultancy basis to enable the project to run to the end - rather than finish early, or attempt to recruit to fill the post.

Lastly on this point, as noted throughout the evaluation, the voluntary sector was most able to 'get up and running' quickly and start delivering services to beneficiaries. Notable examples here included Coventry Body and Mind and the Dove mentoring project. The main reasons for these organisations being able to do this relate to flexibility and size – as well as a familiarity with the need to deliver quickly in a time-limited grant-funded environment.

4.2.2 Attracting, motivating and retaining beneficiaries was a common challenge

As noted in the previous section, nearly all projects met their targets in relation to reaching beneficiaries. In doing so, a number of projects developed specific messages and approaches; examples of this are set out below.

In Stoke, the underlying approach was to use simple messages to promote wellbeing – and also to make it fun. For example, one of the public events for 2010 was the 'Family Fun Try a Sport Day', where there were trampolines and games that the public could try. Over 800 people came and were able to talk to community sports and fitness organisations - where they could sign up to do more activities. Project staff considered this to be an effective way to promote wellbeing - especially in comparison to their experience in Year 1, where they promoted activities such as life coaching, stress management, and self awareness through more 'structured' activity. As one member of staff noted: *"It's always harder to sell the mental wellbeing side of it because it's more nebulous...*[whereas]*...you can always entice people with ideas of eating something and trying new foods!".*

Similarly, in Staffordshire, Changes (the organisation delivering the Wellbeing Workshops) moved away from the term 'mental distress', as some organisations and beneficiaries did not recognise this as 'an issue for them'. Instead, they promoted the service as improving 'mental fitness', which met with wider appeal.

Tailoring Services for Specific Groups – Living Well in Stoke

As part of Living Well, Stoke on Trent PCT delivered a five-week course of 'Cook and Eat' workshops in the community. Messages about healthy eating were tailored to different groups and communities so that participants were taught the skills that they need to eat healthily.

Some of the 'Cook and Eat' workshops were tailored to groups of Asian women. Many were already confident home cooks eager to learn new ways to cook for their families. The facilitator researched how Asian women cooked at home, and ensured that each session focused on cooking healthy meals from scratch, and included the national '5 a day' recommendations. Courses covered a wide range of recipes including vegetarian lasagne with no salt - but with added lentils and spices such as ginger, garlic and chilli for flavour. There was also an emphasis on encouraging the children to be involved in cooking and using healthy recipes that are appealing to children.

For example, at one session observed by the evaluator, the participants cooked a flapjack. At each stage, the facilitator explained how unhealthy ingredients could be substituted for more healthy ingredients and amounts. The facilitator also explained the different products used such as dried fruit

and oats, and how these could be affordably bought and cooked. Attendees were also encouraged to cascade the information taken away from the sessions by telling their children about the tips picked up. The sessions concluded by eating the food together, allowing the participants to appreciate the taste of healthier food.

In a similar way to the example above, Dove Mentoring saw the need to tailor services to meet specific needs. One of the main lessons emerging from the project was that minority ethnic access to mainstream mental health services is made difficult through the general nature of information provision in this area. This information was often inappropriate for specific groups, and was typically going to organisations who did not serve minority ethnic clients. One of the successes of the Dove project was to establish a partnership with MIND – including running services from their offices; this enabled these services to be more tailored and appropriate. Dove also worked with a wide range of different partner organisations to access their beneficiaries. Referrals came from mental health services, health and social care, voluntary organisations and community groups, families and carers, housing agencies, JobCentrePlus, the Police and Courts. Towards the end of the project, Dove also worked with GPs, who began to refer into the project.

The Challenges of Reaching Parents – Healthy Retail

Dudley's Healthy Retail project aimed to increase fruit and vegetable consumption in one of the most deprived neighbourhoods in the borough. The project delivered healthy eating classes at a local school once a week for an hour, rotating the classes on a weekly basis. The theme of the sessions changed each half term, and included: tastings; fruit kebabs; fruit smoothies; fruit faces; glove puppets; salad boats; and, exotic fruits.

The project team cited various examples of cases where there has been a real change in the children's knowledge about different fruit and vegetables and their willingness to try something new. However, the project found it a lot harder to engage parents; attendance at the groups has been limited and relatively few parents bought the fruit and vegetables from the stall in the playground. Efforts here included: running family cooking sessions at a 'mom and tots' group at the school; free giveaways; leaflets, posters and vouchers - but this element of the project proved difficult.

Lastly, it is interesting to note that the project purposely targeted a 'difficult area', with the premise that 'if the model can work here, it can work anywhere'. This touches on the issue of ways in which Lottery money might be best allocated, highlighting questions of experimentation, 'failure' and learning from what doesn't work. (This is discussed at more length in Section 7).

SIFA Fireside (part of the bWell Communities project) worked with the homeless and people with substance misuse problems. As far as possible, there was an emphasis on making the services provided demand-led and participants were closely involved in deciding upon and designing the activities. This was a key success factor for the service. However, the project reported difficulties in motivating beneficiaries to try new activities. The project therefore tested a wide range of different activities – some of which worked well. Activities included: art, photography, music, literacy and writing, and also drama groups, service users' forums, football, and cookery. Photography stood out as a particular success; it led to a commission and an exhibition. In the main, the activities tested proved effective in developing social and communication skills, which has provided a foundation for any later volunteering or work.

Supporting Beneficiaries with Learning Disabilities – Apna Men's Group

As part of the Healthy You! project, the Apna men's group had the opportunity to undertake a range of activities that they would not otherwise have had the opportunity to do. For example, they accessed the Community Gym, where they took part in circuit training, 'boxercise' as well as using exercise machines. The project workers said that they saw a difference within the men and have increased their knowledge of the value and means of exercise. During the summer, the group also went on walking groups. One of the male service users had problems with walking, but as a result of being involved with Healthy You, has seen a reduction in these problems. One of the project

workers also reported that the men *"...are increasing their confidence by mixing in with other people"*.

Lastly, the PCT provided 'eat well' plate cards as part of a healthy eating course. The course lasted 12 weeks and was run by the health facilitation team. It covered areas such as the different types of food, what is relevant for their packed lunches portion sizes and diabetes.

SHINE found (in common with analogous weight management programmes) that there can be high rates of drop-out across a twelve week programme. Project staff considered that this is most likely due to the length of time beneficiaries must commit to complete the service. They are therefore reviewing the model to see if this can be addressed. This review will also see where there are opportunities to make the 'teaching' element of the service more hands-on and practical. This builds on successful aspects of SHINE - such as a using a 'fat suit' to give participants a practical sense of the day-to-day problems of being overweight, and actually showing the amount of fat / salt in some types of food, which seemed to have been more powerful in increasing knowledge than abstract discussion.

Similarly, Coventry Body and Mind reported that retention of beneficiaries was a key issue in the implementation of their services. They found that the fluctuating mental health of their service users meant that the project had to retain a flexible and tailored approach – particularly in trying to keep motivation up. The project realised that some beneficiaries needed longer than the twelve-week block and some needed a shorter 'dose' of intervention. Furthermore, when the project investigated their drop-out rates, two main findings arose:

1 The 'headline' drop-out rates from the service compared favourably with available benchmarks – notably from gyms and health clubs; and,

2 Self-referrals showed much better retention rates. Most clients were referred by professionals, but when people self-referred they were much more likely to be ready for intervention and to engage with the service as a result.

As noted above, around two-thirds of Living Well beneficiaries were female. Some projects considered that recruiting men required specific action. For example in Stoke, Changes worked in partnership with Stoke City Football Club to put on sessions in the evenings at the Britannia Stadium, allowing men to come after work and learn about health and wellbeing in groups where the majority of participants were men. They also used activities such as 'Match Day Walks' to specifically target men.

Reaching Men – Wellbeing Workshops

The first men-only series of Physical Wellness workshops were held at Stoke City Football Club. Open to all men in the City, the workshops consisted of five sessions covering health and wellbeing, self-image, healthy eating, physical activity and relaxation. The feedback from the participants was very positive and a strong bond developed between most of the men, creating a sense of momentum to continue meeting up on a regular basis.

The Action for Wellbeing in Warwickshire project used a community development approach for their buddying activity, relying on volunteers leading community activities. Project staff found this to be effective in accessing beneficiaries. This entailed a very detailed and localised approach to accessing beneficiaries, which generated learning about what is effective in different local areas. For example the project found that in more rural areas advertising in parish newsletters is effective, because it is free and *"goes straight through the door to the target audience"*. Walsall also used a community development approach. They found that this required work 'up-front' to gain a detailed knowledge of the area and communities they were targeting, and that this was eventually invaluable to the implementation of the project.

Lastly, some projects found that managing demand has been a challenge in engaging with beneficiaries. For example, the Women in Motion project saw very high levels of demand for several of its community based exercise classes. The badminton and netball sessions were far more popular than anticipated and the project had to move these sessions to a larger

venue. Making links with other venues and providers – often through the County Sports Partnership – helped the project to remain flexible and cater to this varying demand.

4.2.3 Assessing and tracking beneficiaries was easier for some projects than others

The challenges of undertaking an initial assessment and tracking the progress of beneficiaries was another common theme arising from the project visits. This was very notable (and challenging) for projects such as Being Well in Sandwell, where activities were high throughput / low intensity. Examples of the ways in which projects addressed this issue are discussed below.

Once an older person was referred to the Priority Care project, the Project Manager went out to meet them and carry out an initial assessment of their needs. Depending upon the level of need, people were then signposted or required more information about another service, while others needed the support of the Priority Care staff. Because of their holistic approach, the beneficiaries were matched to staff with similar interests. In addition, staff used a plan which outlined the needs and desired outcomes for the beneficiary. A key part of this role was to develop relationships, as the most effective interventions came when staff had a close understanding of the needs of the beneficiary.

As part of their services, Coventry Body and Mind had robust pre-screening and assessment process that was undertaken with beneficiaries at the start of the programme. This led to an individually-tailored ‘wellbeing plan’, which defined specific goals and the required input. The assessment was then carried out again at the end of the programme to examine changes against the specified areas. This type of more ‘contained’ service allows for the type of assessment and tracking that other projects would not have found practically possible.

Another project that began with a similar intention was Living Well Herefordshire. School nurses were at the heart of the original model there; they were intended to identify children in the most deprived schools that were at risk of obesity or poor mental health, before coordinating referrals to the three services within the project. They were also asked to take baseline measurements and track progress. For a range of reasons – largely relating to problems in engaging with the school nurses - this model was never implemented. School nurses did fill in ‘formal’ referral forms, but did not collect any other information; the schools themselves identified which children and families would benefit from the project, and then informed the three delivery organisations. In Herefordshire, engagement of the Head Teacher, Special Educational Needs Coordinators and/or Healthy Schools Coordinators proved effective in this respect. The effect, in terms of the model tested, was that services operated more as three independent projects rather than the single partnership that was originally envisaged.

The Walsall project also found that it was difficult to work with an ‘unstable’ group that people could enter and leave at various points. The project began working in youth clubs, but gradually moved towards working with a single and stable cohort in schools. They found that this enabled project staff to create a ‘group dynamic’, and that they could therefore better monitor the effectiveness of their work. The project also used these groups to bring all of their project’s strands together in one coherent model – thereby offering service users a logical progression from one activity to the next

The bFit project (part of bWell Communities) noted several challenges in terms of the tracking of their beneficiaries:

- The key challenge was to undertake the three assessments per client through the period of their participation. This was primarily a capacity issue, which was partly overcome by having initial group assessments, meaning that staff would meet with multiple clients all at the same time;
- Staff also struggled to contact clients and successfully make arrangements to carry-out assessments. The experience of using volunteers here was mixed; performance was very variable and many moved on once other opportunities arose; and,

- The project also encountered problems securing health and fitness opportunities that were sufficiently local for some beneficiaries. Childcare costs were also a barrier for some beneficiaries and paying for childcare was important to improving access.

Where these challenges could be addressed, the project saw positive outcomes - including weight loss, mental health improvement and stress relief.

Lastly, Parklife - which was similar to Being Well in Sandwell in that it could also be described as high throughput / low intensity – used walks that varied in their difficulty. They ranged from short walks (45 minutes to an hour), to extended walks (an hour to three hours) and Nordic walks. Beneficiaries were assessed before doing a walk to see which one was more suitable for them.

4.2.4 The ability to recruit and support volunteers was central to some projects' success

The use of volunteers was a feature of many projects. A small number of projects noted that a key issue in this regard was that the training requirements for volunteers to lead exercise sessions was sometimes a barrier to delivery. For example, Wellbeing for Life found the engagement and training of volunteers challenging in relation to getting their volunteers up to NVQ3 in order to lead seated exercise sessions; there was a high level of drop-out from the course and ultimately just one person – the project manager - completed the full qualification. Nevertheless, the volunteers that set out to achieve the Level 2 qualification did so and the project was successful in retaining this group – largely because of the support provided by project staff, but also because the motivations of the volunteers (to improve the wellbeing of older people, and in one case to embellish their work-related skills) was fulfilled through their work. The project is considering training one of the volunteers up to train their peers.

The Women in Motion project found that volunteer recruitment and retention had been critical to the successful implementation of the project. One member of staff noted that: *"The success of the programme overall is volunteer retention. It's amazed me how precious the volunteers are about the sessions"*. The fact that the project workers themselves used to be volunteers has helped this in terms of being able to relate to volunteers: *"We've been able to empathise with the volunteers....They've appreciated us. We're always there and they know that."*

Lastly, the Volunteering 4 Wellbeing project under bWell Communities reported several specific issues relating to the use of volunteering; these included:

- Attracting and converting an employed person's interest in volunteering into a placement proved challenging; this was typically due to other pressures on their time. More generally, achieving a good conversion rate (from interest to starting) was difficult given that police checks take a long time and people's 'momentum' declines or circumstances change. This can take up to three months. Partly to resolve this, a client tracking system was developed, which improved the conversion rate;
- Having a formal arrangement with host organisations was also a positive element of implementation. This was associated with a fee (around £175) in return for a set of expectations. The fee meant that host organisations were more inclined to accept people referred to them; and,
- It was sometimes difficult to sell the concept of 'wellbeing', to both host organisations and clients. A few host organisations were keen to know if the scheme was just for people with mental health problems.

4.2.5 Engaging with employers proved difficult in most cases

As noted in the Second Annual Report, the recession made engaging with employers challenging for those projects setting out to improve workplace wellbeing. This was especially the case for private sector firms, where immediate commercial survival had taken precedence over any medium- / longer- term concerns about employee wellbeing. So, despite a prevailing wind in policy terms (through Carole Black's review and relevant NICE

Guidance), most workplace projects struggled in their engagement with these organisations. Examples of this issue are set out below.

The Workmate project in Dudley, which found work placements for people with learning disabilities and/or mental health problems, reported that the economic downturn made engaging with private sector employers much more difficult. This was because these employers wanted to fill posts immediately with someone who did not need extra training or support. However, the Local Authority was more receptive, and various Directorates were able to offer a six-month placement scheme (which was subsequently extended to a year).

In a similar vein, albeit absenting the commercial pressures described above, the schools cooking element of the Nutrition Training project found that a tailored approach was the key to successfully training staff in schools. Their nutritionist delivered training in each school – rather than expecting schools to release staff for an external event. Schools found it easier to engage with a tailored programme, and Living Well gave the nutritionist the additional capacity to be able to deliver the service in this way.

In general terms, the Employers strand of the bWell Birmingham project was the most problematic project in Living Well. It was relatively expensive, failed to engage with employers in a substantive sense (partly due to a lack of clear message around benefits) and was ultimately 'wound up' by the programme team and the Birmingham Health and Wellbeing Partnership. Within this generally poor strand of work, the most positive element was reported as the Positive Pressure service, which provides acupressure massage. This service was trialled (including the use of an 'experimental' evaluation) and the positive results are being used to attract more employers to the service now that bWell has ended.

Finally on this theme, the notable exception to the problem of engaging with employers was the Wellness Works project. They maintained engagement with small and medium size firms, using a range of services and strategies for doing so. Flexibility underpinned their approach and the project staff worked to understand the individual concerns and – crucially – capacity of the employers they engaged with. Practical examples here included: running lunchtime / evening sessions; and training managers and using organisational policy changes, rather than running 'mass' training sessions for employees. Wellness Works also used senior figures on their steering group to advocate locally for the service. Lastly, and on a less tangible point, the project worked hard to overcome the cultural difference between the voluntary and private sectors – using approaches such as account management and making the case for their services in commercial terms.

4.2.6 Working with GPs (and other parts of the health service) was often challenging

Several projects were originally designed around referrals from GP surgeries – typically providing more 'socially-based' interventions as a means of reducing use of GP services. Last year, we reported that these projects had typically struggled to engage GPs. Vounteering4Health was one such project, where a number of surgeries had been engaged – and initial presentations well received – but few referrals resulted. The project noted that a range of reasons might explain this, notably that: GPs were not being paid for making referrals (as is the case with other programmes); and, they often lack the time in short appointments to gain knowledge of beneficiaries' social needs. In this case, the project used a range of other referral routes – principally other voluntary sector organisations. The Buddying strand of the Action for Wellbeing in Warwickshire also found that their initial model of receiving referrals via GPs was inappropriate and that a more flexible community-based social inclusion model that allows for self-referral was more effective.

The SHINE project also found that referrals from school nurses and GPs were lower than anticipated. The project tried running training for school nurses, which had some limited success. They also tried to get onto the agenda for meetings during the 'protected' time that GPs have for development, but were not able to. Finally, feedback from GPs suggested that they find it difficult to raise the issue of obesity with parents. As a result, the project sometimes struggled to get enough beneficiaries for a group / cohort to go through the programme.

Priority Care was delivered by Heantun Housing Association and the Local Authority chose a GP surgery for Priority Care to work with. The surgery was chosen because of the high proportion of older people who live in the area. Working with the GP surgery was 'hit and miss' - mainly to do with the change in Practice Manager partway through the project. The new Manager 'did not understand' the concept of Priority Care and also wanted the project to pay the surgery for the referrals. Upon reflection, staff said they would have worked with more than one GP practice and used a wider source of referrers. In addition, they would have done the initial groundwork with the GP practice they did work with, so they could be made more clearly aware of what Priority Care had to offer.

Finally on this issue, we reported last year that the Wellbeing Workshops in Staffordshire (led by Changes) had encountered problems in terms of the 'credibility' of the organisation and the services being provided. This was chiefly in terms of resistance from mental health professionals. In the final year of Living Well funding, the workshops overcame many of these problems and Changes delivered three workshops a week for GPs in East Staffordshire. These services also appeared to gain the endorsement of local Community Psychiatric Nurses. The lesson reported here was one of perseverance!

4.2.7 Partnership working was a key strength of several projects

Many projects sought to work in partnership with existing services – most typically to ensure appropriate referrals, but also to make sure that Living Well activity fitted into local service provision. For example, Action for Wellbeing in Warwickshire worked with local statutory services to identify gaps in services at a very local level, before filling them where possible. This led to the delivery of weight management sessions in community centres and Children's Centres, where they were scheduled to run at the same time as 'Stay and Play' sessions. Working in partnership with Children's Centres to identify need for activities and then recruiting beneficiaries also proved effective because the Centres had a good overview of local provision and pre-existing links with their local communities. However, the project also noted that it took time at the beginning of the project to become sufficiently familiar with local provision and to build relationships with partners.

One of the best examples of partnership working in Living Well came from Sandwell:

Partnership Working at Local Level– Being Well in Sandwell

The Being-Well in Sandwell project was delivered by West Bromwich & District YMCA in partnership with seven other organisations. Key partners included the Community Action Project (CAP), the Yew Tree Health Centre, Sandwell Deaf Community Association, Greets Green NDC, the Confidence and Wellbeing Team at Sandwell PCT, and Sandwell Local Authority. Partner roles included acting as satellite delivery locations: 50% of the project delivery took place at the YMCA, 30% at the CAP, and the remainder at the Yew Tree Health Centre. Another role has been to provide funding (e.g. Greets Green NDC provided the funding for the aromatherapy room to be installed in the YMCA).

Partnerships across the organisations worked well. Interviews with partners highlighted how the project was able to achieve greater impact and reach because of this approach. Partners also discussed how the pursuit of common goals supported them to work together effectively, with shared values providing a platform for this to happen. Partnerships were especially effective when there were formalised roles, which made responsibilities of each of the agencies clear and explicit.

4.2.8 Monitoring requirements were generally appropriate, but were too much for some projects

By far the majority of projects considered that the monitoring requirements of the programme were appropriate. Many compared these arrangement favourably with other funds – in particular noting the tailoring of the quarterly and annual performance indicators as a positive feature of Living Well.

However, some projects reported that they considered themselves to be 'over monitored' relative to the size of their grant. This was especially the case where projects were small and they could not see a sufficiently proportionate reduction in their oversight. This varied depending on number of project partners and individual project set up.

The Healthy Retail project was a good example of this. The project was required to report on slightly different themes for the National Social Marketing Centre, Big Lottery, GHK and their steering group. In addition to this, the school where delivery took place had their own reporting requirements. This caused a number of capacity issues and often meant that they were duplicating effort and struggling to manage the trade-offs between reporting / measuring and delivery.

Again, and as reported each year, the fact that Living Well quarters did not run to the financial year was considered unhelpful – as was the requirement to report on spend before the end of a full quarter, which meant having to include estimates and projections in these returns.

4.2.9 Simpler designs helped delivery

Having a simple project design was typically associated with good implementation. For example, Farm to Fork found that their simple model of delivery was appreciated by schools, since it gave them predictability and consistency, which meant they could plan around the various sessions. To support their engagement with the schools, the project used a combination of initial site visits, an information booklet describing the detail of the services, and links into the curriculum and school year. Schools also gained practical support and expertise. These approaches, combined with the experience of the project team ensured that Farm to Fork was relatively straightforward to implement.

Similarly, the Walsall project developed a clear model for engagement with schools, which helped them to ‘sell’ involvement with the project. As the project developed, this was backed by evidence of effectiveness gained from work with previous schools. Sharing Spaces – another project that worked with schools – gave a broadly similar set of findings.

Conversely, our project visit to Sandwell showed that - while the project was effective - it had perhaps been over-ambitious in attempting to deliver too many interventions, stretching the capacity of the team. This lesson has been taken forward into future plans of focussing sustainability of the project on fewer interventions, and trying to extend the reach of these, rather than extending the portfolio of services. Nevertheless, even here there are trade-offs and one of the more successful aspects of the Sandwell project has been to offer a ‘one-stop shop’. Beneficiaries could access a range of services in one place - ranging from aromatherapy to yoga, making use of the gym, and then learning to cook healthily, and stopping at the cafe for a healthy meal – this enabled Sandwell to develop a holistic approach to wellbeing (described further in the next Section).

Lastly, the SHINE project found that service delivery was made more challenging by having a somewhat complex model of using a voluntary sector organisation to deliver parts of the service (rather than keeping all delivery ‘in-house’ at the Local Authority). This arrangement has increased transactions costs and has not necessarily added value as originally conceived. This raises a set of broader questions as to the best model for administering funding and delivering services at local level; we return to this in Section 7.1.

Having outlined the main issues in implementing the projects, we are now in a position to describe the difference they made to the people accessing the services. This is the subject of Section 5.

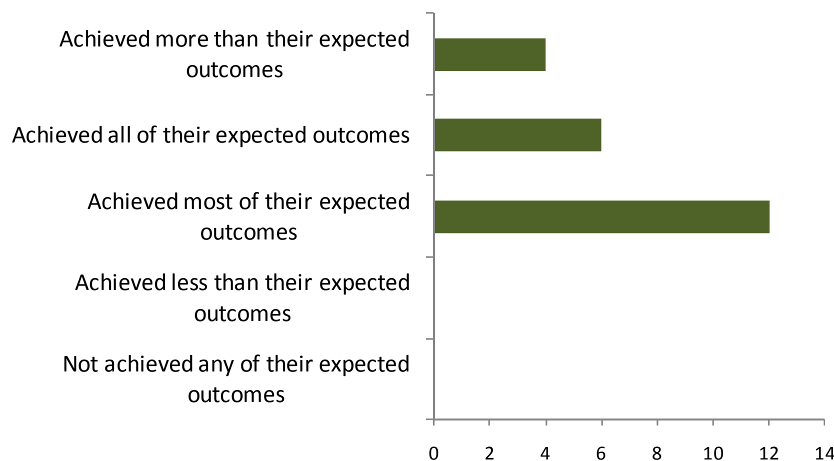
5 What difference did Living Well make?

This section of the report concentrates upon the outcomes achieved by Living Well. It does so firstly by providing a description of the quantitative data provided by projects as part of their annual return. The main body of the section then presents the qualitative information gained as part of the project visits, and from the case studies provided by projects.

5.1 Quantifying projects' outcomes is challenging for a variety of reasons

Before beginning an in-depth description of the outcomes achieved, we first note that projects considered their own achievement to be broadly either as expected (i.e. they achieved all of or more than their planned outcomes) or slightly under expectations (i.e. they achieved 'most' of their planned outcomes). This is shown in the Figure below:

Figure 5.1 The majority of projects achieved their expected outcomes



As noted in Section 1, a key requirement of the evaluation was the aggregation of data from local to regional level. Here we present the results of this exercise. Before doing so, it is important to note the complexity of this undertaking. In essence, this complexity is two-fold in that there are:

1 **Methodological problems**. The main issues here relate to the questions of:

   – 'What would have happened anyway?'. This question can only be resolved through the use of experimental or quasi-experimental study designs[31]. This option was not available to any projects within the programme - primarily for reasons of cost, but there would also have been legitimate questions about the suitability of these approaches in some cases; and,

   – The degree to which some outcomes – especially those relating to more intangible benefits, such as mental wellbeing – can legitimately be quantified. Again, this is a broader debate (as is the previous question of study design) which, for the purposes of the task in hand, has to be left to one side. There were also related methodological challenges relating to the nature of some projects' beneficiaries – where they had learning disabilities for example.

2 **Practical problems**. These overlap with the methodological issues, but are perhaps more substantive; they include:

   – *The limited capacity of most projects*. Very few projects had dedicated resources for monitoring and evaluation. This is in many ways a common feature of the voluntary

[31] Even here there is substantive (and frequently bitter) debate. For a good overview of these issues, see the introductory chapters of Pawson, R and Tilley, N (2007) *Realistic Evaluation*

sector (where the trade-off against increased activity is most keenly felt), but was also a consequence of the decision to evaluate at regional level;

  – *The limited capability of some projects*. In addition to lacking capacity, some projects lacked analytical capability to record and report information; and,

  – *The nature of some projects' activities*. As noted in Section 4, in some cases, projects' services were 'high volume / low intensity'. This includes the provision of 'one-off' exercise classes for example, where a beneficiary might attend just a small number of sessions. In this case, there might be a legitimate expectation of some kind of very modest outcome – yet there is a substantive practical problem in capturing this information. The implication here is that recorded outcomes may well be underestimated.

The challenges at project level are added to when the aim is to aggregate findings up to the Portfolio level. This is predominantly because of the diversity of projects, as described in Section 1, and the need to ensure that 'apples are not being added to pears'.

GHK's approach to addressing these problems has been:

- Firstly, to acknowledge that they exist (and to encourage projects to do the same). This means that figures generated ought to be used as an estimate, alongside appropriate caveats, rather than a precise quantification;
- Secondly, to encourage the use of a 'before and after' approach to measuring outcomes where possible (i.e. beneficiaries are assessed as they enter and leave the project). We backed this with the provision of some standard tools, such as the Warwick-Edinburgh Mental Wellbeing scale, and an investigation of projects' additionality (see Section 3). While this does not fully address the methodological question of 'what would otherwise have happened?' it does increase confidence in the resulting figures. Where a 'before and after' approach was not possible, we recommended using feedback sheets (as beneficiaries leave the services) to estimate outcomes;
- Thirdly, we tried to take a pragmatic and supportive line. In some cases, projects needed to make substantive revisions to their monitoring arrangements to reflect changes in their services and / or capacity to evaluate. In general, we supported this. As a position of last resort, where projects' final returns still appeared to have problems (most notably, this happened with Birmingham), we used samples and informed estimates from project staff; and,
- Fourthly, to use qualitative information as a means of providing a triangulated assessment of achievement.

All of this means that the figures presented below ought to be used with some caution. They are most appropriately used as a set of headline indicators, below which deeper explanations can be offered.

The table below presents the main outcomes from Living Well. It shows that:

- The most commonly reported outcome was an increased level of physical activity. This was closely followed by improvements in mental wellbeing. Improvements in diet were less common (this matches closely to the results one might expect given project's intentions, as shown in the Venn diagram in Section 1);
- There were a significant number of 'intermediate outcomes' in terms of people seeing gains in knowledge / awareness / enjoyment of physical activity, healthy eating and mental wellbeing (see Figure 1.2 for the model behind this distinction);
- Outside of the three themes of Living Well, there were other outcomes relating to:
  - gains in skills, qualifications and employment prospects;
  - access to other services and opportunities; and,
  - changes at an organisational or service level.

GHK

Table 5.1 Summary of main outcomes

Theme	Outcome	No.
Mental Wellbeing	Improved mental wellbeing	6,190
	Mean change in points on the WEMWBS	4
	Increased awareness of issues relating to mental health / strategies to improve mental health	6,120
	Improved opportunities to socialise / feeling less isolated	1,190
Physical Activity	Increased levels of physical activity	6,620
	Now taking the recommended levels of physical activity	1,440
	Improved opportunities / enjoyment of physical activity	5,010
	Increased awareness of the benefits of physical activity	5,090
Healthy Eating	Improved diet	3,110
	Now eating 5-a-day	1,680
	Increased enjoyment / knowledge of healthy eating	5,120
Other Outcomes	With improvements in BMI	370
	Going on to access a mainstream service or related opportunity	630
	Improved knowledge of other services in their area	700
	Beneficiaries with new skills / qualifications	30
	Volunteers with new skills	280
	Volunteers with accredited qualifications	40
	People entering / remaining in employment, or closer to a wellbeing-related career	80
	Professionals with gains in wellbeing-related knowledge or skills	10
	Employers / service providers reporting organisational benefits	250

We now turn to a qualitative description of these outcomes. We begin by considering outcomes at individual beneficiary level, before moving on to look at wider organisational effects. In doing so, we use short case study examples to illustrate more general points. The section then concludes by examining the value of the support structures within Living Well.

5.2 The qualitative evidence shows a range of outcomes for beneficiaries

As shown above, there were a range of outcomes for individuals under the three themes of the Wellbeing Fund; they included:

5.2.1 Improved mental wellbeing

As Section 1 showed, most projects set out to address mental wellbeing as part of a holistic view of 'wellbeing'; improvements in this respect were therefore frequently bound up with wider improvements. For example, Coventry Body and Mind found that 77% of their beneficiaries had improved mental wellbeing scores, 61% had lost weight, 58% had increased their daily intake of fruit and vegetables, and 57% had increased their level of physical activity.

Beneficiaries also reported a range of softer outcomes, including improved: confidence, motivation, energy levels, social interaction and empowerment. The project also had an effect on how seriously the wellbeing of the organisations staff is taken and they have recruited a wellbeing manager; this is not part of the Body and Mind project but has come about because of a change in the organisation's thinking about wellbeing. The case studies below illustrate some of the outcomes achieved by the project:

Improving Mental Wellbeing as Part of an Holistic Service - Coventry Body & Mind

'Clara' was referred to the project by her CPN as she had identified a need to improve both her physical and mental health (she has been suffering with acute depression and anxiety which has left her unable to work). Clara thought the programme offered a good range of services. The sessions provided gave Clara skills she was able to draw on in aspects of her everyday life. Clara lost weight, her blood pressure decreased and she asked if project staff could help her find an evening course, which they did. Clara said that the programme had 'worked brilliantly' for her and it had made lasting changes to both her physical and mental health.

'Alan' was referred to the Body and Mind team initially to increase his physical activity levels. Alan had problems with his weight, was quite shy and had difficulty in controlling his anger. He was also reluctant to try new activities without his parents being there. However, during his time on the programme Alan increased in confidence and was more forthcoming about his diet. Following support from the programme and his parents, Alan plans to start kung-fu and was looking forward to the challenge of commencing a class in the community.

Volunteering4Health also saw some significant changes in the mental wellbeing of its beneficiaries (as measured by the project's 'Wellbeing Wheel'). One of the main mechanisms at work here seemed to be giving the volunteer choice and control. Many people with mental health problems have typically lacked this in the past and gaining it is a key part of improved wellbeing. For the project, this included giving beneficiaries choice over the level of support offered to them.

Improving Mental Wellbeing through Volunteering– Volunteering 4 Health

21 year-old 'Zoe' lost her job a year ago following a period of sickness. Around about the same time her long-term, relationship broke down. These events left Zoe 'devastated' and led to depression. Her GP referred her to a voluntary sector organisation, who in turn referred her to the V4H Project to consider volunteering to build her confidence and gain additional work experience. Zoe has since been volunteering in two roles with two different organisations, one as a nursery worker and the

other as an clerical assistant. As a result, her confidence has improved and she has been able to gain new skills and meet new people.

And the Wellbeing Workshops, led by Changes, showed similar improvements:

Improving Mental Wellbeing through Group Sessions – Wellbeing Workshops

'Nick' has suffered with bouts of anxiety and depression for the last five years. Three years ago he had to finish work due to his worsening mental health condition and he lost touch with friends and colleagues - mainly due to the stigma attached to his illness. Nick also started to drink a lot more, which put stresses on his family life. He was told about the project by mental health services, and initially found it difficult to speak about his problems. Nick has since become an active member of the workshops, is more outgoing and has joined other similar groups. He is now training to deliver the Changes 'Coordinator Training Course'. Nick thinks that the Wellbeing Workshop was a turning point in his life.

Dove mentoring found that their work helped to reduce the stigma associated with mental health conditions in the communities they are working in. The main qualities of the project which helped achieve these outcomes were described by beneficiaries as being the 'flexibility and confidentiality', and the interventions on goal-setting and positive thinking. Beneficiaries also appreciated the fact that the project catered for ethnic minorities, and described this as a positive reason for why they found the services accessible. It was important to them that their cultural needs could be understood, and that there was a 'good mix' of people represented there.

Improving Mental Wellbeing through Mentoring – Dove

'Ali' suffered alcoholism and was on anti-depressants. He was signposted to the Dove Mentoring Scheme by a member of the community. He was assigned a mentor who was from the same ethnic background and had a similar experience. Initially reluctant to work with his mentor, Ali was quickly signposted to other services to help him with his alcoholism and dependency on anti-depressants. Since working with the mentor, his confidence and self-esteem has increased he has now become a fully trained mentor on the project as well as returning to Higher Education.

'Parveen' had been prescribed anti-depressants and sleeping tablets. She referred herself to the programme after the work that Dove had done with a relative who had schizophrenia. She worked with a mentor who explored the underlying issues of her behaviour and developed an action plan specifically to deal with some of her immediate concerns. Parveen was fearful of developing schizophrenia after two members of her family were diagnosed. Her mentor was able to get her GP to refer her to a Community Psychiatric Nurse and to put her forward for counselling at a local centre. Parveen now feels more confident to move forward with her life; she remarked that without the support of the programme she would probably have ended up in a psychiatric unit.

Lastly, several projects noted that using the Warwick-Edinburgh Mental Wellbeing Scale (described in Section 2) was an innovation for them. This was primarily because it gave them far better evidence of effectiveness than had hitherto been the case (when the alternative was no measurement / using less appropriate scales); and also that for projects where mental wellbeing was a 'secondary' outcome – SHINE for example – it provided evidence of these additional effects.

5.2.2 Increased opportunity to socialise

Many projects seemed to 'work' by bringing people together around an activity. The mechanism for improving outcomes was not then necessarily the activity itself, but the associated opportunity for mixing and socialising. This was especially the case when projects targeted isolated and/or vulnerable beneficiaries.

For example, during the project visit to Wellbeing for Life participants stated that the main reason for - and benefit from - attending the sessions was the social side of the activities. A

large number of these beneficiaries rarely left their house during the rest of the week and the clubs were the only chance they had to socialise. In this respect, the exercises provided a shared interest that they could discuss afterwards (even if this was often to complain about how hard it was!). Three of the beneficiaries interviewed stated that: *"This is the highlight of my week"*; *"This is the only chance I get to meet other people...I don't even see my family as often"*; and *"I never see anyone until I come here...it's nice to have the companionship and go out for a meal every now and then".*

The Warwickshire project reported similar findings:

Increased Opportunities to Socialise – Action for Wellbeing in Warwickshire

'Pauline' had been suffering from depression for a number of years following the loss of her child. A neighbour encouraged her to attend a weekly Bingo session set up by the project, and Pauline was subsequently approached by a member of staff about volunteering as an official helper. The Bingo sessions were run by the local community centre and Pauline took the lead in running the sessions. She also started to look at what other activities she could get involved in, and has recently become employed by Age UK Warwickshire as a Support Worker. Pauline says that she no longer feels depressed and is happy and content most of the time.

'Adrian' lost his wife six years ago and has since had a stroke, which affected his memory and speech, and subsequently his confidence to socialise with others. Adrian's daughter was concerned that her father had no contact with his peers or family, so responded to an advertisement for the Buddying Service. Adrian attended a weekly coffee morning; he attended a walk with his dog, brought in books to share with others, and generally became an active member of the group. He has greatly increased his confidence.

The Healthy You! project also reported similar outcomes, but for a different target group:

Access to New Opportunities – Healthy You!

'Imran' is in his 40s, is from British Pakistani background and has severe learning disabilities. He attends Apna Group twice a week. Before joining Apna Group, Imran had very limited opportunities to access any kind of health activity and was totally reliant on his elderly parents for day-to-day support. Since attending Apna he has improved his general health, learnt about the importance of leading a healthy lifestyle and generally become more conscious of the opportunities available to him to improve his wellbeing - not only physically but mentally too.

Imran was never short of confidence but he now appears to have a more focused outlook on life and is beginning to take steps to lessen the amount of support he requires from his elderly parents. He has improved his general fitness, understands more about how to cope with his epilepsy and not allow it to hinder his social interaction.

One of the main benefits of the Parklife project was the opportunity to socialise. Project workers and beneficiaries noted that they also became fitter. As one beneficiary noted: *"It's the company and exercise. I don't want to turn into a couch potato."* One of the walk leaders also identified that the *"...social side of walking is very important,"* especially for beneficiaries that had been recently widowed or may live alone: *"...it's helping those who might have lost partners who feel they might not be able to go away* [on holiday] – *they can now because they have made that friendship with other people in the group."*

The project manager noted that the walks made a difference to those who may suffer depression or have mental health problems, as it gave them an opportunity to be outdoors and also belong to a group. Some of the beneficiaries went on to organise holidays together - a group of 44 went on a trip in May and have booked another holiday for 2011. Walkers also took part in other activities such as bowling, skittles, barge trips and theatre trips.

Similar findings were also reported by beneficiaries in Sandwell. Here the most frequently cited benefit of attending the mental wellbeing elements of the project (such as yoga) was

that beneficiaries felt more relaxed and less stressed. Another was increased socialisation, such as meeting new people and making new friends, and therefore increasing confidence. The model of wellbeing used by the Sandwell project was explicitly focussed on improving these social connections. It had six elements:

1. Keeping in **contact** with friends and family - the project delivered groups which targeted older people and younger people.
2. To **give** - The project encouraged beneficiaries to volunteer in the community cafe, or to distribute YMCA leaflets in the community. The project participated in the 'Timebank' scheme coordinated by the PCT, which is a point system for volunteering, linked to prizes such as free gym memberships, and use of the computer suite.
3. Keep **learning** –volunteers were encouraged to obtain training, for example, a learning disabled volunteer who worked in the cafe obtained a food hygiene certificate.
4. Be **mindful** – this concept considered mental health as a precursor to physical health, and is about staying in the present rather than being distracted and 'cluttering' the mind.
5. Be **active** – this included making use of the gym and other physical activities delivered by the project; and,
6. To **eat healthily** – this included the diet and nutrition based interventions such as healthy menu advice in the nursery and out of school club. The 'can't cook, won't cook' course was also part of this element.

This rounded approach to promoting wellbeing was reported by the project as being central to the success of their work[32].

5.2.3 Improved levels of physical activity

One of the main features of the Living Well projects has been the diverse range of target groups worked with. As a result of this, several projects have shown different ways of increasing levels of activity for different groups of people. Examples here include:

The Wellbeing for Life project used a range of creative means of enlivening seated exercise for older people. For example, they used flags (during the World Cup), footballs and balloons. During our project visit, the session included a balloon, which the service users had to try to hit to each other using a foam tube. Service users were committed to, and enjoyed, the exercises more because of the increased energy and fun that the props brought to the sessions.

The Shropshire projects both aimed to improve the physical activity of different target groups:

Increasing Physical Activity for Specific Target Groups – Shropshire Outdoors

'Keith' has experienced depression in his life and has on several occasions been admitted to hospital for episodes of psychotic illness. Having seen a Shropshire Outdoors leaflet, he got involved because he enjoys physical activity and wanted to make a difference in his community. Keith thinks that outdoor work is beneficial to his health and wellbeing – and that making a contribution in the community, and doing something that the public can see and appreciate, helps to take his mind *"off his problems"*. Keith has also learnt new skills as well as meeting new people; he now volunteers once a week with another project in the county.

'Andrew' has been involved in a series of training days and countryside assessments and has visited various countryside sites throughout the county. Andrew has had poor mobility from birth and as he gets older this is deteriorating further. He enjoys being in countryside settings however as his friend/carer also has a disability he finds opportunities to do so are becoming rarer. In a supported

[32] It is interesting to note that – while not being by design - these elements map closely onto the '5 Ways to Wellbeing' developed by the new economics foundation for the Foresight project on mental health.

setting Andrew has been able to participate in a wide range of activities and his confidence in his abilities has increased. The project has offered opportunities to use his photography skills and has helped renew his interest in this former pastime.

Increasing Physical Activity for Specific Target Groups – Shropshire Indoors

Shropshire Indoors yoga class is a 45 minute, low-level exercise class with a focus on breathing. Beneficiaries are able to do the class in their normal everyday clothing. The class includes a gradual build-up of simple exercises, starting from the arms, neck, and legs, before combining all of these. Abilities vary, and they are encouraged by the tutor to only work at the level which is comfortable to them. Where they are unable to move, beneficiaries are asked to visualise the movement.

'Mike' has been attending a daycentre for five years, since he had a major brain bleed. He used to attend an 'armchair exercise' class, which was stopped when the tutor moved on. The yoga class was recommended to him by daycentre staff and he has attended three sessions so far. He found that the class was a lot easier than he expected and that he is able to work at his own pace. Mike has found the class very good for relaxation and has seen a difference in his ability to bend. He used to have trouble putting his socks on, and had bought an adaptive aid to help him with this task. Since doing the yoga classes, he has been able to put his socks on unassisted.

The Women in Motion project found that their beneficiaries reported improved levels of fitness – as well as increased socialising and making new friends. In turn, there was evidence of improved confidence and self esteem. Three success factors identified by the beneficiaries interviewed during the project visit included:

1. *Price*. The activities were mostly free (or 50p if beneficiaries wanted childcare);
2. Offering *childcare* to beneficiaries (they found that lack of childcare is one of the biggest barriers to participation); and,
3. *Atmosphere*. A number of the beneficiaries interviewed said that they had stopped going to gyms because they felt that people were watching them all of the time and felt intimidated by men. The project's facilities offered a no-pressure and friendly environment: *"I'm very impressed with the equipment and facilities...there's no pressure here like upstairs in the proper gym."*

The project also offered its beneficiaries a way of developing their skills and confidence as a means of progressing onto other activities. For example, the running clubs offered by the project (five times a week) led to some women going on to enter 10k races.

Coventry Body and Mind also emphasised the progression of their beneficiaries once their intervention had ended:

Physical Activity & Mental Health – Coventry Body & Mind

'Bob' first found out about Coventry Mind after being referred by the hospital during a lengthy stay there some years ago. Bob attended relaxation, nutrition and physical exercise sessions, and was pleased with the outcomes: *"It totally surpassed my expectations. The people are excellent. The skills of the physical instructor are absolutely outstanding. I couldn't give high enough compliments to the team. They are not only tutors but have become friends. I don't usually get so excitable but just talking about it gives me a good feeling."*

The physical exercise sessions made a big difference to Bob; he has lost two stones in weight and feels much better about himself. This has been supported by the relaxation sessions – the techniques (and book / CD) used in these sessions mean that Bob is more able to cope even when he feels down.

'Roger' referred himself onto the programme stating his reasons for starting the programme for *"general wellbeing and weight loss"*. On joining the programme, Roger had a poor diet and his needs were to lose weight and to improve his fitness levels. Roger also had problems with his knee; he therefore wanted to improve his strength and mobility. Since finishing the twelve-week

programme Roger got further involved in physical activity and regularly attends group sessions. He also trains 3- 5 times per week at home. As a result, Roger made great improvements and has gained a place on a gardening project

5.2.4 Improved diet

One of the most common findings in relation to improving diet was the need to target families. Where this was not possible, projects were often less effective. For example, Farm to Fork helped to improve pupil's knowledge of healthy eating; however, this was not typically then translated into improvements in diet, because the children were not in control their diet at home. Partly as a means of addressing this, the project has worked with some schools to use the produce as part of school dinners.

The Healthy Retail project used a similar approach:

Improving Children's Diet - Healthy Retail

'Oliver' has a packed lunch four out of the five days as Fridays are *"chips and pizza day"*. Oliver has a cooked meal at home three times a week that comprises of meat and vegetables and has a takeaway at least once a week. Since the Healthy Eating Sessions started at the school Oliver said he has *"learnt loads"* about fruits and vegetables that he never knew before. Before the sessions Oliver had never tasted kiwi, vegetable soup or pita bread and is glad that he had the opportunity to taste them. Oliver stated that his going to miss the Healthy Eating Sessions as he has enjoyed tasting new and different fruit and vegetables that he had never tried before.

'Lilly' has school dinner's everyday and has a cooked meal at home five days a week that consist of meat and vegetables, with her favourite being a beef stew. She never has takeaways. She has learned not to judge food on the way it looks and that fruit and vegetables provide humans with essential vitamins and minerals that keep them healthy. Before the Healthy Eating Sessions Lilly had never tasted butternut squash, dragon fruit or swede. Lilly now purchases fruit from the Bostin Value Stall around once a week (such as strawberries, grapes and pineapples). Lilly believes that since the Bostin Value Project started she has started to eat a lot more fruit and vegetables than she used to. Lilly said that she wants the Healthy Eating Sessions to continue because she wants to continue learning about new different fruit and vegetables and the ways they can be eaten.

The Wolverhampton Nutrition Training project also found that targeting whole families was a vital element of promoting behavioural change. Some of the schools wanted whole class sessions but the project dissuaded them from this, considering the family to be a more effective way of engaging. A nutritionist interviewed as part of the project visit noted that: *"Behaviour change is probably the key element so we're looking at them to break habits or to make new goals around food and health, but also to improve cooking skills, so it's a combination* [of] *healthy eating, education and cooking skills together"*.

Similarly, SHINE staff reported that there were three key success factors where good outcomes have been achieved; they were:

- *Using a family-based intervention*. This was vital for looking at the problem of childhood obesity: they make few decisions about diet / exercise and so change needs to take place at the level of the family;
- *Promoting strong tutor-family relationships*. The effectiveness of the service depended very largely upon the subtleties of this relationship. One of the areas of the service did not develop as fully as project management would have liked is the 'solution-focused' element, where trainers would spend time coaching families to arrive at their own ideas for changing behaviour. This is difficult and takes time; one idea for development will be to reduce the formal 'teaching' time in sessions to allow more one-to-one contact between trainers and families. This could then help identify other issues in these families – e.g. referrals onto smoking cessation.
- *Using non-traditional and non-competitive games to promote physical activity*. Most of the project's beneficiaries had not had a good experience of 'traditional' sports, so there

was a need to do something differently. This can be a challenge when most trainers are from a sports coaching background.

These approaches are illustrated in the case studies below:

Working with Families – SHINE

The 'Smith' family achieved the bronze award for the Shine programme and have signed up for the Silver award. The family identified problems and worked with the Shine team to decide upon small achievable goals each week. These problems were solved with the family taking steps to improve their lifestyles further (such as taking homemade lunches to work, shopping as a family and joining a local fitness centre).

The 'Jones' family attended 11 out of 12 weeks and their goals of reducing the amount of salt consumed by the family and working on portion control was set early on. Working through the programme, the family set goals each week which resulted in small steps towards a healthier lifestyle and by the end were more confident and in control of the health. The family also used Shine as 'family time'.

The 'Richardson' family also attended 11 out of 12 sessions. Their concerns were around physical activity levels, five a day and menu ideas for meals at home. The family tried a new piece of fruit each week and reported back to the group about what they thought of it. Active Play was incorporated at home with games such as 'tig' being played. The Shine team worked with the family to develop different menu ideas with ingredients being chosen as a family.

Lastly, a number of projects worked to improve the knowledge and skills of adults, as these case study examples show:

Improving Adults' Knowledge – Action for Wellbeing

'Caroline' decided to join the weight management sessions because they are free. She has recently been made redundant and so saving money is crucial. She valued *"getting weighed in front of someone"* and thinks this helps to keep her motivated to lose weight. She also appreciates having the opportunity to talk to a trained professional: *"it is helpful to talk to someone, it gives you a moment to look back and think back to why you did things. It puts you in a better frame of mind going forward"*. She was encouraged to keep a food diary by the weight management professional and this helped her to realise she was eating unhealthily at stressful times. Knowing this means she is better able to resist reaching out for bad foods. As a result of taking part in the sessions, she is also going to the gym more frequently.

Improving Adults' Skills – Can't Cook, Won't Cook in Sandwell

'Vicki' had recently retired and was feeling down because of all the free time she suddenly found she had. She had put on some weight as when she was working had never had the time or energy to exercise after a busy day.

The 'Can't cook, won't cook' programme is a six-week intervention aimed at educating people with nutritional information, and teaching people to cook in a healthier way. Vicki found the programme really helpful, more so for the practical tips than for any of the recipes they used to cook. She particularly liked how the programme was very different to commercial weight management programmes: *"There were no weigh-ins, they weren't patronising, and it was so relaxed, just like having someone in your own kitchen."*

Vicki found that just by making small changes in her lifestyle she was able to lose weight. This motivated her to try the aromatherapy intervention; previously she thought it was self-indulgent to try things like this. She now thinks she is worth the attention and Vicki books regular pamper days for herself and has an aromatherapy session at least once a month.

The Sandwell project also used this element of the work to target the 'community development for deaf and hard of hearing groups' through partnership with the Sandwell Deaf Community Association. In practice, this meant providing signers for beneficiaries to attend interventions such as 'can't cook, won't cook'.

5.2.5 Gains in skills / work related outcomes

Within the programme, several projects aimed at improving employee wellbeing in the workplace. Through their evaluations, Wellness Works found that employees typically had higher levels of psychological resilience following their intervention. Less tangibly, they also noted cultural changes in some of the organisations worked with. This included:

- Improved understanding amongst managers, (reported as being a key factor in the cultural shift of an organisation becoming 'wellbeing literate');
- Employees' increased readiness to speak about workplace wellbeing; and,
- Moving from policy to practice, with wellbeing messages being embedded into organisational cultures - including wellbeing in employee appraisal processes for example.

One of the other main outcomes of the project has been to increase the ability of the VCS to address emotional wellbeing. Wellness Works supported several VCS organisations who did not have their own resources for HR support. The most successful element of this work was a series of courses, including 'mind master' and 'mental health first aid' training.

Improving Workplace Wellbeing - Wellness Works

A new manager at a day centre received support from Wellness Works as they were interested in a structured programme that would help to maintain support and pastoral care for staff and volunteers. This meant developing a framework to action plan and prioritise, and setting clear goals - such as the development of policies and a new staff handbook - backed up with training. Wellness Works has enabled staff to access opportunities to build their emotional resilience and staff are now being offered courses that support them to develop and learn related techniques. This has meant that those with management responsibility have been supported in their role in a confidential environment. Previously this support was not available to the day centre, and cost would also have been a barrier.

'Brian' is a manager of a small cleaning company in Worcestershire. He attended training delivered by Wellness Works. He particularly found the six sessions on employment law 'extremely useful'. The sessions helped Brian acquire new knowledge, which he was able to directly to support an employee who had hit a crisis point that meant she could not work some of her shifts; as a casual worker this put the employee at risk of losing significant earnings. Brian was able to provide information as a result of his training which meant that the employee was financially supported through this crisis point.

The workplace strand of the Action for Wellbeing in Warwickshire project comprised a course that covered:

- Training line managers to recognise the symptoms of stress;
- Explaining depression and anxiety to reduce the stigma;
- Making sure employers understand legislation;
- Providing advice about how to conduct an interview with someone who is suffering from stress; and,
- Advising managers about lifestyle advice they can give to their employees.

Most participating organisations were in the public sector (e.g. the ambulance trust, police and other parts of the NHS). Despite successfully improving the knowledge of those attending, engagement of senior managers presented a barrier to achieving wider organisational change.

Beneficiaries from the Workmate project gained work experience and a reference at the end of their placements. The experience was also reported as having reduced some of the barriers to employing people with mental health issues and learning difficulties. For example, the Local Authority Human Resources department was planning on using the

project to inform policy. One of the project partners stated that: *"It makes a big difference, people really enjoy their placements. It makes people more confident. They like the independence that having their own money and their own job gives them. It increases their self-esteem and it makes them feel valued".*

Supporting People with Learning Disabilities in the Workplace - Workmate

One employer who was contacted by the Employment Liaison Officer decided to get involved with Work Mate as he wanted to give someone with learning disabilities an opportunity to work in a busy office environment. The work placement is for two hours a week and duties have been tailored to what 'Clare' feels comfortable doing. The placement has made a difference to the office and the employer also noticed a difference within Clare – *"...she has become extremely well integrated with other staff in the office. It's brought her out really, she's blossomed...At first she'd find it very difficult to have a conversation with you, but she can now."* The employer would recommend the project to others and would like to offer another opportunity.

In addition to projects directly working with employers, other projects have worked with volunteers that have also seen outcomes in this area. For example, volunteers in the Women in Motion project gained work-related skills and qualifications. Nearly forty of their volunteers gained an accredited qualification - fifteen completed a gym qualification and twelve undertook a 'circuits' qualification. These volunteers are then able to set up their own private organisation as long and one volunteer is pursuing an interest in delivering seated exercise. The project also made good use of the skills of its staff – one of whom has a Level 3 instructor's qualification and is a qualified tutor; they delivered in-house activity workshops, which the project estimates would otherwise have cost around £3,000.

Work-Related Skills through Volunteering – Women in Motion

'Ruth' became involved with Women in Motion, following an unsuccessful attempt at promotion, which suggested she needed a better understanding of equality and diversity, and also to undertake an activity in her spare time. As part of the project, Ruth successfully gained her Level 2 Gym Instructor qualification and also her first aid training, which enabled her to independently lead gym sessions within the local community. She has since gained a Later Life Training qualification, which qualifies her to teach specialised Falls Prevention exercise to older adults. As a result Ruth has improved her confidence, problem solving and decision making skills, and she states that she now feels more able to her goals of personal development.

Around 20% of the beneficiaries of the Volunteering 4 Employment project (under bWell Communities) found employment, which was higher than expected. These outcomes were also related to gains in mental wellbeing and physical health. The project found that good quality assurance measures with the host organisations (with a particular focus on skills development) were vital to ensuring a beneficial experience for the volunteer and promoting these outcomes.

Volunteering & Employment – bWell Communities

'Mark' started volunteering for Friends of the Earth. After time away from the labour market, he joined a friendly team of people who were working to maintain and repair the organisation's building. The role helped Mark to regain his confidence and he completed more than the 30 hours required for the bWell programme. Since leaving the organisation, he has found paid employment.

'Salma' wanted to volunteer as a way to develop English Language skills, meet new people and gain office related skills. Since joining the bWell project Salma has made huge gains in confidence. In addition, she has gained further employment in the voluntary sector and has been given a new volunteering opportunity in a financial department of another voluntary organisation.

Volunteers from the Wellbeing for Life project noted that they had gained a range of 'softer skills', such as increased confidence, changes in attitude, greater awareness, and a greater

ability to deliver suitable activity sessions. Similarly, the Wellbeing Workshops in Staffordshire also saw beneficiaries progressing through these 'softer' outcomes and into employment. In a small number of cases, this meant using beneficiaries as volunteers – and in one instance then as a paid member staff. This type of progression is a practical expression of the Changes' user-led ethos:

Volunteering & Employment in a 'User-Led' Organisation – Wellbeing Workshops

'James' is a recovering addict. He started drinking and taking drugs at the age of twelve. Now in his 50s, James was living in supported housing, where he was offered detox therapy. This is where James heard about Changes. He had not realised that he may have mental health needs, and thought that his problem was just related to drink and drugs. Through the project, James gained knowledge of mental health conditions, realising that mental health and addiction are linked.

James particularly valued the holistic approach of the programme: *"It's not just about addiction and medication, it looks at support networks, and diet, and hobbies and interests. It looks at the whole and has given me the opportunity to meet others and have a good time."*

The project helped to change James' life. He realises he will always be a recovering addict and will always have mental health needs, but now knows how to manage these problems. James began to volunteer with the project, attending meetings and assisting around the office. He now works full time, delivering Wellbeing Workshops. James recently returned to the supporting housing agency that had provided him with accommodation to deliver the wellbeing workshops to staff.

Lastly on this point, a small number of project managers noted that using volunteers was not necessarily 'a cheap solution' in delivering services. They highlighted the costs of supporting volunteers and also of any training provided[33].

5.2.6 Access to other services

As noted in Section 4.2.7, many projects worked to become part of local service provision in order to join up services for their beneficiaries. This helped improve access to other services and opportunities.

Shropshire Outdoors was a notable example of this. In order to promote quality outcomes with its service users, Shropshire Outdoors worked to change the culture and capacity of countryside agencies. One of the outcomes of this work was the way the project fed into active volunteering in accessing countryside agencies, such as Wildlife Trust, Natural England, and countryside volunteering with Shropshire Council. Around a quarter of beneficiaries progressed to volunteering work, and some service users started their own walking for health groups through partner projects. Beneficiaries interviewed commented how the activities kept them 'busy', giving them something to do which they would not otherwise get a chance to do.

Similarly, within the Herefordshire project, the Wye Woods service was sometimes offered as a reward for parental and family engagement in the sports activities; this was seen as helping the process of behaviour change. Wye Woods was also able to develop relationships with the parents and families that attend – taking on their ideas for activities (e.g. an introduction to camping so that people who would not normally camp can try it out). Volunteers from other Wye Woods activities – often people with mental or physical health conditions and their carers – also took part in the woodland activities. Over the last year, project staff worked on an exit plan that concentrates on helping people with recovery – i.e. if people have a personal budget to pay for their health or social care, they can use it to pay a fee to help sustain the walks and pay for the activities.

[33] New Philanthropy Capital has looked at this issue, noting that – in training costs alone - it costs the Samaritans an average of £100 per volunteer (http://newphilanthropycapital.wordpress.com/2010/09/14/how-cheap-is-free/). The costs of supervision, management and support are likely to be several times this.

Signposting to other Services - Wye Woods in Herefordshire

Wye Woods delivered activity sessions in the local woodlands for children and their families – beneficiaries from deprived parts of the County who do not have access to, or the habit of, accessing such activities. This was targeted at families with multiple needs – and the activities are intended to help build confidence and family resilience among families who may suffer from mental health problems, as well as having physical health needs.

In the view of the project workers, family members of vulnerable children often have mental health or wellbeing issues themselves, and the woodland walks offer an ideal opportunity for these parents to be introduced to other activities and walks that Wye Woods put on – with some parents going on to volunteer or train up as walk leaders with the support of the PCT. Therefore the project acts as a gateway or signpost into other health improvement services.

Lastly, SIFA Fireside used their services to promote progression onto other services and opportunities:

Moving to New Opportunities – SIFA Fireside

'Liam' arrived in the UK from Eastern Europe in 2004. Despite being an experienced chef, he found it difficult to find stable employment but took work where he could. Liam started using SIFA Fireside in September 2008 as a way of getting showers and food; he also made use of the basic skills group sessions. Liam says that the group has been effective in helping him improve his communication skills and confidence. With the help of SIFA Fireside and the groups that they run through the bWell scheme Liam is hoping to improve his prospects of finding work and move forward into a more positive future.

5.2.7 Reduced use of treatment services

Finally in terms of outcomes for individuals, a small number of projects were focussed on reducing the use of mainstream health and social care services. The Priority Care project has perhaps the strongest evidence of the effectiveness of their model in this respect. This evidence has come both from a previous similar project (which had a quasi-experimental evaluation attached), and also the data collected for this project.

At the time of our visit, a report was being produced for the GP Practice who carried out the referrals to show the difference it has made to the lives of beneficiaries. Results showed that since being seen by Priority Care:

- 75% of beneficiaries said they have more contact with other people;
- 90% say they feel less lonely;
- 81% have more options and choices to get the support they need;
- 72% said HHA have put them in touch with other organisations that have helped them;
- 47% are doing more healthy activities;
- 81% are enjoying life more;
- 94% have not been admitted into hospital; and,
- 56% said HHA have supported them to attend medical appointments.

In addition to these data, the project is undertaking a cost-benefit analysis of the service (supported by GHK), which will be given to the PCT, Local Authority and other commissioners to demonstrate the value for money and positive impact the project has had on its beneficiaries.

More Appropriate Use of Services – Priority Care

'Joanne' is in her 90s and lives alone in her own house in Dudley. She is very independent but she is suffering with dementia. After being referred by the GP Surgery, staff visited Joanne and her son to undertake an initial assessment. A support plan was devised which included two visits each week from a Priority Carer who provided companionship to Joanne and also began to understand the extent of her memory problems.

The Priority Care worker liaises with the GP surgery, as well as talking to Joanne about food and eating and home security. Joanne has not missed any medical appointments since involvement with the project. She is continuing to live successfully at home and her son is less anxious about his mum's wellbeing and safety; he is considering making a direct purchase for this support service.

On a related point, the Wellbeing for Life project saw a range of rehabilitation-related outcomes from their seated exercise classes. Two of the beneficiaries GHK interviewed said that the classes had helped them become more mobile following operations; another noted the exercises had helped her regain some mobility following a stroke. Similarly, several considered that – accepting the problems of attributing improvements to these classes – they thought that they were less likely to suffer falls. One service user mentioned that he was not falling as much as he used to, despite growing older: "*...if you think about it, I should be having more now than I was having 5 years ago, but I'm not!";* he attributed this to increased balance as a result of the exercises: "*I couldn't or wouldn't do it if it wasn't beneficial"*. Finally, and by way of further evidence on the question of additionality (see Section 3), the majority of the project's beneficiaries did no other form of exercise because they were not willing to pay for classes elsewhere.

Lastly, in Staffordshire, one of the aims of the Wellbeing Workshops was to keep people from entering secondary care. As part of the project visit, we gathered some limited evidence that this had happened. One beneficiary noted how he attended the programme whilst he was on a CBT waiting list, but no longer needed it because of the support he received from the project: *"The best way I can say this is that I was still on the waiting list for CBT and I got a call to remind me that I was still on the waiting list and I said I didn't need it anymore and asked to be taken off."*

5.3 There have also been improvements in organisational capacity

As well as supporting improvements for individual beneficiaries, Living Well aimed to improve the capacity of organisations – especially those in the voluntary sector – to deliver similar services in future. Therefore, as part of the final monitoring return, we asked projects for their views in relation to these outcomes. The results are shown in the Figure below; they suggest that most organisations involved have seen some improvement as a result of delivering a Living Well project.

Figure 5.2 There were some organisational level outcomes following delivery of a Living Well project

Examples of this type of outcome are illustrated by the approach taken in Stoke:

Building Organisational Capacity – Living Well in Stoke-on-Trent

Building organisational capacity was a central aim of the Living Well in Stoke project. The PCT set out to improve the ability of two third sector organisations' (Changes and Magmh) ability to engage with mainstream commissioners and deliver public health services. The PCT worked closely with these organisations and has delivered specific training (e.g. in running light physical activity sessions), as well as bringing the organisations together on specific topics to share expertise. A manager from one of the organisations noted that this had added value to the project: *"I think it's been a really good partnership ... with the expertise that we've had at different times, it has worked quite well ... from health promotion to media action expertise - organising events and promoting events ...* [combined with] *our expertise in general wellness and delivering wellness programmes to people"*

According to both Changes and Magmh staff, the improvements in organisational capacity and knowledge have been one of the most important outcomes achieved. Even though the current funding landscape is very uncertain, both organisations are now much better connected to local funders and know more about what funders want; they are able to point to a track record of delivery that will help them to win more commissioned work; and have experience of integrating 'health' messages into their day to day activity. Changes have been able to incorporate simple activities such as seated exercise into their core activity of mental health support and recovery.

Other, more specific examples of outcomes in this area included:

- Several projects also reported that their organisation was better linked to local networks of similar organisation. For example, Through the Doorway is a small, local voluntary sector organisation that has – as a result of running the Shropshire Indoors project – stronger links to a range of different organisations, such as MIND, Headway and local social landlords;
- The Women in Motion project saw a gain in local (and regional) profile after being a runner-up in the BBC Power of Sports Awards;
- Groundwork has used the Farm to Fork project to develop a service that can now be used in other areas. Relations between Groundwork and the schools have been established and they can go back to these schools if they had additional resources. The Graduate Volunteers have also benefited from the project as a lot of them wanted to work with children and young people and they have gained that experience;
- For Coventry Body and Mind, their Living Well project supported a broader cultural change in the ethos of the organisation. The understanding of 'wellbeing' and how it relates to mental health is much improved. They have revised their contracted support services to include the usage of 'my wellbeing support plans', and there is now much more emphasis on wellbeing and the whole person not just on mental health. 'Wellbeing' also now features as part of the strategic business plan and is reflected in each of the service plans;
- The Walsall project found in Year 1 that their staff did not feel able to cope with issues arising from the administration of the WEMWBS (which was causing some beneficiaries to reflect on their life and become upset). They therefore commissioned some specific training for their staff on this issue; and,
- In the case of the Healthy Retail project, good practice was learnt in promoting cultural change regarding healthy eating in one of the most disadvantaged areas in Dudley. Lessons were then fed back into the PCT to inform future initiatives and funding opportunities. As one member of project staff noted, *"...we had the right rationale, and the right approach...we have just been learning what buttons to push"*.

Finally, and accepting the obvious conflict of interest (!), we note that several projects cited the approach taken by the evaluation as being useful to building organisational capacity.

The main points noted here were: the approach of building from 'the projects up' (meaning that their evaluation system was useful to them); offering conceptual and practical support to specify and measure outcomes; and, being flexible and changing requirements as projects themselves changed.

5.4 From the projects' perspective, the value of the local and regional level support structures varied

As described in Section 1, projects were supported primarily by Local Communication Leads (LCLs), the PR contractor and the regional programme management team. Here we describe a summary of the projects' views in relation to each of these elements.

5.4.1 Local Communication Leads were generally highly valued

Nearly all projects considered that there was clear value to them in having the support of their LCL. This was mostly in terms of giving them clear messages and support around the requirements / development of Living Well, but also in terms of keeping projects informed about key local developments.

In some areas – notably Staffordshire – there were also some improvements in statutory / voluntary sector relationships; in this case this is most likely because the LCL was also the relevant local commissioner for these projects. A further factor here was the clear thematic focus in the county – all projects were established to address problems relating to mental health. This increased the usefulness of local meetings and also the ability to provide consistent local messages.

5.4.2 The programme management team were considered to be both competent and supportive

Projects considered that the programme team had 'set the right tone' in their engagement with the projects. It was recognised by project managers (and LCLs and regional stakeholders) that the management team had performed especially well in terms of their engagement with BIG Lottery - satisfying the needs of the funder while minimising the burden on projects. The programme team were also praised for their constructive engagement with the LCLs. These relationships improved over time, following some early tensions that largely related to the process of assembling the bid and control over the final content (discussed further in Section 7).

But the most substantive points made related to the support provided to promote project sustainability. This support comprised: bid writing workshops and support; workshops on engaging with commissioners; and workshops on presenting projects' work in economic terms (supported by a Guide). One project manager noted that: *"This project supported us far more than any other"*, and another that: *"I've had all the support I could have wished for, every time I've had a query I've heard back within the hour"*. Not all projects accessed this support; nevertheless, several of those that didn't noted that they still valued this structure and approach.

This was not a unanimous view and a small number of projects considered that the regional level probably represented too high an opportunity cost. Projects making this point noted that their main point of contact had been local (through their LCL), and that the resources used at regional level could have been better directed to local projects and project support.

5.4.3 The PR support was of more varied value

The PR support contract was an innovation within Living Well. Project staff reported that some aspects of this work – notably the newsletters – had proved useful and were valuable to the programme (if not always their local work). Some projects also reported that the PR support offered had been useful to their project, with one project manager describing it as *"...flexible and supportive"*, and another noting that their project had benefitted from specific advice on targeting GPs. Regional stakeholders also noted the value of the newsletter and annual conferences in terms of distilling and disseminating information to an audience outside Living Well.

However, a number of projects – especially those led by the public sector - did not see the support as valuable to their work. This was largely because they already had access to communications support, thereby limiting the value of the support available under Living Well. Furthermore, some projects did not fully engage with this element of available support. This combination of factors meant that this element of the programme did not add as much value at local level as originally hoped.

Having described the benefits of Living Well, we are now in a position to examine the extent to which the services established will be sustained. This is the subject of the next section.

6 Have Living Well Projects been Sustained?

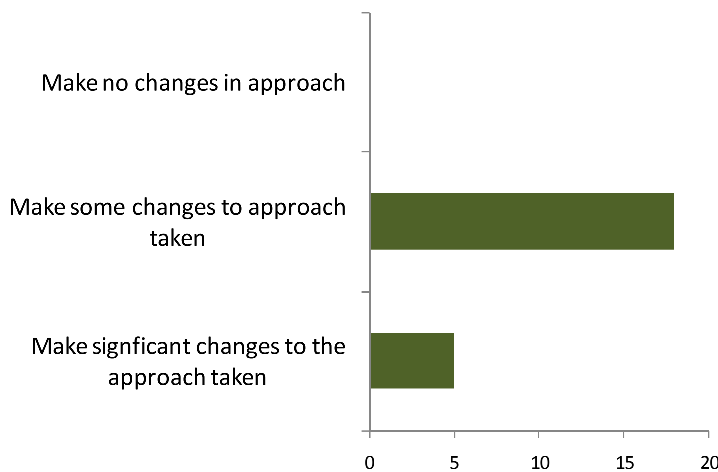
In this section we describe projects' approaches to sustainability. In doing so, we draw upon monitoring returns, project visits and a recent survey of the projects undertaken by the programme management team. We begin by providing some 'headline' figures before exploring the detail of the approaches taken and results achieved. The section ends with a brief description of the emerging policy context.

6.1 'Sustainability' is a subtle concept; most projects will not continue in their current form, but their work will continue in some respect

Before entering a discussion of the numbers of projects and services sustained, it is first important to outline what we might mean by being 'sustained' – and, perhaps more importantly – whether projects want to be sustained in their current form.

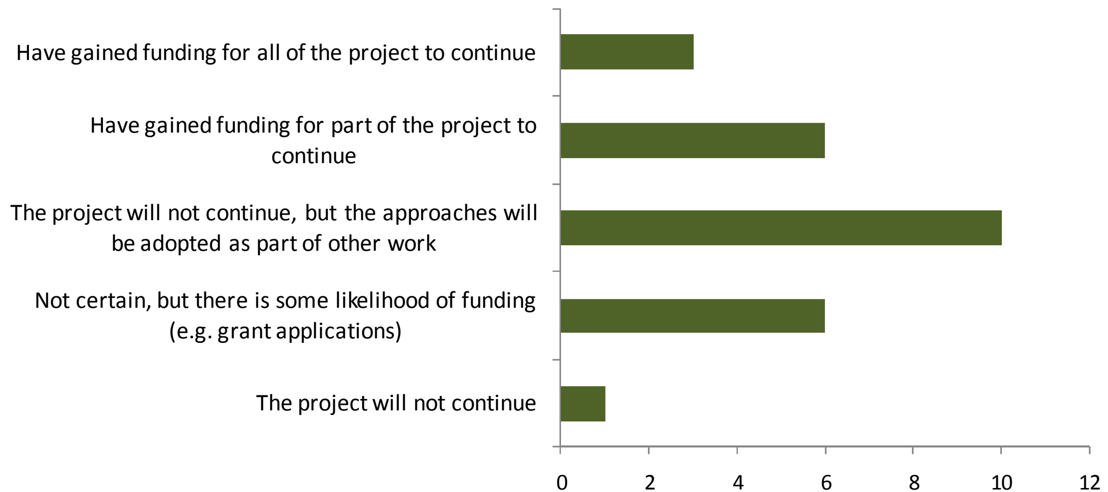
The answer to the second question is that nearly all would want to make some changes to the way their services were set up under Living Well; these changes would be 'slight' in the majority of cases, and 'significant' in a minority. This is shown in the Figure below, which presents the results of question from a survey of the projects undertaken as part of the final monitoring return.

Figure 6.1 Given the opportunity, nearly all projects would make 'some changes' to their approach



The question of what 'sustainability' might mean is also relevant here. Taking a broad definition that encompasses a range of approaches from 'all of the project will continue' to 'approaches will be adopted under other work', we see from the Figure below that the majority of activity established under Living Well will be sustained:

Figure 6.2 Nearly all of the work started under Living Well will continue in some form[34]



We now turn to examine some of the detail underneath these headline figures.

6.2 Projects have taken a range of routes to sustainability

Different (and somewhat overlapping) approaches have been taken; they include:

6.2.1 Approaching mainstream commissioners

As noted elsewhere in this report, there has been a substantive change in context over the lifetime of the Portfolio. This has been in relation to both government policy and also general economic conditions / the availability of public funding. In short, government funding – through Local Authority and PCT commissioners - is less available than it was. This factor, combined with questions around what BIG funding has been / ought to be used for (discussed further in Section 7) has meant that very few projects have been directly sustained as a mainstream service. Examples here include:

- The SHINE project has now been commissioned by the local Care Trust. Funding is guaranteed to March 2012, but there are indications that it will form part of local services in the longer-term to 2015. Project managers have also met with emerging GP consortia and will be developing similar 'lifestyle' services for the north of the borough. In this way, BIG funding was used as 'pump-priming' - to establish the model, test things out and to develop the service before it is commissioned as a mainstream public service.
- The weight management element of the Nutrition Training project in Wolverhampton will be sustained by the PCT.
- It was not intended that Living Well in Stoke would lead to new services, although it was expected that there would be a greater 'opening' for the local VCS to offer new services based around wellbeing. The current funding situation makes this very difficult. However there will be some funding available for Magmh's core activities that they were doing prior to Living Well (Sanity Fair) and Changes has been commissioned by the PCT to deliver additional health promotion work, combining the programme's messages about combining healthy eating, physical activity and mental wellbeing.
- Volunteering 4 Health was preparing to respond to a local invitation to provide a similar type of service to that delivered under Living Well. Changes was also awaiting the outcome of a commissioning decision for a service similar to that established under Living Well.

[34] As the categories are not mutually exclusive, project managers were invited to 'mark all that applied'.

On a related point, a small number of projects were looking to the development of personal budgets in health and social care; for example:

- Priority Care is to continue with Heantun Housing Association funding it in the immediate future. However, there are changes in the wider social care context, with the shift towards self-directed care and personal budgets. Therefore, the Priority Care team will develop their service to respond to individual's demands; they will also have to raise their profile and market themselves more. One member of staff noted: *"...it's a time of big change and we're trying out new things on a smaller scale. The project could potentially be rolled out in the whole of Dudley. We will have the freedom to market ourselves across Dudley after the lottery funding has come to an end and this fits with the new way of working."*
- The Healthy You! project is also investigating personal budgets. With local day centres closing, service users will be given a personal budget, which will enable them to purchase the service; this should help towards sustainability. The Local Authority also ran an event for families in October at Dudley College where Healthy You promoted the support they offer. They are also putting a Comic Relief bid together for a development worker.
- In Herefordshire, the Wye Woods organisation hopes to sustain some of their funding by marketing their walks and activities to people with personal budgets – for example, people with disabilities or people recovering from physical or mental ill health.
- The Shropshire Outdoors project has secured around £10,000 (it was originally £18,000, but this was subject to public sector cuts) from a 'personalised social care' programme; this will be used to fund a post to coordinate services according to personalised budget spending by beneficiaries/carers. The project has also gained a £10,000 stroke grant from the PCT to continue work with a cohort of beneficiaries, working in partnership with Headway and Shropshire Enablement Team. These funds do not fully sustain the work of the project, and it is working to develop relationships with the Local Authority team responsible for implementing the personalisation agenda.

Finally on this point, a small number of voluntary sector projects noted that their ability to be sustained through this route was, in large part, dependent upon the development of local commissioning arrangements. In some areas, commissioning and – crucially for the areas of service covered by Living Well – joint PCT/LA commissioning in particular was reported as being well developed. In other areas, these arrangements were reported as being under-developed and inconsistent – and that 'in-house' providers (LA/PCT) were therefore in a better position than the voluntary sector.

6.2.2 Bidding to other funds

The most common approach has been to seek alternative sources of (typically grant) funding; examples here include:

- Women in Motion have put in a bid for further funding from Sport England under the title 'Active Women', which will be more focussed on sport rather than fitness and would include walking, dancing, football and netball (activities have changed because existing projects are less favoured under this fund).
- Volunteering 4 Health and Being Well in Sandwell were both putting together bids for the BIG Lottery 'Reaching Communities' fund, using the most successful elements of their Living Well project as the basis for a new project. Coventry Body and Mind was successful in their application to this fund (gaining over £370,000) and will provide similar services to those established under Living Well for the next three years.
- The Walsall project submitted a bid for further funding in partnership with the external funding manager from the Local Authority.
- Dove mentoring is planning to build on their partnership with MIND to develop joint bids.

- BVSC, which led the Volunteering 4 Employment and Volunteering 4 Wellness work under bWell Communities has now developed a 'Open Door Volunteering' project, which works to the same design as the service established under Living Well (funded through a 'social capital' programme). RSVP, which also ran a Communities project has received funding from the Ministry of Justice to sustain their work for another year.

6.2.3 Training professionals and volunteers

Some projects have – as a central part of their work – tried to change the way local services operate (typically this would be referred to as an element of 'mainstreaming') and / or ensure that volunteers engaged have sufficient skills to maintain the work.

Parklife has taken this approach to sustainability. Firstly, walking now sits within the Healthy Towns project and the project manager is now responsible for delivering these services, taking on elements of the approach used under Parklife. Secondly, the number of volunteers has increased and some are becoming walk leaders. The Parks Physical Activity Manager delivers the training for the volunteers to become walk leaders. Over time, the volunteers who are training to become walk leaders will shadow a walk leader on their route for a few weeks and then eventually lead that walk with the walk leader assisting for support. Lastly, Parklife has trained a volunteer as a 'cascade' trainer who can train other volunteers in walk leadership:

Training Volunteers for Sustainability - Parklife

'Nigel' has volunteered for the Dudley Walking Programme since the beginning. His role as a volunteer walk leader involves delivering a regular weekly health walk. In addition, Nigel organises social events as well as helping out with lunches at a day centre. Although he has suffered health problems recently, Nigel has attended the social events and the walks and often uses himself as a role model to unsure participants and says that if he can do it they can. Nigel has put himself forward to become a walk leader trainer and has completed his Cascade training course which will enable him to recruit and train new volunteers (a service that is vital to the sustainability of this project.)

Improving Other Services – Nutrition Training

The Nutrition Training project provided weight management training to staff in a Children's Centre, which had very few health related services. To enhance the service offered, the centre was encouraged to train other members of the team and to engage other health professionals in the delivery of the programmes. The effects of the intervention on the centre were wide-ranging as centre usage has increased and other health services are now offered at the centre. The programme has provided an additional service for individuals in the local community to access healthy weight loss support which they wouldn't have readily accessed their GP surgery for.

Two schools received the same intervention. One school had support for the first three sessions and now have continued with it on their own, and is proving to be successful with the numbers of families attending. The school is now working on sustaining the programme with the parents delivering it. The other school has implemented their cookery club in a different way to benefit the school, such as integrating new Year 7 pupils into their new secondary school by inviting their families to the club while their children were in.

Lastly, in Walsall the creative arts tool developed as part of the project is being 'handed over', with training, to the creative development team; and in Staffordshire, the Sharing Spaces project has left improvements to school grounds – and also better links between the grounds maintenance team in the Local Authority and the schools involved in the project.

6.2.4 Handing over to the market / charging for services

The challenges of establishing a service in the anticipation that it can then be sustained by private funding have been illustrated by a small number of projects. For example:

- Healthy Retail engaged with local retailers to see how any changes in demand for fruit and vegetables brought about by the project could be sustained through changes in local shops' supply. This approach has seen some success – achieved primarily through a local green grocer continuing to run a stall at the school, despite making a slight loss. The reasons for doing so are a recognition of the wider implications of his service (in terms of improving public health), and also the possibility of growing a new customer base. Outside of this success, other shops did not engage with this element of the project.
- In another example, Shropshire Indoors has also looked at trying to make the classes self-sufficient by charging. However, this has not been successful – even when they charged classes were not self-sufficient and most will not continue after Living Well (around five out of 30 classes have been sustained). Classes which have been sustained have been those where costs could be brought down, for example, venue costs being waived in sheltered housing, or where the class was opened up to include the general public. Some mainstreaming has happened by integrating beneficiaries into other community exercise classes outside project.
- Similarly, Wellbeing for Life is also now considering charging for their services. The problem facing this project is that the activities had previously been offered to beneficiaries 'for free', meaning that there will now be reluctance to pay.

These problems most likely relate back to the initial arguments for funding, which would have shown a 'market failure' (e.g. services are not being delivered because there is a lack of information – perhaps relating to there being a commercial opportunity). These examples show that such 'failures' are difficult to correct using short-term project funding. Nevertheless, there was a notable exception to this:

Trading for Sustainability – Change Kitchen

Perhaps the most successful project in terms of sustaining projects through market activity is the 'Change Kitchen', which was a part of the SIFA Fireside project under bWell Communities. The Community Interest Company provides six month paid placements to beneficiaries completing SIFA Fireside's Development Programme - providing accredited training and a route to employment.

As noted in the last Annual Report, Wellness Works was considering charging for the services established under Living Well (which led to questions around BIG Lottery's policy on this issue). They also investigated the possibility of becoming a social enterprise (which they decided against because of the restrictions on accessing certain types of funding) and also established a sustainability working group. Current plans include involvement in the Improving Access to Psychological Therapies programme and the Challenge Fund, which has provided a small amount of continuation funding.

6.2.5 Increasing awareness and making 'wellbeing' a part of core services

Finally, some projects are trying to raise general awareness of their work (partly targeting commissioners), and others are incorporating activities started under Living Well into other services run by the organisation. For example:

- Wellbeing for Life are planning to have a DVD made to leave a legacy of the project, which will sit alongside the project's evaluation report. Three volunteers will help with this. They will be filming luncheon clubs, speaking to volunteers and also to the service users. The rest of the DVD they will have exercises classes so that people can buy it and do the exercises at home; this will be distributed at the luncheon clubs. Age UK, which ran the project, was also planning to run a town centre event in an attempt to make the organisation more visible; this is being done as part of a more general attempt to get a higher profile amongst key decision makers and commissioners.

- Farm to Fork also held a celebration event which they hoped would raise the profile of the project with commissioners to attract more funding and sustain the work. The event was also a chance to celebrate the achievements made by schools.
- In the case of Action for Wellbeing in Warwickshire, some of the physical activities will be sustained by Age Concern Warwickshire, although if many are to be sustained they will need to be taken on by partners. At this stage, the proportion of activities to be sustained is not clear. The walks will largely be sustained: some will continue to be run by Age Concern Warwickshire under different service banners; some will continue to be run by trained volunteers who will be supported by Walking for Health Warwickshire; and other walks will be run by community partners.

6.3 Accepting substantive challenges in terms of structural reform and funding cuts, the policy agenda is very favourable to Living Well

There are substantive practical concerns – notably funding cuts and the uncertainty of structural reform – that present an immediate threat to the efforts described above. Notwithstanding this, there are a number of policy developments that present Living Well projects with a supportive environment. We take the two main White Papers produced in this area, before summarising the underpinning theme of the 'Big Society'.

6.3.1 The NHS White Paper 'Equity & Excellence'

In July 2010 the Coalition published the NHS White Paper 'Equity and Excellence'. The aim of Equity and Excellence is to drive further improvements in health and healthcare, against the context of a much reduced financial settlement for the NHS. The main mechanism for change is to use market-type forces – such as patient choice and competition amongst providers – to reform incentives within the system to increase pressures for better self-regulation and improvement.

Philosophically, there are large elements of continuity and many elements of the reforms were features of Labour policy. For example: the emphasis on greater self-correction and a relaxation of targets; the desire for greater patient choice, with better information to inform decisions; a focus on quality and safety; the drive for a clearer demarcation between purchaser and provider; and, greater freedoms for higher-performing providers.

Nevertheless, the structural reforms proposed to deliver these aims are fundamental. For example, these reforms include: the abolition of PCTs and SHAs; the establishment of a National Commissioning Board; a central role for GP consortia in commissioning (controlling 80% of all NHS health spending); the creation of a new Public Health Service under Local Government control; a new performance monitoring regime based on 'clinically relevant' outcomes; and that all NHS trusts will become or be part of a foundation trust. Moreover, these changes are to be implemented rapidly – again, against the context of an almost unprecedentedly tight increase in resources and consequent need to greatly increase productivity.

Reaction to the Paper has been very mixed, but has in general concentrated upon the practical questions of implementation, rather than the fundamental direction of the reform. Various think tanks, policy commentators and professional groups have raised significant questions. Particular areas of concern have included: the role of GP consortia, the more mixed and independent provider base, and the speed and cost of the reforms.

6.3.2 The Public Health White Paper: Healthy Lives, Healthy People

On the 30th November the Public Health White Paper was published. It sets out a range of structural and policy reforms aimed at addressing a series of major public health problems.

In structural terms, the main changes proposed by the Paper include the creation of a new national Public Health Service within the Department of Health. There is also to be a ring-fenced budget – partly as a response to the historical problem of 'raiding' public health budgets in response to crises elsewhere in the NHS. The desire for greater localism (see 'Big Society' below) is furthered by giving local authorities responsibility for public health at

local level (rather than GP consortia). This will be supported by local Health and Wellbeing Boards and the retention of the Joint Strategic Needs Assessment. The rationale here is that the influence of Local Authority action can have a greater effect on the determinants of public health than the NHS.

In terms of the policy agenda, there are several interesting features of note. The first is the concern with health inequality. Indeed, the report is presented as a response to the Marmot Review and much of the analysis presented is framed in terms of inequality. This is a significant departure from Conservative thinking in the 1980s (see reaction to the Black Report). In practical terms, the paper also suggests the use of a 'health inequalities premium' (although more detail is being awaited here).

The second is the use of 'nudge' theory – as articulated by Thaler and Sunstein in the book of the same name; this suggests an emphasis on individual decisions, with the role of the state being to construct the 'architecture' within which these decisions are made (discussed further in Section 7). There is a related desire to involve industry in 'responsibility deals', rather than use regulation. Finally, it is also interesting to note the high priority accorded to mental health, alongside the more 'traditional' public health concerns such as smoking, obesity and sexual health.

6.3.3 A 'new' under-pinning theme: The Big Society

> *"It's time for something different, something bold – something that doesn't just pour money down the throat of wasteful, top-down government schemes....The Big Society is that something different and bold."*

David Cameron, speech on the Big Society 19th July 2010

Finally in this section, we describe the tenets of the 'Big Society' – a body of ideas currently being used to underpin much of the Coalition's policy development. Overall, the Big Society is a commitment to increasing the involvement of communities in their local areas and in the development and delivery of public services.

In more specific terms, this means commitments to[35]:

- Giving local communities more powers;
- Encouraging more people to be active within their communities;
- Devolving power from central to local government;
- Supporting the creation and expansion of mutuals, co-operatives, charities and social enterprises; and,
- Publishing more government information.

The roots of these ideas are long and can be traced back to Edmund Burke and others in the conservative / classical liberal tradition; but the current emphasis relates partly to the project of re-defining the relationships between the citizen, the state and intermediary organisations (such as those found in the voluntary sector). It is also an attempt at articulating a response to perceived weaknesses of both the previous administration (seen as 'Big Government') and even previous Conservative leaders (seen as over-emphasising individuals at the expense of communities). Increasing voluntary action and the involvement of the voluntary and community sector in local service provision is thereby a key theme of this agenda[36].

This agenda is being implemented through a range of different policy initiatives, including: encouraging social enterprise and employee-ownership in the NHS; the Big Society bank; a Decentralisation and Localism Bill; allowing parents / voluntary groups to set up 'free schools'; the National Citizen Service; and, publishing information on civil servants' salaries.

---

[35] Adapted from *Building the Big Society* policy programme, launched by the Cabinet Office 18th May 2010 http://www.cabinetoffice.gov.uk/media/407789/building-big-society.pdf accessed 26th October 2010.

[36] Office for Civil Society (2010) *Building a Stronger Civil Society: A strategy for voluntary and community groups, charities and social enterprises*, London: Cabinet Office

Having described the approaches taken to sustainability within Living Well, and described some of the notable features of the emerging policy context, the report now turns to consider whether the experience of Living Well offers any more widely applicable lessons.

7 Did Living Well suggest any broader lessons: a) for this type of programme, & b) for changing behaviour to promote 'wellbeing'?

This section brings together a set of broader lessons. These are examined in two specific areas. Firstly, we look at ways in which Living Well highlights issues (and some possible solutions / areas for development) in the design and administration of this type of fund. Secondly, we examine the ways in which Living Well has provided a set of lessons in relation to promoting behavioural change.

7.1 Living Well has highlighted four key issues that are likely to be generic to this type of fund

These include:

7.1.1 The question of the boundary between state and BIG Lottery

This issue is perhaps irresolvable - and may even be a question of political philosophy / local availability of public funding, rather than of fund design – but several Living Well projects highlighted the considerations in thinking about where these two types of funding are best used.

The essential issue here is that BIG Lottery states that its funding should not be used to 'fill gaps' in existing public services. Guidance for the Wellbeing Fund notes that, while funding ought to operate in support of existing policy goals:

"BIG funding should be distinct from government funding and add value."

Yet what is funded by government varies from area to area. This means that services funded under Living Well in some areas are an established part of provision in other areas. The most notable example here is the SHINE project (elements of the Nutrition Training project are another). Analogous services form part of an obesity care pathway in neighbouring Birmingham; moreover, these services have an existing evidence base – lending weight to the case for state funding. Furthermore, this service has subsequently been commissioned (see Section 6) and sustained by the local Care Trust – again perhaps raising the question as to whether this service should not already have been provided by the state.

This case highlights a second factor: sustainability. The trade-off here is that there are reasons to think that more 'experimental' services (i.e. those furthest from current government funding) are then less likely to be sustained. There are also reasons to think that the most experimental services are least likely to be effective, since their evidence base will be least well developed.

These factors present challenges in the use of BIG Lottery funding in terms of wanting to support activity that:

- Is supportive of current policy aims, but that adds value to public services; and,
- Is innovative, but stands a reasonable chance of becoming part of mainstream service provision.

Interviewees at regional level, and several LCLs, reflected on these difficulties. Points – and possible ways forward – raised here included:

- Setting up projects to make specific policy points, and so contributing to debates about what public services might be doing to address a particular issue;
- Designing projects against clearly specified gaps. One interviewee noted that there could be a role here for providing practical examples of ways to implement NICE public health guidance; and,

- Channelling funding through local commissioners. This might increase the likelihood of Lottery funding 'plugging gaps', but might also allow commissioners to test new approaches at reduced risk – thereby enhancing the chances of sustainability.

This final point is discussed further below.

7.1.2 The question of an 'ideal' model of local delivery

Within Living Well, there were three broad models for administering the funding and delivering services at local level:

1. Local statutory bodies receive the funding, act as the accountable body, and commission the voluntary sector to deliver (e.g. bWell, Priority Care);
2. The voluntary sector receives the funding and delivers the services (e.g. Coventry Body and Mind, Action for Wellbeing in Warwickshire, Wellness Works); and,
3. The statutory sector receives the funding and delivers the services (e.g. SHINE, Parklife).

Each of these approaches has advantages and drawbacks. In the case of the second approach, advantages typically related to the speed at which delivery began, while the disadvantages related to 'being on the outside looking in' when it came to approaching mainstream commissioners. For the third approach, these factors tended to be the reverse.

So, although no interviewee cited a straightforward argument for any one of these models being the most appropriate, interviewees tended to favour approaches based on some form of partnership at local level. As a minimum, this would also ensure that funded projects formed part of local service delivery / responded to identified local need.

Finally, several regional level stakeholders noted that a programme could not now be delivered in the same way following the cuts in public spending and disbanding of regional-level bodies. This was in terms of both bidding for funding (coordinating efforts) and administering funds.

7.1.3 Issues relating to the bid process / fund design

All interviewees involved in the bid process considered it to have been unclear, changing and rushed. Initially, the Wellbeing Fund was designed to be administered locally. This was then changed to regional / national, which meant a process of re-negotiation between local and regional level stakeholders.

In the case of Living Well, this was supported by strong regional networks established through the Regional Health Partnership. Nevertheless, the early days of Living Well were affected by the tensions generated through some of these (re)negotiations. The views of stakeholders were therefore centred upon the need for greater clarity around the bidding process.

On a similar, but more detailed, note, interviewees also raised the need for clearer guidance on:

- *Policy relating to charging for services*. Again, this issue was noted in previous Annual Reports; the essential point made was that there should be clearer guidance / policy on the circumstances under which projects might begin to charge for their services as a route to sustainability. The current approach, which was noted as being adverse to changing, was cited as hampering efforts towards sustainability.
- *Definitions for setting targets*. As noted in the previous Annual Reports, the bid was marked by a lack of clarity over targets – especially in relation to beneficiary numbers and outcomes to be achieved. Interviewees involved in the bid process therefore considered that clearer guidance – for example on what counts as a 'beneficiary', or how specific outcomes might be measured – was needed.

This final point relates to the issue of performance management and the challenge of establishing – within a three-year programme – which services are underperforming and how

to address them. Having a more informed process of target setting would give the programme management team a stronger and clearer rationale for intervention.

7.1.4 Ways of evaluating 'wellbeing' programmes, and diverse programmes with a requirement to aggregate findings

Accepting that there is some conflict of interest in the evaluator reflecting upon the success of the approach they designed, it is perhaps useful to do so, building in the feedback of projects and programme staff. On this basis, GHK's reflections on the lessons arising from the evaluation of Living Well are that:

- It is challenging to look across a range of diverse projects – especially in relation to quantifying and aggregating information. Our approach to this - approaching the evaluation from the projects up, and using a common model of an intervention – worked well. The model we used 'made sense' to projects, and tailoring indicators to their work was appreciated. The alternative approach – designing a tool for measuring 'wellbeing' (whatever this might mean – see Section 2) and asking all projects to use it – would not have taken enough account of the diversity at project level;
- The provision of standard tools and guidance also worked well. Notably, projects using the WEMWBS generally considered the tool to be useful. There were also lessons here in terms of the tool's administration – principally in using it as part of a more general 'initial assessment', and in being prepared for some beneficiaries to become upset in completing the scale;
- A capacity-building approach also worked well. We hope that the evaluation was seen as a resource by projects. Guidance on measuring intangible outcomes, in-kind support, and in economic analysis appeared to be especially well received; and,
- The role of programme management in commissioning the evaluation at the start, and in allowing performance measures to be informed by the evaluator was also critical.

Each of these factors offers some lessons for programmes of this type.

7.2 Living Well provides examples for promoting behaviour change

This final part of the section addresses the question of behavioural change and wellbeing. In doing so, the focus is on physical activity and healthy eating. This is partly because these areas entail more concrete and obvious behaviours than mental wellbeing, and partly because the problem of obesity (as an outcome of poor diet and inactivity) is a good case study in behavioural change. Nevertheless, the concepts and problems are generic and the holistic model of wellbeing used by Living Well means that the examples provided by the programme also cover mental health.

We begin by outlining the challenges associated with behavioural change, before moving on to look at the deficiencies in the models of behaviour that have 'traditionally' informed public policy. The section concludes by outlining new approaches – focusing on those drawn from behavioural economics and adopted by Cabinet Office – and examining ways in which Living Well provides lessons and examples that illustrate this new thinking.

7.2.1 Changing behaviour is a mainstream government concern, yet the models of behaviour that have informed policy are deficient in several important respects

At heart, interventions to address healthy eating and physical activity – in common with most other public policy interventions – are an attempt to change people's behaviour. In designing these interventions, policy makers have used theory from a range of different disciplines[37]; one theory that has proved durable in most policy areas, including public health, is Rational Choice Theory (RCT)[38]. In essence, RCT states that individuals seek to maximise their

[37] See NICE (2007) *public health guidance 6: Behaviour change at population, community and individual levels*

[38] For example Healthy Weight, Healthy Lives and Choosing Health both draw on this model, e.g. around the provision of better information – such as food labelling - for decision making.

wellbeing by rationally weighing the likely costs and benefits of an action[39]. There have been a series of variations upon this essential theme, but this core insight has been / is used to inform the design of interventions in many fields of public policy.

However, there are cases where the explanatory power of RCT seems insufficient. Obesity is one such example. Under RCT, explanations for obesity would, in the main, be limited to either:

- *imperfect information* (the individual didn't know the likely effect of a lack of exercise / consuming too many calories); or,
- *preference* (the individual prefers being overweight to the alternatives (the size of the diet industry being evidence contrary to this explanation!)).

Basing policy on RCT has therefore tended towards interventions based upon the provision of information, which would, under the theory, then lead to individuals changing their behaviour. However, as the King's Fund notes:

> *"...providing information, on its own, has little effect on people's health behaviour. Health behaviour is complex, and is determined by more than just an individual's level of knowledge."* [40]

This suggests a gap for fuller set of theory about what makes people behave the way they do.

7.2.2 Behavioural Economics offers some useful insights and is informing current government policy on behaviour change...it aims to substitute 'nannying' for 'nudging'

Recently, behavioural economics (BE) has brought together insights from economics, social psychology and sociology to refine RCT by adding some richness, complexity and reality. BE's model of behaviour includes factors such as habits, social norms, and decision-making heuristics (rules of thumb rather than deliberative calculation); it has also discovered seemingly systematic biases in the ways we make decisions. A recent Social Market Foundation report summarised the promise offered by BE as follows:

> *"Despite the common assumptions of economics in many circumstances, people, it turns out, often aren't actually all that 'rational' in their behaviours and decisions. They don't conduct some sort of complicated cost-benefit analysis when faced with a choice. In fact, they are just as likely to do what they have always done, what impulse tells them to do or what their neighbours or friends generally do as to do what is most beneficial. And what's more, they're often well aware that their own actions aren't in their best interests."*

As well as offering some insights into decision making at a micro-level, BE also seems to sanction a greater degree of state intervention – especially in areas where it seems to be clear what is in our best interests, but that where we may need help to act, that we can be 'nudged' to take better courses of action[41]. This thinking is a central part of current public health policy (see the description of 'Healthy Lives, Healthy People' in Section 6).

BE thereby seems to offer a (partial) answer to the charge of 'nannying', which is often levelled at public health interventions[42], since the focus is on helping people to make choices

---

[39] Almost no economists actually believe this to be true, but some, such as Milton Freedman, defended the assumptions of RCT on the grounds that people may behave as though it were.

[40] The King's Fund (2008) *Commissioning and behaviour change: Kicking Bad Habits final report.* Moreover, other studies have shown that just a small minority lack knowledge in relation to the benefits of exercise: the problem does not seem to be solely one of information.

[41] See, *inter alia*, Thaler, R & Sunstein, C (2008) *Nudge: Improving Decisions About Health, Wealth, and Happiness*

[42] It also opens discussion of the appropriate limits of state intervention - as suggested by Thaler and Sunstein's phrase 'libertarian paternalism'. This issue is far beyond the scope of this report, except to note that children are a group where state intervention is more generally accepted, since they are not judged capable of making rational

that they want to make in the face of their 'bounded rationality'. Retaining some emphasis on individual choice therefore goes some way to explaining the attraction of these ideas to the Coalition[43]. Also, BE does not discount the traditional levers of public policy – taxing, incentivising, regulating, exhorting – but rather adds some subtlety to these sometimes blunt instruments. These insights may therefore be of greater use at the local level, where discretion over policy does not extend to the 'heavier-end' of intervention, and the detail of design is more paramount.

It is beyond the scope of this brief review to systematically set out a full discussion of the insights of the BE literature, but the chief points concern:

- *The powerful influence of habit*. Rather than consciously weighing the costs and benefits of alternative courses of action, we operate largely according to previous patterns of behaviour and habits. This is especially the case when it comes to our food choices, when deliberative and conscious choice is typically over-ridden by habit and emotion. This can lead to the individual choosing something they know not to be in their own (long-term) self-interest.
- *The effect of our peers and social norms*. We do not make decisions as individual actors; our social context – and what our peers think and do - is important to us. The furthest reaches in this literature concern social networking theory and the social transmission ('catching') of obesity[44] from other people.
- *The effects of framing choices and 'priming'*. The way information and choices are presented to us affects the result in a way that does not seem rational (e.g. yogurt is more appealing to us if marketed as being '95% fat free', rather than being '5% fat'). We are also loss averse and framing choices as potential gains or losses also affects our decision making. Similarly, and potentially most controversially, we can be subconsciously 'primed' towards certain decisions / actions[45].
- *Our attraction to the default option*. Especially when faced with complex choices, we tend to 'not choose' and go with a default option (which is related to habit).
- *The effect of the source of our information*. We do not necessarily objectively evaluate information, but use the source as a shortcut to assessing its usefulness; we are especially influenced by their perceived authority and 'similarity' to ourselves.
- *The way we discount future benefits*. All things being equal, we prefer a benefit now to the same benefit at some future point (and the reverse for costs). This is standard economics and is the basis for interest rates, but what BE seems to show is that when it comes to exercise and diet we tend to systematically and greatly undervalue future health benefits and favour immediate gratification[46]. The result of this is a tendency to inaction and procrastination on beginning exercise programmes or improving our diet[47].

---

decisions: this is relevant given the age profile of Living Well beneficiaries and the weight of evidence behind early intervention.

[43] Richard Thaler is part of the Cabinet Office Behavioural Insights Team

[44] Christakis, N (2007) *The Spread of Obesity in a Large Social Network over 32 Years*. The New England Journal of Medicine, July 26th 2007

[45] By way of an intriguing example, in one experiment people asked to write about the last time they ate soup then went on to consume twice as much soup as the control group over a subsequent two week period. Wansink, B., Deshpande, R. (1994), *Out of sight, out of mind': the impact of household stockpiling on usage rates*, Marketing Letters, Vol. 5 No.1, pp.91-100

[46] This factor plays an important part in the case for government intervention in the case of obesity in adults - see McCormick, B et al (September 2006).

[47] For example, a report for Sport England – Foster et al (2005) *Understanding Participation in Sport – A Systematic Review* – suggested that between one and two thirds of people are in a state of 'chronic contemplation' over doing more physical activity.

None of the above is to deny the influence of more structural factors – such as economic and social inequalities[48] - and to suggest that health outcomes are exclusively the result of individual choices that can be 'manipulated' as such. There is also the ever-present question of the extent to which findings from experiments (where much of the BE evidence comes from) can transfer into the real world (we return briefly to this issue below). Rather, what BE seems to offer is some additional insight that can be used at the margins to support people in their desire to make healthy choices; as one of the authors in this field concludes:

> *"...behavioral economics provides a new tool to design policies that can resolve problems where an individual's own decisions do not fully account for their well being. Policy makers must be careful when applying these tools to preserve individuals' free will. This can be accomplished by making subtle changes in decision contexts that individuals themselves may not recognize as having an impact."* [49]

7.2.3 The 'MINDSPACE' framework provides a richer understanding of behaviour change. Some of the Living Well projects provide examples of ways in which it can be put into practice

Many of the factors described above have been summarised in the 'MINDSPACE' framework by the Behavioural Insights Team in Cabinet Office[50], as shown in the Figure below.

[48] See the work of Sir Michael Marmot, and Richard Wilkinson / Kate Pickett.

[49] Just, D & Payne, C (September 2009) *Obesity: Can Behavioral Economics Help?* The Society of Behavioral Medicine

[50] The framework is described in detail in this report: Institute for Government and Cabinet Office (March 2010) *MINDSPACE: Influencing behaviour through public policy*. 'MINDSPACE' is then applied to health in a more recent discussion paper: Cabinet Office (December 2010) *Applying behavioural insight to health*

Figure 7.1 ‘MINDSPACE’ as a framework for behavioural change

Messenger	Our responses to messages are affected by our relationship to the person delivering them. We are most influence by people we see as having specific expertise – and also by people who are ‘similar’ to us in demographic and behavioural terms.
Incentives	Economics has long shown that incentives matter. More subtly, we: dislike loss more than the equivalent gain; over-estimate small but significant probabilities; and – of pertinence to obesity – prefer small rewards now to larger gains later (to an ‘irrational’ degree).
Norms	We are social creatures - not individual, calculating agents. Our behaviour is affected by the groups we belong to and their formal and informal rules of behaviour. These ‘norms’ can be transmitted through networks.
Defaults	Especially when faced with a complex set of choices, we tend to opt for the default option. This is important in situations where the default can be ‘manipulated’ to promote desirable outcomes (while retaining choices).
Salience	We are attracted by novel and simple things. Given the competing claims on our attention, messages relating to behaviour change must distinguish themselves. Making messages salient to our personal experiences is an effective way of doing so.
Priming	Our behaviour can be subconsciously influenced by cues in our environment. These might be smells, sounds, sights – and they affect our responses and behaviours. This can be controversial, especially given the potential for ‘manipulation’.
Affect	Our decision making can be affected as much by feeling as by reason. This then affects the way we respond to information.
Commitments	The act of committing to a behaviour increases the likelihood that we will ‘go through with it’. This is especially the case where the commitment is made publically. We also have a strong instinct to reciprocate – to ‘pay back’ investments made in us by other people.
Ego	We like to think of ourselves as consistent, and being able to do so makes us feel good. This can be helpful to behaviour change – small initial changes in activity may lead to bigger changes as we try to maintain this consistency. This is a challenge to the model of changing minds first and behaviour later.

We can use this framework as a means of highlighting areas where approaches developed under Living Well address these elements. This is not done as a means of ‘evaluating’ Living Well against each criteria, it is a means of pulling out examples of practice from within the programme that accord with the framework. Moreover, it is not the intention to present a set of ‘proven’ interventions. Rather, the aim here is to offer examples of ‘promising practice’ – projects where there is good reason to think that the approaches taken have been effective in these areas. .

Figure 7.2 The MINDSPACE framework and examples from Living Well

Element of Framework	Examples from Living Well
Messenger	Living Well projects have shown the value of using people 'like' the beneficiaries they are working with to deliver messages and support behavioural change. Notable examples here include the Dove mentoring project, which used minority ethnic mentors to work in 'similar' communities – using their cultural understanding to empathise with and support beneficiaries. Changes, the organisation that led the Wellbeing Workshops, also has a 'user-led' approach; many of their staff have experienced mental health problems, which seems to add to the salience of the messages they provide.
Incentives	Living Well projects did not in the main make use of incentives.
Norms	Use of norms was a key factor in Living Well project's approach to promoting behavioural change. The main approach here was in the use of group activities and the use of group norms to affect individual's behaviour. Parklife is a good example here – beneficiaries developed informal group rules – for example about still turning up in bad weather – and the group would 'self-police' these rules, ensuring a good take-up of the walks. Other projects worked with families as a unit – Herefordshire and SHINE for example; in these cases, the aim was to change norms within the family to adopt healthier behaviours.
Defaults	Defaults were not widely used within the programme. The SHINE project attempted to use the results of the National Child Measurement Programme – to have the project as the default in the event of pupils falling within a given threshold, but this was not put into place during Living Well.
Salience	Several projects worked to try and make their messages novel and salient to their beneficiaries. Projects working to improve diet - Nutrition Training and Action for Wellbeing in Warwickshire for example – used practical demonstrations of the content of fat, sugar and salt to show beneficiaries the ingredients in their food, rather than using more abstract methods.
Priming	Priming was not a commonly-used technique within Living Well, except perhaps for projects that made use of nature / outdoor settings to then promote messages around mental wellbeing. This was used in Herefordshire, and also Sharing Spaces. In a related way, Wellness Works used a training environment and courses on HR legislation to address mental wellbeing – framing the issue in a very particular (and successful) way.
Affect	Having fun was a key approach to behaviour change within Living Well. This was used in many projects, such as SIFA Fireside, Living Well Stoke, Wellbeing for Life, Farm to Fork and Healthy You! Being Well in Sandwell had a very strong emphasis on the enjoyable aspects of physical activity (e.g. through the Street Dance classes) and healthy eating (through the community cafe). Indeed, very few projects in the programme sought to change behaviour through a deliberative or 'rational' approach – most were practical, hands-on and enjoyable.

Element of Framework	Examples from Living Well
Commitments	A small number of projects used commitment devices to increase the likelihood of behaviour change. Coventry Body and Mind, for example, used 'Wellbeing Plans', which were put together in conjunction with their service users, as a means of getting beneficiaries to commit to changes in specific areas, supported by the project. Body and Mind also operated (and publicised) a 'three strikes and you're out' policy to enhance users' commitment to attend. Other projects, such as Dove Mentoring and Women in Motion, used the commitments engendered in relationships between staff and beneficiaries to get people to commit to change.
Ego	As noted in relation to 'Affect', projects were typically practical, action-oriented and fun. In the main, beneficiaries were encouraged and supported in a positive sense as a means of helping them to adopt healthier behaviours. The Priority Care project, for example, used social activities such as trips out and befriending as a means of supporting isolated older people. The relationships established between staff and beneficiaries were also cited as being central to the behavioural changes seen through the project.

8 Final Conclusions & Recommendations

This final section begins by setting out the overall conclusions from the evaluation. Having done so, we then turn to our recommendations. Because the programme has finished – and so detailed, practical recommendations on programme development are not therefore available - these recommendations are broad in scope.

Our main conclusions are that:

- Living Well was established under the BIG Lottery 'Wellbeing Fund'; it has addressed the three main themes of that Fund – giving particular emphasis to mental wellbeing, but also examining the links between the three themes. The approach taken to 'wellbeing' is therefore broad and holistic. This is in keeping with the definition of the concept in academic discourse and policy development. Living Well therefore offers some potential lessons in addressing an important set of questions in current policy.
- The total level of resources used across the whole programme was around £8.6 million. BIG Lottery funding accounted for by far the majority of this, but Living Well projects also 'levered in' other resources. Most significantly, around £1.2 million of resources were provided 'in-kind' – through volunteer time or donations of other 'free' resources.
- The implementation of the programme improved over time. The first year was 'slower' than perhaps expected, as projects encountered a range of challenges in establishing their services against a short lead-in time. Years 2 and 3 saw improved delivery. The 'typical' beneficiary was female, young and 'White British'; this profile is largely an artefact of a few high throughput projects. Services were also very largely additional (i.e. were 'because of' Living Well) and were provided at a cost that compares favourably with analogous programmes.
- In delivering services, nearly all projects performed well. A range of challenges were encountered and projects evolved a series of ways of addressing them. Some of the most effective approaches in relation to implementation included: simple project designs; tailoring services to specific groups; providing high-quality support to volunteers; and, working closely in partnership at local level. Several challenges remained however - most notably in engaging with mainstream health services and with some private sector employers.
- There are methodological and practical problems inherent in quantifying outcomes in a programme like Living Well. Nevertheless, nearly all projects produced good data. This showed that: around 6,500 people increased their levels of physical activity; 6,000 had improved their mental wellbeing; and 3,000 improved their diet. There were also a series of substantial improvements in labour market / workforce related outcomes. In achieving these outcomes, the 'active ingredients' of Living Well included: using social contacts and opportunities to improve wellbeing; working with families (rather than individuals) to improve diet; using an 'holistic' approach to wellbeing (not isolating physical activity from mental health or healthy eating); and, the quality of relationships between project staff and beneficiaries.
- 'Sustainability' is a somewhat complex notion when considering Living Well projects. Very few will continue in the form established under the programme, but the majority of services will continue in some guise. The main routes to sustainability included: approaching mainstream commissioners; personal budgets in social care; accessing other grant funding; and, charging for services. Moreover, accepting a range of substantive barriers – most notably in relation to public spending cuts and service re-organisations - the emerging policy agenda is very favourable to Living Well projects.
- Living Well also highlights a broader set of issues and lessons. Principally, these lessons relate to the ways in which BIG Lottery funding is administered in a programme such as this (e.g. in setting targets; where BIG Lottery or government funding ought to be used; in monitoring progress, and, more detailed lessons on the bidding process); and

also in terms of promoting behavioural change, where Living Well projects offer examples that correspond to current government thinking.

And, based on these conclusions, our recommendations are that:

- The current broad emphasis on wellbeing should continue. Accepting the problems of having somewhat 'fuzzy' definitional boundaries, the concept of wellbeing allows for a broad range of health issues to be addressed in a positive way. Most notably, framing services as being about 'wellbeing' enabled many projects to address mental health problems in a way that talking about 'mental health' does not.
- Programmes and projects similar to Living Well should measure 'in-kind' support. This provided a means of both recognising this contribution (especially that of volunteers), and of showing the comparative advantage of the voluntary sector in delivering these services.
- Projects within a time-limited programme should be screened at bid stage for 'deliverability'. The main question here should relate to the simplicity of the project design, and the focus should be on having as few 'moving parts' as possible. BIG Lottery and other funders should also note the lifecycle of Living Well (and similar programmes); this should principally be in relation to the time services take to become established. There is also learning in highlighting the typical problems encountered along the way. For example, the challenges of engaging with employers and mainstream health services (and GPs in particular) are well documented. Again, this knowledge could be used – perhaps to provide some constructive challenge and improve project design at bid stage.
- BIG Lottery and other funders should note the particular success of volunteer-based approaches, both in terms of promoting wellbeing (of volunteers and beneficiaries) and also in terms of the labour market related benefits. The success of approaches based upon increasing people's opportunities to socialise and have fun should also be noted.
- In promoting project sustainability, the support provided by the Living Well programme team was valuable. It is also unusual within a programme of this type. This provides an area where funders can build upon the experience of Living Well to offer programmes of support – especially to smaller voluntary sector organisations – as they deliver projects. This support could be staged, using the project lifecycle as a structure: moving from design to set-up, from implementation to promoting outcomes, and into disseminating lessons seeking sustainability.
- BIG Lottery should examine the possibility of providing clearer guidance in the areas identified by Living Well. Chiefly, this should cover areas where definitions then go on to affect performance management arrangements – such as beneficiary and outcome targets. BIG should also examine the issue of sustainability. It is not clear from the experience of Living Well whether there is an expectation from BIG that funded projects are expected to continue and – if there is – the means by which this is expected to happen.
- The Living Well programme team should disseminate the learning from this report and their experiences as much as possible in the short time remaining to the programme.

GHK

ANNEXES

Annex 1 Interviewees

The following people were interviewed for this report. GHK extends thanks to them for their participation – and to those interviewed for previous reports

- Alan Crawford
- Ali Mohammed
- Alice Blakemore
- Alice Verlander
- Amanda Wright
- Armanda Winwood
- Andrea Muirhead
- Angie Abraham
- Ann Hart
- Ann McLeod
- Ann Seymour
- Becky
- Beverly Slowly
- Caley Moyer
- Carole Fox
- Claire Lojko
- Clare Wichbold
- Craig Perry
- David Elliot
- David Healey
- Denise Vitorino
- Diane Addis
- Diane Gay
- Gayle Webster
- Gloria Rye
- Graham Bailey
- Helen Davis
- Helen Garbett
- Holly Penwarden,
- Janet Chand
- Jayne Longfield
- Jo Sartori
- Joe Penfold
- John Dews
- John Gibson
- Joyce Grundy
- Justin Haywood
- Karen Humphries
- Kate O'Hara
- Kate Tudge
- Kerry Gordon
- Kim Braznell
- Kirsty Leatherbarrow
- Leslie Stanley
- Mark Lowndes
- Mary Staples
- Mel Charters
- Mel Parker
- Melanie Baker
- Michael Rossington
- Miranda Ashwell
- Nicki Evans
- Nicky Bancroft
- Nicky Burns
- Nikki Gill
- Paul Dodd
- Patricia Bussell
- Pundeep Kaur
- Raj Chahal
- Ravi Ruberu
- Russell Cartwright
- Sally Elliot
- Sarah Redpath
- Stacey Jones
- Sue Edmunds
- Sue Cook
- Susan Jones
- Suzzane Gardner
- Yasar Riaz
- Zena Lynch

Annex 2 Topic Guides

Project Staff, Regional Stakeholders and Local Communication Leads

1. Please describe the way your project has progressed over this final year
2. Thinking about the project over its entire lifetime, what are the main lessons you have drawn in relation to implementation?
3. Please describe the main outcomes from your project in relation to:
    - Beneficiaries;
    - Your organisation; and,
    - Local services / other wider effects.
4. What are your reflections on the way you monitored and evaluated your project? Do you require any support to fulfil the requirements of the final monitoring return?
5. What lessons have you drawn in terms of promoting outcomes?
6. What are your views on the regional-level support structures that were put in place for projects? i.e., the: Local Communication Leads; Regional-level programme management; PR support; Evaluation support; and, Specific support to projects around sustainability (e.g. workshops, bid writing support).
7. Is there any other support that you would have valued as part of the programme?
8. Having almost completed your Living Well project, what are your reflections on its original design? What – if anything - would you change if you could set out to deliver the project again?
9. Please describe the work you have done to try and sustain your project. Has this been successful - will your project continue once the Lottery funding has ended?
10. Do you have any recommendations you would like to make to BIG Lottery, or the Living Well management team?
11. Finally, do you have any further points you would like to make in relation to the topics discussed, or are there any other issues you would like to raise?

Beneficiaries

1. Please describe the way you became involved with the project
2. Why did you become involved?
3. What were your initial impressions of the project?
4. What have you done during your involvement?
5. What are your views of this involvement?
6. Do you think that the project has made a difference to you? If so, please say how; if not, why do you think this is?
7. Would you recommend this project to others?
8. Are there any ways you think the project could be improved? If so, please say how.
9. Finally, do you have any further points you would like to make, or are there any other issues you would like to raise?