South West Well-being Evaluation: Adding Value

Contents

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Abbreviations

CVS	Community & voluntary sector
HLC	Healthy Living Centre
PSSRU	Personal and Social Services Research Unit
SWWB	South West Well-being programme
UWE	University of the West of England, Bristol

Executive Summary

Overview

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

This second of three evaluation reports on the programme focuses on the nature and extent to which SWWB projects add value to local service provision. Added value can be defined as the additional benefits gained as a by-product of a service or project, which would not have occurred, had the service or project not gone ahead.

Using a mixed methods approach, we drew upon a variety of forms of evidence including records of service users registering with projects, a regional survey of practitioners in partner agencies, unit cost analyses and case studies.

The Service Users of South West Well-being Projects

The records of 2007 service users registered with ten projects[1] show that people participating in SWWB activities include a wide spread of age groups and other demographic characteristics such as employment, housing and family status.

Seventy per cent of the service users are women and 40% are aged between 25 and 54 years of age. Twenty three per cent are in some form of employment and 21% are retired. Just over 1 in 10 service users report that they are seeking work. In terms of domestic status, the largest group of service users are single people living alone (17%). Forty one per cent own their own home.

Whilst participants come to take part in SWWB activities through a variety of routes, personal networks and project publicity play key roles. Formal referrals and recommendations from professionals appear to be less significant. Forty per cent of participants hear about the project through word of mouth, for example through a family member or a friend. Twenty per cent hear through a health professional or agency or another statutory or voluntary sector agency.

Somewhat fewer people (15%) describe themselves as being formally referred by professionals from partner agencies. Forty seven per cent described themselves as 'self referrals'. Early data indicates that individuals formally referred may have higher levels of need compared to individuals who come to participate in project activities through informal routes.

[1] For projects where data is not reported on, all are collecting service user records but are not in a position to provide a full set of data at the point of producing this report.

SWWB projects are by no means alike. Some projects clearly rely upon informal community networks whereas, for others, formal links with practitioners in partner agencies have much greater significance.

The personal goals of participants reflect the main themes of the programme, although more seek to improve mental well-being than physical activity or improve healthier eating. Data on self reported outcomes using the pre- post- SWWB Well-being questionnaire is currently being collected and will be presented in the third evaluation report.

Perspectives of practitioners from partner agencies

Out of 310 questionnaires sent out, 173[2] (56%) practitioners responded from agencies operating in the same areas as SWWB projects. There was an average of just over 13 responses from each project. Out of those who responded there was a fairly even spread between those in NHS, Local Government and Third Sector agency employment.

The responses show that SWWB organisations have partnership links that span a wide range of fields and all sectors. Most, but not all projects, have established links with NHS GP services. Thirty one per cent of practitioners stated that their agencies share information with SWWB staff about service users and share venues for delivery. Seventeen per cent of partner agencies have started to engage in formally contracting SWWB services.

Of those who were aware of the SWWB programme, 71% of practitioners have recommended SWWB activities to their service users. Fifty nine per cent stated that they had formally referred their service users to SWWB activities. There was no significant difference across service sectors in terms of patterns of recommendation. However, NHS practitioners were more likely to formally refer compared to those in local authority and third sector agencies (71% cf. 44%). Conversely, recommendations and referral *from* SWWB staff to partner agencies were received by fewer respondents (35% and 28% respectively).

Practitioners indicated that there are effective links between SWWB projects and their agencies. For example, 75% thought that communication between staff was either good or excellent. Overall, 69% practitioners felt informed about aspects relating to SWWB target groups and the aims of project activities (77%), and how the activities fit with local services (64%). Fewer respondents (59%) felt well informed about the outcomes for participants in SWWB services. This trend was stronger for NHS sector respondents.

Nevertheless, written feedback showed that respondents receive very positive anecdotal feedback from individual service users and often have a good level of trust in the quality of SSWB provision. This feedback provides examples of highly significant outcomes for individual service users. These successful cases are also of considerable assistance to the wider goals of partner agencies in terms of preventative work, rehabilitation, enriched care or learning and so forth.

[2] As of 8th March the total is 176

Practitioners are in general agreement that SWWB activities complemented other services and fill gaps which otherwise would not be filled. Practitioners both in the NHS and other sectors share the same positive views about the role of SSWB projects in supporting NHS preventative services. However, there was a common impression that neither the local community nor the local statutory bodies were aware of the project activities.

A majority (54%) were of the opinion that there were opportunities for closer working between their agency and their local SWWB project. Those who do not *recommend* individuals to SWWB project activities are less likely to believe that there are opportunities for closer working. The written feedback presents a picture of frontline services working under pressure in which the scope for closer links with preventative and community agencies is clearly desirable to practitioners.

Case Studies

Case studies of three initiatives illustrate how SWWB is delivering work on improving mental well-being, physical activity and healthier eating in association with a range of local statutory agencies. They demonstrate how SWWB services have developed mature cross agency links in which the benefits to practitioners are evident in terms of the concept of 'added value'.

The case studies highlight the breadth of referrals and the complexity of identifying the advantages for beneficiaries, both short- and long-term, as well as the overall benefits to the partner agencies.

Unit Costs

Using a nationally recognised approach, unit costs were calculated for eleven services including open access groups, rapid response provision and one-to-one intensive mentoring.

SWWB activities show a wide range of unit costs from £3.29 to £96.30. These costs reflect the level of specialism, intensity and personalisation of the service. Higher cost services correspond to higher client needs, the professionalism of the service and the health outcomes intended. Lower cost services tend to be group based activities engaged in preventing ill health and promoting wider aspects of social well-being.

Unit costs for multiple aspects of provision give an insight into 'whole service' operations whilst costing for individual services offer a platform for developing a detailed understanding. These levels of analysis are different and are likely to be of value when internal and external stakeholders wish to consider options for developing services.

Simple comparisons with statutory sector provision are not advisable owing to the complexity of factors that need to be taken into account when unit costing. Nevertheless, it appears evident that aspects of SWWB service provision represent good value for money.

Conclusions and Recommendations

Further evidence on the well-being outcomes for participants will be presented in the next evaluation report. This will provide a fuller basis for analysing the value added to local services. Drawing upon the findings in this report, a number of recommendations arise. These include the need to share evidence of uptake and service use with partner agencies on a regular basis; the importance of gathering and disseminating self report and other forms of outcome evidence; work to market and refine the theory base of SWWB services; the further development of the unit costs approach; and the scope for developing further case studies of best practice. Work towards these ends can help SWWB organisations achieve their goal of local health collaboration.

1. Overview

1.1 Introduction

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

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

This is the second of three evaluation reports on the South West Well-being programme. The first report was produced in March 2009 and the third report is planned for Autumn 2010.

1.2 Aim & Objectives of this Report

This report focuses on the nature and extent to which SWWB projects add value to local service provision. The objectives of the report are to:

1. analyse the demographics and the routes by which beneficiaries come to take part in SWWB activities,
2. examine the perspectives of practitioners in partner agencies of their knowledge, awareness, attitudes and working relationship with SWWB activities,
3. drawing upon case studies, explore how SWWB projects can contribute to the work of partner agencies,
4. analyse the unit costs of selected SWWB activities using a nationally recognised approach for costing in the statutory sector,
5. identify central themes in terms of how SWWB projects might add value to local services,
6. produce recommendations for projects and the SWWB programme in the next stages of delivery.

1.3 Audience for this Report

This report is intended for practitioners and decision-makers from both the statutory and third sectors with an interest in community-based promotion of health and well-being. The report is of interest to those working in the local project areas and in regional development in the South West of England. This report will also be of interest to individuals associated with the Big Lottery funded national and regional well-being programmes.

2. The South West Well-being Programme

2.1 Big Lottery Well-being Fund

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

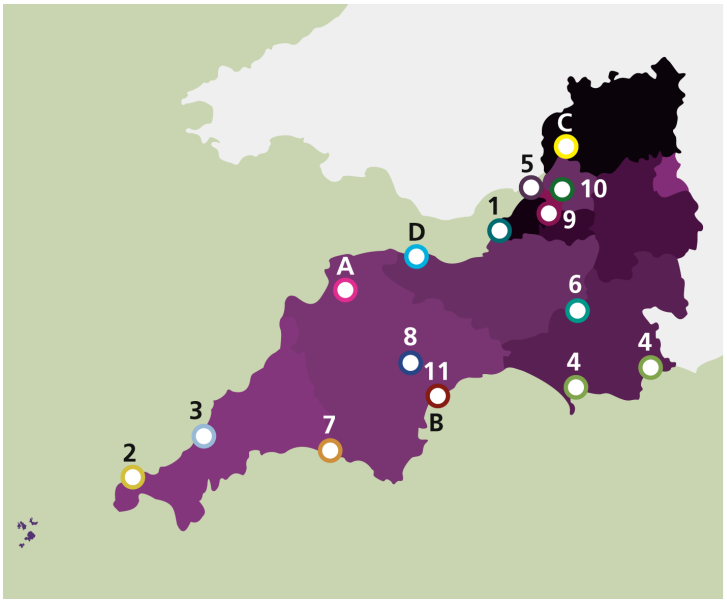
- healthy eating
- physical activity
- mental health

Between 2006 and 2008 the Fund issued grants to 17 Portfolios, seven of which are thematic portfolios managed mostly by charities or coalitions of charities and ten which are regional portfolios mostly managed by statutory organisations. South West Well-being differs in this respect as a regional portfolio managed by a voluntary sector organisation. The regional 'portfolio' funding model reflects an approach developed by the Big Lottery Fund to issue larger scale grants to a single managing body, which in turn devolves funding to a number of local project providing organisations.

2.2 South West Well-being Portfolio

"South West Well-being: a healthier way to live" is a Big Lottery supported region wide programme. At the local level partners contribute varying amounts of match-funding or in-kind support for the programme.

Westbank Healthy Living Centre is the lead management organisation for the portfolio. In the first phase of delivery eleven projects across the region were funded under the scheme. Ten of the eleven projects are hosted by voluntary sector organisations. In the first year of the programme, 'seedcorn' grants were awarded to four further organisations in the South West to deliver well-being projects. .



South West Well-being Programme

First eleven projects:

1. **Mental Health for All**, For All HLC, Weston super Mare
2. **Pathways to Health**, Cornwall HLC, Penwith
3. **Step by Step**, Cornwall & Isles of Scilly HPS
4. **Activate Your Life**, Healthy Living Wessex, Dorset
5. **Lawrence Weston Health Steps**, Barrowmead HLC, Bristol
6. **The Well-bean Project**, Balsam Centre, Wincanton
7. **Health Matters in Plymouth**, Plymouth
8. **Health Maps**, Upstream HLC, Crediton
9. **Pathways to Health**, Knowle West Health Park, Bristol
10. **Wellspring Community Kitchen**, Wellspring HLC, Bristol
11. **Westbank New Steps**, Westbank HLC, Exminster

Four additional 'seedcorn' projects:

A. **Children's Activities & Support Programme**, Community Action, Barnstaple
B. **5x30 Devonwide**, Westbank HLC, Exminster
C. **Be Healthy Be Happy Gloucestershire**, Gloucester
D. **Living Well-West Somerset**, West Somerset Leisure Trust

Figure 1: South West region and SWWB projects.

2.3 South West Healthy Living Alliance's strategy

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

In 2006 SWHLA produced a strategy document, "Well-being in the South West: a healthier way to live", that defined its vision for community-based service development in the south west:

> *"The Vision is to improve the health and well-being of the most deprived communities within the South West over three years with projects that will provide an holistic service, aiming to reduce health poverty by targeting those with low level mental ill health, those approaching older age and families by improving mental well-being, increasing physical activity and encouraging a healthy diet.*
>
> *The portfolio aims to achieve this through engaging with the target beneficiaries with fun, non-threatening activities and then supporting them to make positive lifestyle changes, depending on their needs and wishes. Focusing on reducing stress and anxiety and increasing physical activity and healthy eating, all activities*

will include confidence building and encouraging the development of friends and social networks all contributing to improve mental well-being. […]

In all, this approach might be described as:
Supporting the healthy living and well-being of individuals and communities by providing locally accessible, people-focused and holistic approaches to tackling health inequalities particularly for those people most in need.

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

- ***Engaging Individuals and Communities***
  To improve the opportunities for mobilising community and individual activity towards improving health and tackling inequalities;
- ***People and Lifestyles***
  To support people in meeting their full potential, helping them better access mainstream and alternative health services and particularly to develop lifestyle approaches that prevent future illness;
- ***Local Health Collaboration***
  To provide a local focus for bringing together health promotion in the broadest sense, across a wide range of interests, which do not necessarily have a tradition of working together.

3. Context

Added value can be defined as the "additional benefits gained as a by-product of a service or project, which would not have occurred, had the service or project not gone ahead. Sometimes this is referred to as 'additionality'" (Jackson & Smith, 2008:53). The added value that Community and Voluntary Sector (CVS) health and well-being services can bring has been an increasing focus of interest in recent years. Many commentators have suggested that CVS health and well-being initiatives can play an important role in supporting statutory sector agencies and existing mainstream providers (Hills et al: 2005, Jones & Kimberlee: 2004, Platt: 2005). From the perspective of these agencies some of the benefits can include:

- ***Prevention***. By supporting health and well-being, CVS initiatives may reduce the need for individuals to seek more intensive or specialised services and benefits.
- ***Access****.* CVS initiatives can help individuals get the services they need by matching needs to appropriate mainstream services.
- *Complementary support. CVS initiatives may be able to offer support* that runs alongside, and enhances, mainstream services.
- ***Alternatives****.* CVS initiatives may be able to provide local alternatives to mainstream services that meet individual preferences.
- ***Transfer****.* CVS initiatives may be able to offer ongoing, longer-term or rehabilitation support for individuals exiting mainstream services.
- ***Capacity****.* CVS initiatives may help to strengthen communities and social networks to develop informal alternatives to formal services. In doing this they may also enable individuals to have greater independence from mainstream services.
- ***Multiplier effects****.* Similarly to building community capacity, CVS initiatives may catalyse new projects through attracting further external support or bringing together new partnerships.
- ***Innovation***. CVS initiatives may be well-placed to innovate or pilot new services that can then be adopted more widely.

Whilst these are benefits that can be considered over and above the core outcomes for CVS health and well-being services, it is also evident that there may be some drawbacks. CVS health and well-being initiatives work in a complex local service economy and there may be circumstances where they do not add value. Some of these circumstances include:

- ***Duplication****.* CVS initiatives may duplicate existing services that are already meeting needs.
- ***Substitution****.* CVS initiatives may take the place of existing provision without any net gain for a target group or area.

- ***Displacement***. CVS initiatives may draw resources away from existing provision, including provision from outside the target area.
- ***Leakage***. CVS initiatives may deliver services to individuals outside the target group or area. Whilst these services may have benefits for their participants, they may be failing to address local priorities.
- ***Complexity***. CVS initiatives may introduce layers of complexity into local service provision that generate problems with efficiency, coordination and access.

Guidance from English Partnerships regarding additionality has emphasised, therefore, the need to consider both potential strengths and drawbacks in any evaluation:

> *"Most projects will have both positive and negative impacts. In appraising the effects of a project it is important that all of these are taken into account in order to assess the additional impact or additionality of the project – in other words, the net changes that are brought about over and above what would take place anyway." (English Partnerships, 2004:3)*

For CVS health and well-being initiatives it is often not possible to determine what would happen in their absence or to locate suitable reference cases, or locations, for comparison. It is not surprising, therefore, that there has been little research to date about the additionality of these projects. Nevertheless, exploration in this field is important. Local commissioners and service planners need to be able to make evidence-based judgements on the potential dividends – or lack of them – when looking to invest in CVS services that are not currently available within the statutory sector or from established CVS providers. With this view in mind, the current study seeks to draw upon a range of data sources to investigate added value in relation to SWWB services.

4. Methods

4.1 Rationale

For evaluation, according to Green and South (2006:84), an overarching question is how to apply evaluation principles in a way that is consistent with the nature of the activities and the values that underpin programme delivery. The approach adopted in this report has been to explore the additionality of SWWB services by drawing upon a variety of forms of evidence. This mixed methods approach (Tashakkori & Creswell: 2007) intends to reflect the richness and many layered character of the programme. The study consists of an analysis of project beneficiary monitoring records, a survey of the perspectives of practitioners in local partner agencies, case study illustrations and evidence of service economics. These multiple data sources are intended to enable an analysis of added value from a range of perspectives.

4.2 Profile of SWWB service users

The majority of the SWWB projects use a common approach to recording the demographics and service user characteristics of their beneficiaries. Individuals who take part in activities are asked to complete a standard registration form. The data from this are then entered onto a standard SWWB Microsoft Access database system. Staff exported anonymised data from this system to the UWE research team for analysis using SPSS.

The value of this data collection and reporting system has been to standardise procedures for organisations that had previously worked independently. It has also enabled project workers to get a broader awareness of the SWWB portfolio. The common approach has developed out of the best practice within the consortium and has been facilitated by the research team.

4.3 Survey of practitioners from partner agencies

For each project we sought to define a list of practitioners that would represent a range of service links and potential service links. Using a standard list, project leads were first asked to identify a selection of approximately fifteen local practitioners that would include representatives from the NHS, local government and third sector services. The researchers then identified a further set of local practitioners who could also have links with the SWWB organisation. Practitioners working for other SWWB projects, or the SWWB project in question, were excluded from the analysis. The sample also sought to exclude practitioners who had a purely strategic or commissioning role, although, in practice, it was not always possible to apply this rule. From the resulting list a total of 310 questionnaires were sent out, with an average of 23 per project (a minimum of 13 and maximum of 32). 172 practitioners returned completed questionnaires, giving a response rate of 55%. A further two

respondents did not meet the inclusion criteria and were excluded from the analysis.

Practitioners were asked to complete a standard questionnaire that included both closed and open questions. The questions covered the following aspects: the character of links with the SWWB service, perceptions of effectiveness and awareness of the SWWB service, the potential contribution of the SWWB service, evidence of outcomes and opportunities/barriers to closer partnership working. A copy of the questionnaire is provided in Appendix A. Each questionnaire included an introduction outlining the specific project in question.

The questionnaire data were entered on to SPSS, a statistical software package. Descriptive statistical analysis was used to present responses to each question, with cross tabulation to explore key associations in the data. Qualitative responses were recorded into Excel and explored using content analysis.

4.4 Case studies

Whilst each project is well placed to present a case study on added value, we decided to select three case studies to exemplify the activity themes (healthy eating, physical activity, mental well-being) for the SWWB programme. From the research team's knowledge of the activities that are taking place across projects we selected three SWWB services that could demonstrate a contribution to the goals of partner agencies – as well as show evidence of supporting the health and well-being of service users. Project staff were interviewed or played a role in drafting sections of each case study. Where possible we also interviewed practitioners from partner agencies. Inevitably, this selection does not profile all the SWWB projects or illustrate all forms of additionality of the programme.

4.5 Unit Costs

The research team adopted a nationally recognised approach for unit costing. Unit costing has not been widely explored in the context of voluntary healthy living services. The approach was initially explored with two of the projects, then rolled out to the other projects that had been in operation since the start of the SWWB programme funding period. We were interested in developing unit costs for established services. For this reason the 'seedcorn' projects were not included in this exercise.

4.6 Ethical issues

Prospective participants were provided with written and verbal information on the study. They were given the opportunity to ask questions about the study, verbally or in writing. Practitioners who completed the questionnaire were assumed to have consented to participate in the study. Individuals were contacted independently by the research team and not by SWWB project staff. All responses have been anonymised for the purpose of reporting. The study has been given ethical approval by the Faculty of Health and Life Sciences Research Ethics Committee of University of the West of England, Bristol (UWE).

5. The Service Users of SWWB Projects

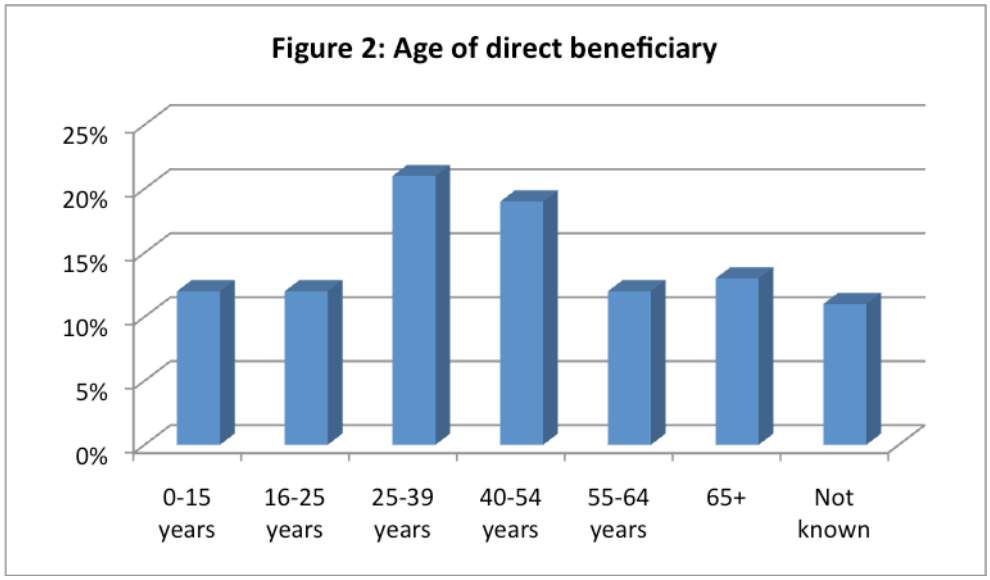
5.1 Introduction

This section outlines the information provided by direct beneficiaries at registration with SWWB activities. Projects submitted anonymised database reports to UWE between November 2009 and March 2010. We have received reports from 11 projects. In total, these projects provided information on 2539 direct beneficiaries at the time of writing. Three seedcorn projects are yet to report. Of the 11 reports received, one project has not currently supplied sufficient information on direct beneficiaries at registration and has been excluded from this analysis. Thus, this section looks at reports from ten projects (N=2007) where most of the required information on registration forms has been collected from direct beneficiaries. This section will outline information on the SWWB portfolio's direct beneficiary profile and their goals.

5.2 Demographic characteristics of SWWB service users

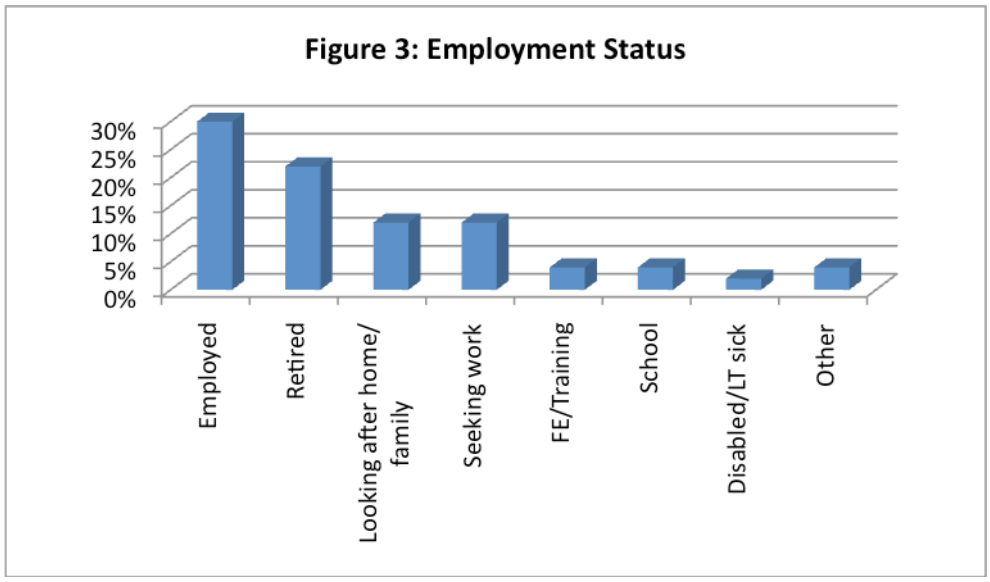
At the time of reporting, 87% (n=1778) of the direct beneficiaries were still active on the project, 7% (n=138) had completed their activity with less than 1% (n=17) reported as early leavers. 70% of the direct beneficiaries are women. Gender differences vary considerably across projects. Westbank HLC's New Steps project report that 40% (n=95) of their direct beneficiaries are male. The Cornwall and Isles of Scilly Primary Care Trust: Step by Step project have only 10% (n=1) who are male. 11% of all SWWB direct beneficiaries self-report a disability with 3% (n=41) reporting that they claim a disability benefit. Almost 3% (n=57) report that they are a carer.

SWWB direct beneficiary age profile shows there is a broad range of ages across the portfolio. 40% (n=800) of the direct beneficiaries are aged between 25 and 54 years of age. One project reports that two beneficiaries are under 5 and all (n=87) of the Upstream Healthy Living Centre: Health Maps direct beneficiaries are aged 65+ years.

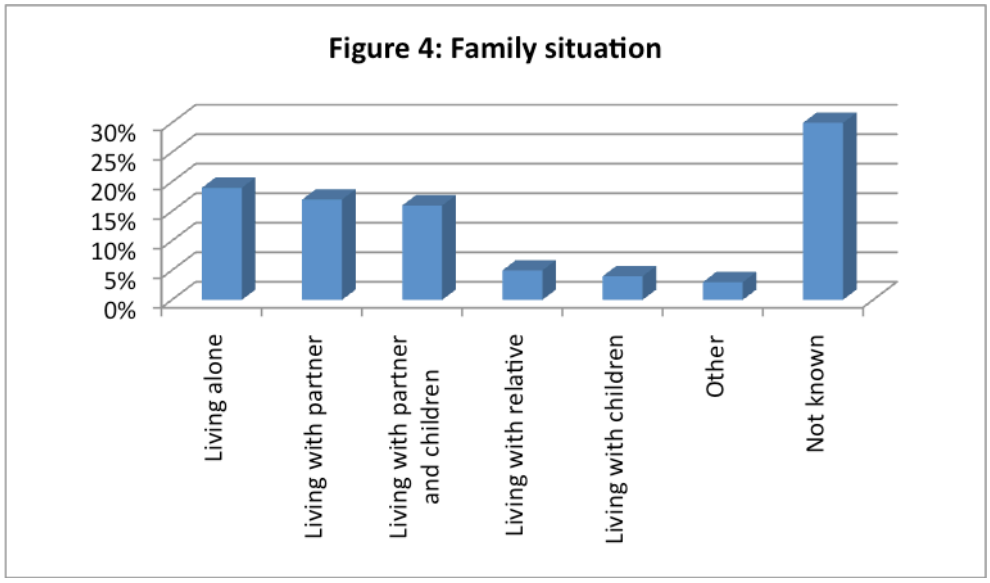


In terms of SWWB's direct beneficiary national and ethnic profile, 98% (n=1975) report English as their first language. 32 direct beneficiaries had an alternative first language including Arabic (n=8), Russian (n=4), Ukrainian (n=2) and Somali (n=2). Most people reported their ethnicity with only 7.4% (n=148) of direct beneficiaries not completing this question. 93.7% (n=1743) of direct beneficiaries described themselves as white. This compares with 97.7% for the South West region as a whole (National Statistics, accessed March 2010). 3.3% (n=63) described themselves as mixed, 1.3% (n=25) as Black or Black British, 0.9% as Asian or Asian British. The three Bristol-based projects and the For All Healthy Living Centre: Mental Health For All project in Weston-super-Mare account for 85% of the non-white population. Two beneficiaries defined their ethnicity as Cornish.

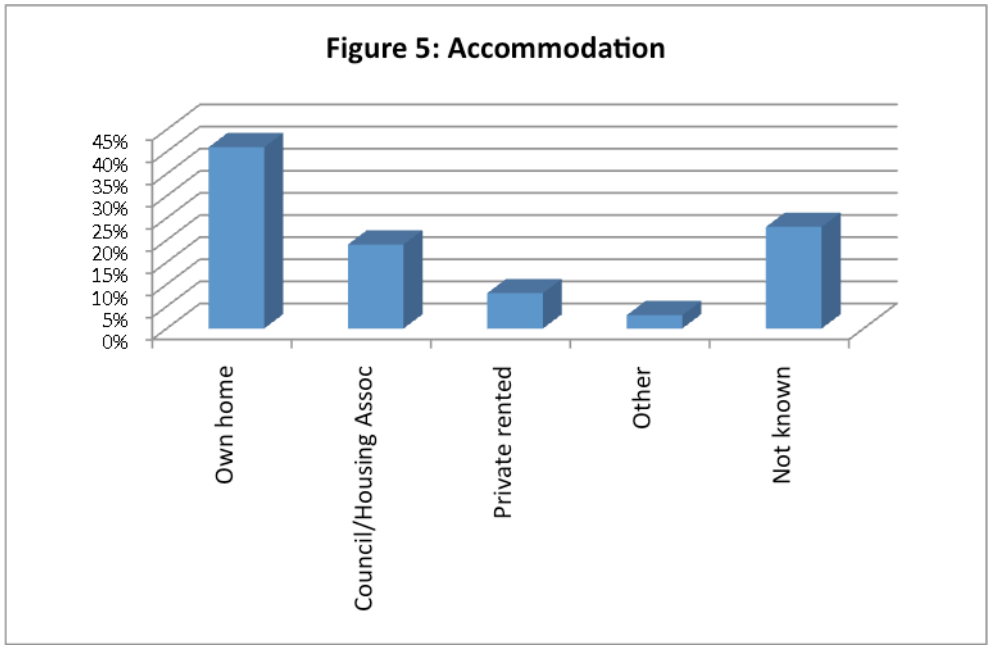
Across the SWWB portfolio employment status of direct beneficiaries varied. A considerable number were in some form of employment (n=466). The second biggest group is the retired direct beneficiary (21%, n=348). But just over one in 10 direct beneficiaries reported that they were seeking work (n=169).



Direct beneficiaries appeared more reluctant to provide information on their familial situation. However, where we do have information, a considerable number of the direct beneficiaries were single people living alone (17%, n=340). However, there was a range of living arrangements which reflects the familial diversity of a broader society: including couples, single parent families and people in residential care.



Beneficiaries were more willing to provide information on their accommodation arrangements. Most owned their own home (n=556, 41%); but the portfolio includes one person who lived in a caravan, three people who were homeless, 12 people who lived in a resisential or care home and 11 people who lived in a family or friend's house.



5.3 Project activities: pathways and project goals

Direct beneficiaries were asked to state how they had heard about the project and who had referred them.

Figure 6 below shows that most people heard about the project through word of mouth e.g. through a family member or friend. The project venue or through the media were also a more likely source of hearing about the project rather than directly from a health professional.

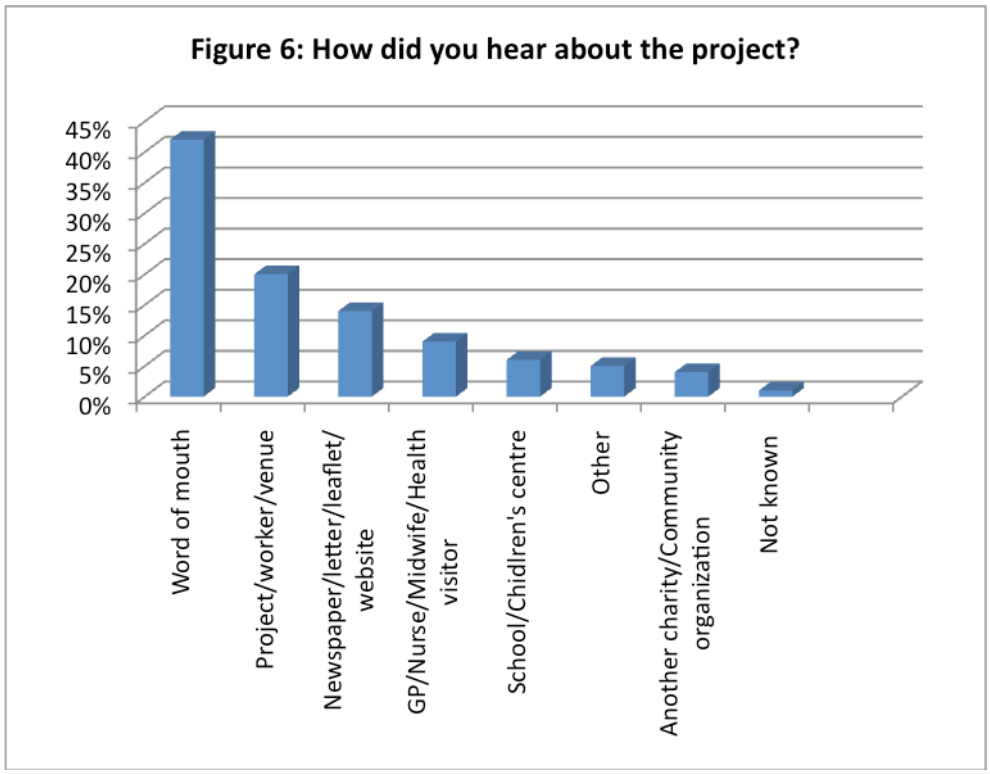
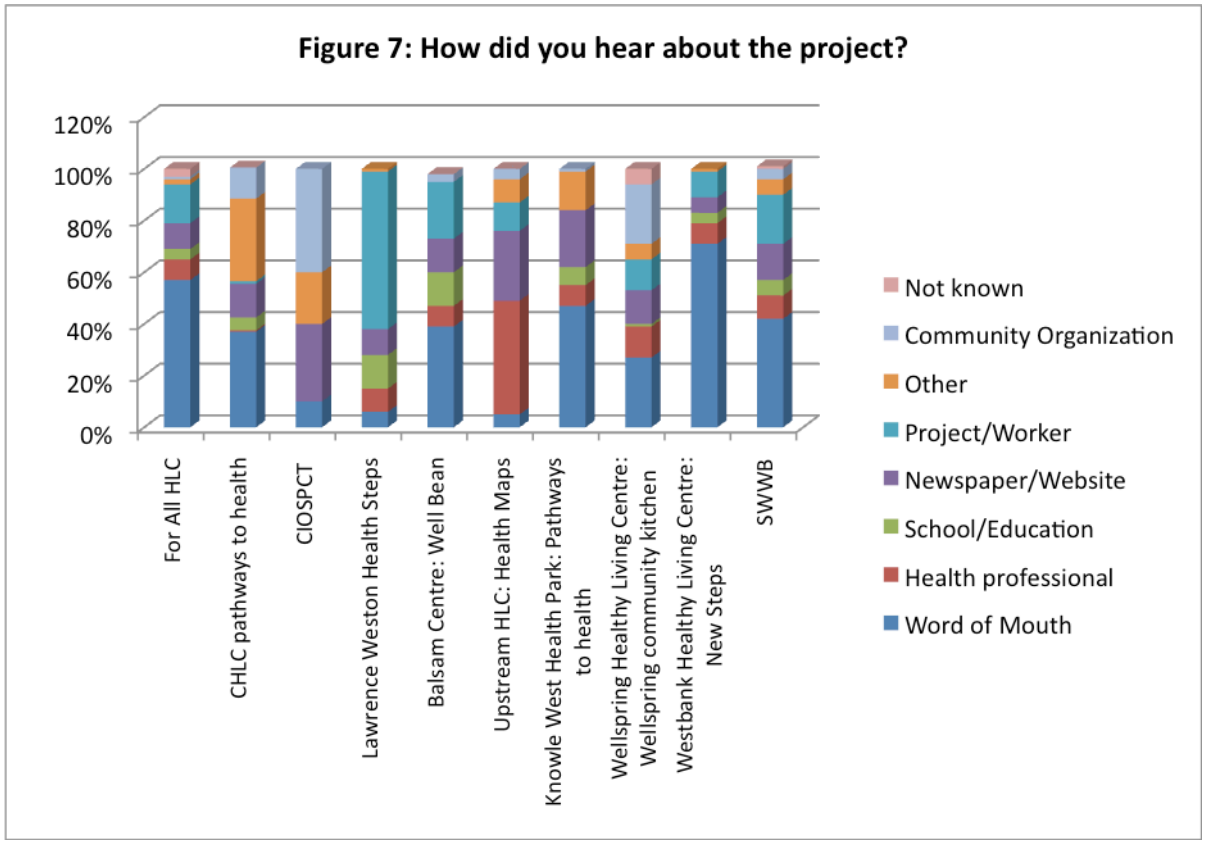


Figure 7 shows that there are some clear differences between projects as to how they were heard of by direct beneficiaries. Word of mouth was the most popular reference for just half of the projects. Lawrence Weston: Health Steps project was more likely to be heard of through the project venue/worker or through an event and Upstream Healthy Living Centre Project was more likely to be heard of through a health professional. Newspaper advert, website or leaflet was how direct beneficiaries were likely to have heard of the Cornwall and Isles of Scilly Primary Care Trust: Step by Step project.



A couple of projects have virtually no referrals from health professionals. Seven per cent (n=20) of Cornwall Healthy Living Centre: Pathways to Health project reported that they heard the project through their website. There was a general tendency for older people to have heard of the project through a professional and younger and middle aged people to have heard of the project through word-of-mouth or newspaper/website.

Figure 8 below reveals that almost half the referrals to projects were 'self referrals' (49%, n= 989). Non health professionals (8%, n=166), like social workers or youth workers, were more likely to refer a beneficiary to a project than a health professional (7%, n= 133). A few direct beneficiaries (1%, n= 28) were referred by family members or friends. Less than 5% (n=86) of direct beneficiaries were referred by someone at the project itself.

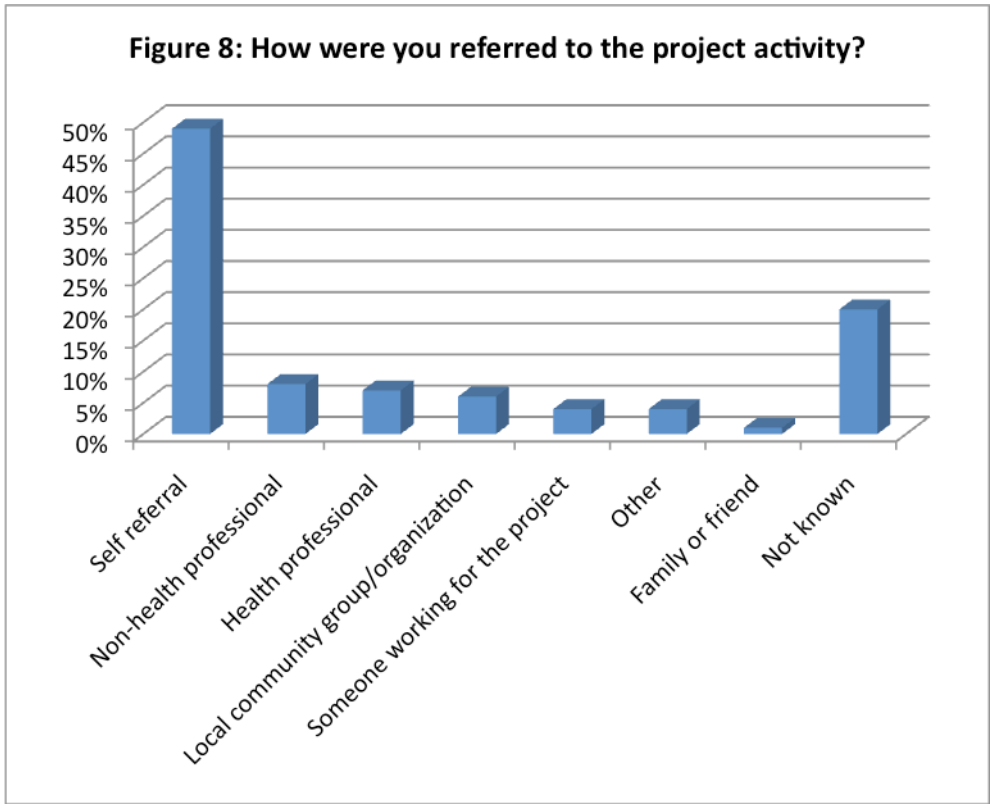
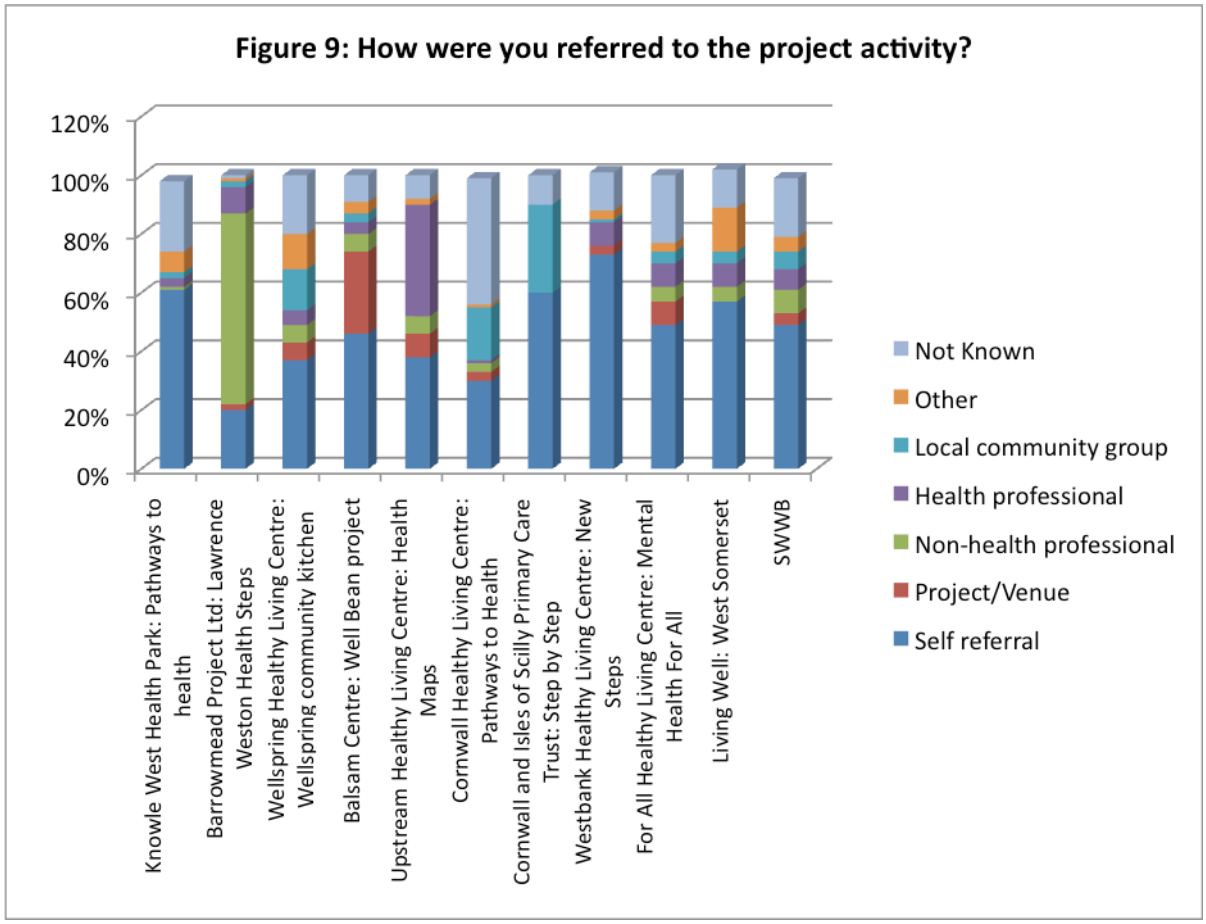
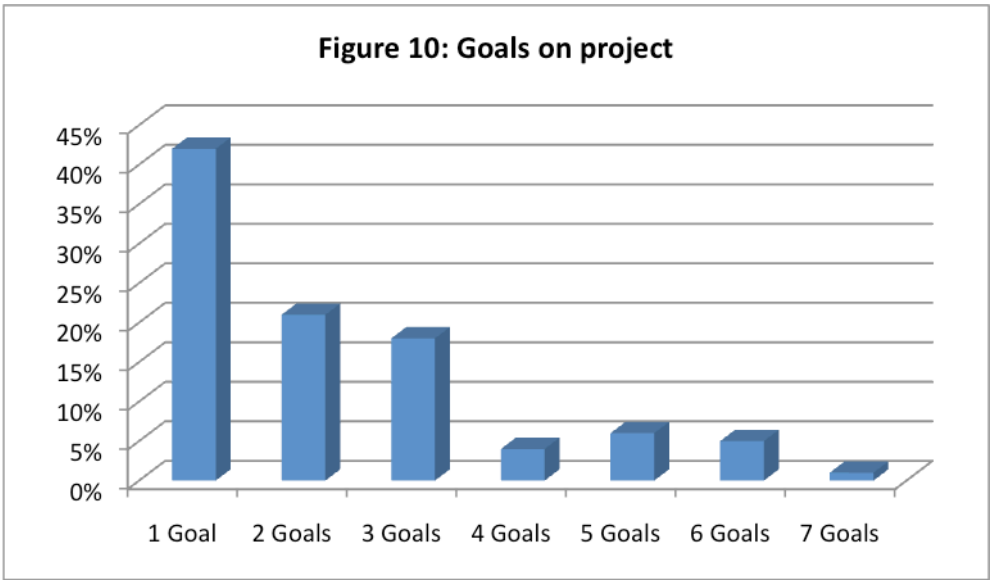


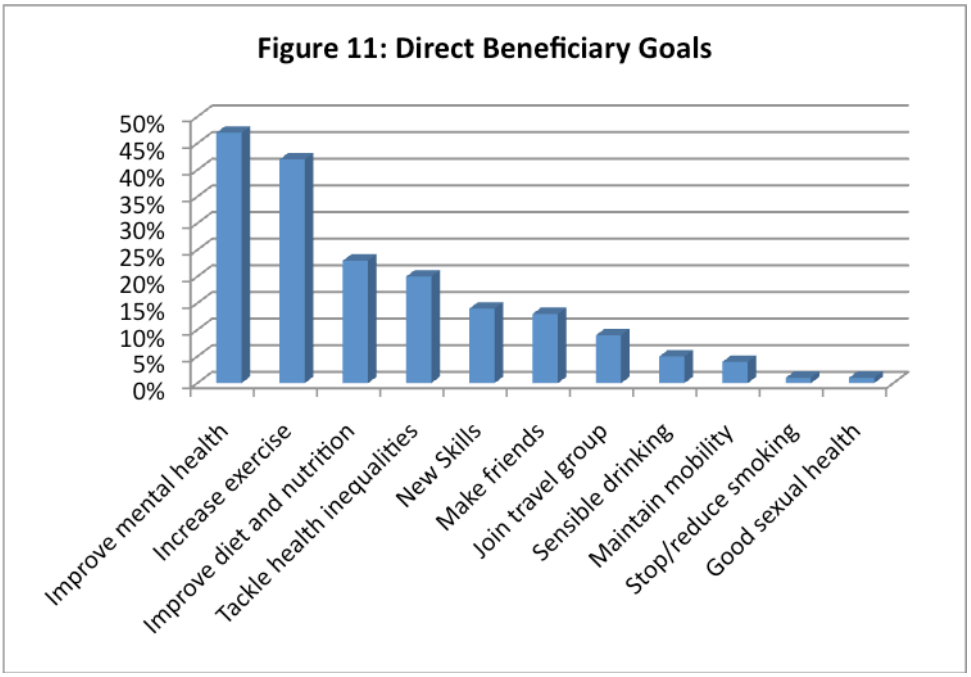
Figure 9 gives the source of referral by project. Most of the project direct beneficiaries had self-referred; with 73% (n=173) Westbank Healthy Living Centre: New Steps direct beneficiaries self-referring. The Barrowmead Project Ltd: Lawrence Weston Health Steps project had 65% (n=112) of their direct beneficiaries referred to the project by a non-health professional.



Direct beneficiaries were asked to identify personal goals. Although 25% (n=500) of direct beneficiaries had no goals recorded on their respective project database, 75% (n=1507) reported between one and seven goals. The majority 42% (n=626) had one goal to aim for while two direct beneficiaries had seven goals.



In addition to the three prime goals addressed by SWWB portfolio, eight further beneficiary goals were categorised. Almost half (47%, n=939) of the direct beneficiaries said they were aiming to improve their mental health, 42% (n=836) increase exercise and 23% (n=461) improve diet and nutrition. Other goals included wanting to gain new skills (14%, n=285) and to make new friends (13% n=267). Project teams also used the category 'tackle health inequalities' (20%, n=391) to refer to all beneficiaries who they identified as being on benefits or low income. Some projects concentrated on achieving one goal with clients e.g. Cornwall Healthy Living Centre: Pathways to Health project. Other projects, like the For All Healthy Living Centre: Mental Health For All project, had direct beneficiaries who aimed to achieve a between one and seven goals. The average was just under two goals per person.



5.4 Professional referral/ recommendations and SWWB service users

For most projects there were no significant demographic differences between SWWB service users who had been referred or recommended by statutory agencies and those who had heard of project activities through informal networks. However, patterns are likely to emerge as projects consolidate their beneficiary records and health goals. For example, for Upstream, of the 25% (n=33) direct beneficiaries who had been referred by a health professional, a majority were living alone, over 70 years old and were referred on the basis of defined health and social care needs. A similar pattern may emerge from other statutory – and particularly NHS – referrals.

5.5 Key Points

- People who were participating in SWWB activities included a wide spread of age groups and other demographic characteristics such as employment, housing and family status.

- Whilst participants took part in SWWB activities through a variety of routes, personal networks – particularly word of mouth – and project publicity play key roles. Formal referrals and recommendations from professionals appear to be less significant.

- SWWB projects are by no means alike. Some projects clearly rely upon informal community networks whereas, for others, formal links with practitioners in partner agencies have much greater significance.

- The health and well-being needs of project beneficiaries who hear through, or are referred by, practitioners in partner agencies requires further analysis. Early data indicate that these individuals may have higher levels of need compared to individuals who came to participate in project activities through informal routes.

6. Perspectives of Practitioners from Partner Agencies: quantitative data

6.1 Descriptive analysis of questionnaire responses

Out of 310 questionnaires sent out, 173 (56%)[3] practitioners responded from agencies operating in the same areas as SWWB projects. Of these respondents, 22 (13%) had not heard of the SWWB project in question and therefore they only completed the first part of the questionnaire. There was an average of just over 13 responses from each project (Table 1). There are likely to be some differences between the responses for each project due to the difference in the number of activities and agency links. Out of those who responded, there was a fairly even spread between those in NHS, Local Government and Third Sector agency employment. Those employed in children's services were the least well represented group. This reflects the fact that SWWB activities are mainly targeted at the adult population (Table 2).

Table 1: Questionnaires sent out and number of responses by project

Project	Questionnaires sent out (%)	Number of responses (%)
1	17 (5)	12 (7)
2	32 (10)	11 (6)
3	28 (9)	14 (8)
4	30 (10)	13 (7)
5	14 (4)	11 (6)
6	13 (4)	6 (3)
8	29 (9)	18 (10)
9	22 (7)	16 (9)
10	22 (7)	10 (6)
11	32 (10)	15 (9)
12	26 (8)	16 (9)
14	13 (4)	10 (6)
15	32 (10)	21 (12)
Total	310	173

[3] *Note that by 5th March there are 176 returns*

Table 2: Responses by sector and employment (n=172)

Sector & Employment	Frequency (%)
NHS MEDICAL: General Practitioner, Medical Director	20 (12)
NHS THERAPIST: Physiotherapist, Occupational therapist, Speech & Language therapist, Dietician, Counselling therapist	12 (7)
NHS NURSING: Nurse practitioner, Practice nurse, Staff nurse, Community nurse	13 (8)
NHS PUBLIC HEALTH: Public health, Health improvement, Health promotion, Health visiting	25 (14)
THIRD SECTOR & LOCAL GOVT: children's services. Child care worker, Family support worker, Play worker, Teacher, Youth worker	29 (17)
THIRD SECTOR: adult care & development services. Community development, Sports, Leisure, Volunteer coordinator, Care services manager	36 (21)
LOCAL GOVT & THIRD SECTOR: adult learning. Welfare, Housing, Employment, Adult learning advisor & support worker	13 (7)
LOCAL GOVT: adult care and development services. Leisure, Sports, Health, Community development, Adult social services social worker	24 (14)

Once the people who had not heard of the project and those who had not had any contact with any of the SWWB project staff or activities were excluded, there were 150 (87%) who completed the rest of the survey.

When asked whether agencies *recommend* project activities to individuals, 107 (71%) said yes compared to 88 (59%) who said that they *referred* individuals. The results of the questionnaire highlight the difference in responses for those who recommend compared to those who would refer individuals to activities; the latter being a more formal process. There was a majority of agencies who felt that SWWB project staff did not recommend and did not refer individuals to their agency (n=98, 65%; n=108, 72%, respectively). A minority of practitioners stated that their agencies share information about service users, share venues for delivery or contract the SWWB project to deliver their services (Table 3).

Table 3: Links between agencies and the SWWB projects (n=150)

Question: What are the links between your agency and the SWWB project?	**Yes (%)**	**No (%)**
SWWB project staff recommend individuals to your agency	52 (35)	98 (65)
SWWB project staff refer clients to your agency	42 (28)	108 (72)
You share information about service users with the SWWB project staff	46 (31)	104 (69)
The SWWB project is contracted to deliver services for your agency	25 (17)	125 (83)
The SWWB project contracts your agency to deliver services	16 (11)	133 (89)
You collaborate or share venues for service delivery	39 (26)	111 (74)
You collaborate on joint funding proposals	19 (13)	131 (87)

A group of questions asked about the effectiveness of the communication and the working relationship between the agency and the SWWB project. Generally, practitioners indicated that there are effective links between SWWB projects and their agencies. For example, 75% (n=113) thought that communication was either good or excellent (Table 4). Similarly, there was seen to be an effective working relationship between agencies and SWWB projects: the projects were seen to be good or excellent at supporting people's needs and effectively working in the local community.

Table 4: Practitioner perceptions of the effectiveness of projects

Question: In your view…	**Good (%)**	**Other* (%)**	**Total**
How effective is communication between the SWWB project staff and your agency?	113 (75)	37 (25)	150 (100)
How effective has your working relationship been with the SWWB project staff?	113 (75)	37 (25)	150 (100)
How effective is the SWWB project in supporting people's needs?	107 (72)	41 (28)	148 (100)
How effective is the SWWB project in working with local community needs?	108 (73)	41 (27)	149 (100)

*includes 'neither good nor poor', 'poor', 'very poor', 'don't know', 'not applicable'.

Overall, practitioners felt informed about aspects relating to SWWB target groups, aims of project activities and how the activities fit with local services, but less so about feedback about participants' outcomes (Table 5). In addition, there was a belief that the projects support the NHS by providing preventive services and supports other statutory services (n=116, 79%; n=102, 70%, respectively)(Table 6).

Table 5: How well informed practitioners feel about SWWB project activities

Question…	**Well informed (%)**	**Other* (%)**	**Total**
How well informed do you feel about target or priority groups?	97 (69)	44 (31)	141 (100)
How well informed do you feel about aim of activities?	111 (77)	34 (23)	145 (100)
How well informed do you feel about participants' outcomes?	82 (59)	56 (41)	138 (100)
How well informed do you feel about the availability of activities?	93 (66)	48 (34)	141 (100)
How well informed do you feel about how activities fit with local services?	89 (64)	51 (36)	140 (100)
How well informed do you feel about the projects overall aims?	105 (75)	35 (25)	140 (100)

*includes "neutral", "not well informed"

Practitioners were also in general agreement that the activities complemented other services and filled a gap, which otherwise would not be filled. However, there was a common impression that neither the local community nor the local statutory bodies were aware of the project activities (Table 6). Whilst not many agencies felt that there were barriers to closer working with the projects, a majority were of the opinion that there were opportunities for closer working (n=71, 54%). Agencies demonstrated their interest in giving feedback about the projects by adding several comments to the questionnaires but also indicating that they were willing to participate in an interview, if needed (n=97, 68%).

Table 6: Practitioners' opinions of potential benefits and drawbacks of SWWB projects

Question: To what extent do you agree with the following statements on potential benefits and drawbacks of the SWWB project?	**Agree (%)**	**Other† (%)**	**Total**
"The SWWB project supports NHS by providing preventative and/or alternative services"	116 (79)	31 (21)	147 (100)
"The SWWB project supports other statutory services by providing preventative and/or alternative services"	102 (70)	44 (30)	146 (100)
"The SWWB project appears to lack clear outcomes for participants"	13 (9)	133 (91)	146 (100)
"The SWWB project addresses local priorities for promoting health and well-being"	113 (78)	32 (22)	145 (100)
"The SWWB project appears to duplicate other locally available services"	7 (5)	138 (95)	145 (100)
"Local communities/ target groups have a good awareness of the SWWB's project services"	41 (28)	104 (72)	145 (100)
"Local statutory bodies have a good awareness of the SWWB's project services"	51 (35)	94 (65)	145 (100)
	Yes (%)	**No (%)**	**Total***
Do you have evidence that the project supports the health and well-being of users?	80 (58)	33 (24)	139 *
Are there any barriers to closer working links between the project and your agency?	27 (19)	93 (67)	139 *
Are there any opportunities for closer working links between the project and your agency?	71 (54)	23 (17)	132 *
Would you be willing to participate in a further interview?	97 (68)	45(32)	132 *

† Includes: "neither agree nor disagree" to "strong disagree", "don't know"

* Total may not sum to 100%. Frequencies exclude multiple responses and non responses.

6.2 In-depth analysis of questionnaire responses

The above has described the general feedback from practitioners in local agencies. This section examines the relationships between different groups of practitioners and their responses, thus highlighting any differences and/or similarities in their replies.

As described above, there tended to be different responses from those agency staff who refer compared to those who recommend. Table 7 shows the discrete responses when the replies from those who recommend are compared with those who refer individuals (x^2= 20.1, p<0.001).

Table 7: Recommend and/or refer individuals to project activities (n=139)

Recommend	Refer: yes	Refer: no	Total	*p value*
Yes	75 (70)	32 (30)	107 (100)	
No	13 (30)	30 (70)	43 (100)	†
Total	88 (59)	62 (41)	150 (100)	

†: $x^{2=}$ 20.1, <0.001

In response to the question about recommending SWWB project activities to individuals, there were no differences between the three main sectors (NHS, Local Authority and Third Sector for adult services and a separate group for children's services). There was a majority who did recommend (66-77%). However, there was a difference between the sectors for those who *referred* individuals, with most from the NHS (n=44, 71%) and least from the Local Authority and Third Sector for adult services (n=28, 44%)(x^2= 10.37, p=0.006). This latter group was the one who were most likely to believe that projects recommend individuals to their agency (n=28, 44%) but, unsurprisingly, all the sectors felt that projects were unlikely to refer individuals to them (70-75%). There were no real differences in responses from these three groups but there was a suggestion that the group for children's services tended to be less likely to share information with the SWWB projects and that the NHS felt less informed about participants' outcomes than the other two groups (Table 8).

Table 8: Examples of different associations for those agencies who recommend or refer individuals to project activities and the statements below:

	Yes n (%)	**No n (%)**	**Total**	***p value***
***Recommends* clients to activities**				
Informed about participant outcomes	53 (38)	46 (33)	138	*
Projects address local activities	85 (59)	18 (12)	145	*
Opportunities for closer working links with projects	55 (42)	18 (14)	132	0.073
Evidence that project support health & well-being of users	60 (43)	20 (14)	139	0.229
Project effective in supporting people's needs	80 (54)	26 (18)	148	0.170
***Refers* clients to activities**				
Informed about participant outcomes	48 (35)	33 (24)	138	0.963
Projects address local activities	68 (47)	17 (12)	145	0.475
Opportunities for closer working links with projects	43 (33)	17 (13)	132	0.114
Evidence that project support health & well-being of users	56 (40)	9 (7)	139	***
Project effective in supporting people's needs	68 (46)	18 (12)	148	*

*= $p<0.05$, **= $p<0.01$, ***= $p<0.001$

In respect of how effective the SWWB projects are in working with the needs of their local communities, there were strong associations between agencies feeling informed about various aspects of the projects, including the aims, targets and priorities, participant outcomes and how the activities fitted with local services. The same was true if agencies felt that the projects were effective at supporting people's needs (Table 9).

Table 9: Examples of associations between effectiveness of communication between agencies and projects, and effectiveness of project in supporting people's needs and the statements below

Effective communication	**Yes n (%)**	**No n (%)**	**Total**	***p value***
Good information about participant outcomes	73 (53)	29 (21)	138	***
Informed about availability of activities	82 (58)	24 (17)	141	***
Informed about activities fitting with local activities	81 (78)	23 (16)	140	***
Informed about overall aims	90 (64)	14 (10)	140	***
Effective in supporting people's needs				
Informed about project targets/priorities	85 (61)	17 (12)	139	***
Project activities support NHS	93 (64)	11 (8)	145	***
Projects supports other sectors	86 (84)	17 (12)	144	***
Projects address local priorities	91 (64)	11 (8)	143	***
Projects do not duplicate other services	76 (53)	23 (16)	143	***

***= $p<0.001$

When we examined the issue relating to whether agencies refer and/or recommend individuals to activities, there appeared to be no association with levels of communication and/or knowledge about project activities. However those who do not *recommend* individuals to project activities are less likely to believe that there are opportunities for closer working with the project ($x^2= 5.25$, $p=0.070$). There is a smaller proportion of agencies who do not recommend, compared to those who don't refer, who feel they are not informed about participant outcomes (26% vs 40%, respectively). Those agencies who *refer* individuals to project activities are more likely to believe that the project is effective at supporting people's needs ($x^2= 4.7$, $p=0.03$) and have evidence that project does this ($x^2= 17.68$, $p<0.001$) compared to agencies who do not refer. They may also be more likely to feel that the community is aware of project activities ($x^2= 5.51$, $p=0.064$).

We explored potential differences of view across individuals from different sectors: NHS sector, Local Authority and Third Sector. Due to the organisation of many posts within Local Authorities and the Third sector, from the descriptions given by the respondents, it was not always possible to determine which individuals were employed by a Local Authority and those who were employed by a Third sector organisation. The comparison was therefore made between the NHS sector and an 'other' group that comprised of both Local Authority and Third sector respondents.

There were few differences in responses between the NHS and 'other' sectors except in relation to those who referred individuals to project activities, feeling informed about participant outcomes and the view that local communities were aware of project activities. Practitioners in NHS and 'other' sectors shared the same views about the role of SSWB projects in supporting NHS preventative services. Compared

to the NHS sector, there was a larger proportion from the Local Authority and Third sector group who did not refer individuals to project activities than those in the NHS sector (x^2=6.59, p = 0.01), felt informed about participant outcomes (x^2=5.41, p = 0.02) and felt that the local community was aware of project activities (x^2=8.25, p=0.01) (table 10).

Table 10: Examples of associations between the NHS sector and the local authority and Third sectors in relation to the statements below

	NHS n (%)	**Other n (%)**	**Total**	***p value***
Not recommend individuals to project activities	14 (9)	29 (19)	150	0.166
Not refer individuals to project activities	18 (12)	44 (29)	150	**
Informed about overall aims	42 (29)	69 (48)	145	0.062
Good information about participant outcomes	29 (21)	53 (38)	138	*
Local community/target groups aware of project activities	10 (7)	31 (21)	145	**

*= p<0.05, **= p<0.01

Key Points

- Practitioners tend to recommend individuals to SWWB project activities rather than to formally refer them.

- Partner agencies have a wide range of links with SWWB organisations. For a minority these links consist of information-sharing on service users and collaborative forms of service delivery. A small number have started to engage in formally contacting SWWB services. SWWB organisations have links that span all sectors and a wide range of fields. Most, but not all projects, have established links with NHS GP services.

- SWWB projects are generally thought of as being effective in terms of their external communications, working relationships, support for people's needs and work with local community needs.

- Practitioners feel informed about SWWB project targets and aims, the availability of activities and how they fit with local services. Agencies, especially in the NHS sector, feel less well informed about participant outcomes.

- Projects are felt to support the NHS preventative services and other statutory services and did not duplicate other locally available services. However, as a general pattern, neither local statutory bodies nor the local community is felt to have a good awareness of SWWB project services. The outcomes of projects could be clearer. Nevertheless, some agencies, with the majority in the NHS, had evidence that the projects support the health and well-being of users.

- There are thought to be opportunities for closer working between projects and agencies with few stating that there were barriers to closer working links.

- This sample suggests practitioners from the NHS sector were more likely to refer individuals to project activities than those from other sectors. Despite having evidence from client feedback, they are also more likely to feel that they know less about the overall aims of projects and participants' outcomes .

7. Perspectives of Practitioners from Partner Agencies: qualitative data

7.1 Introduction

This section follows on from the previous section. It focuses on the written feedback provided by practitioners who responded to the questionnaire on their links with SWWB services.

7.2 Evidence that SWWB services support the health and well-being of service users.

Practitioners were asked whether they had evidence that the SSWB service supported the health and well-being of their own service users. This evidence could consist of client self evaluation, practitioner feedback and/or clinical indicators. The written feedback of 78 respondents showed that personal feedback from service users was the main route by which practitioners received evidence of health and well-being outcomes:

> *One client referred to us said if help had not been at hand he was contemplating suicide, he now brings people in himself!! Advice Worker#90*
>
> *Feedback from my patients has been excellent; they have all been very fulsome in their praise. Dietician#129*
>
> *The children selected from our school (identified in conjunction with the project) benefitted greatly and have a better knowledge of how to prepare healthy food. Deputy Head Teacher#130*
>
> *I have had clients who have benefited enormously from the project, e.g. for a lady with depression it made all the difference to her. Occupational Therapist#21*

Respondents also expressed general confidence that the project could show evidence of health and well-being outcomes based upon their personal observations of the services. It is noteworthy that fewer respondents (n=10) identified formal reports from the SWWB projects or data arising from the monitoring within their organisations (n=11).

> *The clients I refer are on my case management list and I can see clearly the evidence of how much they benefit from the interventions provided. Practice Nurse#45*

We have conducted a clinical audit of the outcomes for people including those who participated in the project. Occupational Therapist#99

Re physical activity, we have positive feedback from SWWB instructors and records of increased uptake from families participating in project. Health Development Manager#114

For 12 respondents it was clear that they would appreciate more detailed feedback from SWWB projects on evidence of outcomes.

Table 11: Evidence of SSWB health and well-being outcomes for service users.

Content analysis of written responses. 78/164 of responses

Category of written response	**Occurrences**
Informal/ verbal/ anecdotal evidence directly from service users	36
Personal expression of confidence Direct observation of service delivery	14
Internal clinical / health evidence/support from external research evidence	9
Formal reports from SWWB project	10
No current feedback available from SWWB projects	12
Other	6
Total	87

*9 respondents gave multiple responses

7.3 Barriers and Opportunities for Closer Working Links

Practitioners were asked to identify barriers and opportunities for closer working links between the SWWB service and their own agency. Only a minority of respondents (n=40) identified 'barriers' to closer working relationships. A greater number (n=78) stated 'opportunities'. Overall, respondents covered similar themes for both these questions and therefore we consider this qualitative feedback in one section.

Of those reporting barriers to maintaining engagement, half (n=20/40) wanted to emphasise wider constraints of funding, organisational resources or staff capacity. Respondents felt that SWWB staff time was largely consumed by delivery and administration – with little opportunity to develop relationships:

They seem to be very busy 'doing' with no time to 'develop' their networks. We have met with them but nothing came out of it. We would love to work with them more. Social Care Adult Services Practitioner#31

Communication about the services available was the second most commonly identified barrier. Most respondents felt that this was an issue shared by both parties, although a minority felt that the SWWB organisation needed to be more pro-active in marketing their services:

There is relatively little contact between the project and the general practices, and we don't interface with each other. GP#38

I would like more regular updates of services at meetings and leaflets about services they are offering and how to refer patients on to them. GP#51

[SWWB] staff don't access our setting to introduce themselves to clients. We rarely have posters for advertising in good time. We have a large clientele and we cannot inform them fully of services if we are not informed ourselves. Family Centre Manager#106

There have been numerous instances of admin changes that haven't been communicated to [staff in partner agencies] … This is not to criticise the staff involved… they are unfailingly polite and helpful once they know what's needed. Exercise Trainer #112

More specifically, eight NHS respondents felt that clearer communication and agreement was needed to ensure that they could enable their clients to access SWWB services:

Some of my work is with people suffering from mild to severe dementia. The [SWWB project] is wary of engaging with those people. It would be great if we could achieve more involvement [from the Project]. Occupational Therapist #21

I work in a specific clinical area and it would be advantageous to know the skills that the service that I'm referring to have in this specific field. Physiotherapist#16

We would like to know more information to see if we can refer our CHD patients into the service. Physiotherapist#12

Consent to the sharing of information can be a tricky point between statutory and voluntary sector. However, I feel the people who benefit from the service give valuable feedback to their benefits. Community Matron#87

In terms of opportunities, the overarching theme covered the desire of many respondents to develop closer and more formal relationships with SWWB services. These opportunities addressed agreements for sharing client information on needs and outcomes and joint service delivery and development opportunities:

> *New project work tends to be shared with my agency in a very informal way. It would be very useful for [the SWWB organisation] to have formal contact with County Hall or the local service team [to develop services]. Children's Centre Worker#23*
>
> *We need more collaboration with regard to cross referral of individuals with severe and enduring mental health problems. Community Development Officer#68*
>
> *We should explore the possibility of a 'gateway' worker who sees patients within the surgery. GP#8*
>
> *Consortium working to link our befriending service, reduce duplication and increase support. Voluntary Sector Adult Care Manager#154*

7.4 Key Points

- Written feedback from practitioners in partner agencies confirmed the overall findings from the quantitative questionnaire data. For example, the importance of anecdotal reports from clients and the potential for further collaborative working.
- In addition, the written feedback provides examples of highly significant outcomes for individual service users. These successful cases are also of considerable assistance to the wider goals of partner agencies in terms of preventative work, rehabilitation, enriched care or learning and so forth.
- The written feedback also presents a picture of pressurised frontline services in which the scope for closer links with preventative and community agencies is clearly desirable to practitioners.

8. Case Studies

8.1 Introduction

The case studies presented in this section provide examples of how SWWB services can enhance and complement statutory provision. In addition, they help put into context the quantitative information presented in this report: the profiles of SWWB service users, unit costs and the perspectives from partner agencies.

8.2 Physical Activity: supporting GP services through community-based dance activities.

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

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

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

There have been two courses run so far with 39 direct beneficiaries, the majority of whom reported that they benefited in some capacity, whether that was socially, medically and/or physically. There were some who did not attend the end appointment and therefore any benefits they experienced were not recorded. However, no one reported any adverse effects from the sessions.

Participants were referred for a variety of physical, psychological and emotional reasons: hypertension, obesity, depression, anxiety, arthritis, asthma, diabetes, back pain, injury rehabilitation and cardiac rehabilitation. Written feedback from clients has been very positive in terms of improvement in mood and weight loss:

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

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

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

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

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

Added value

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

One more detailed example of this relates to a woman aged 43 years who was referred to healthy lifestyles (gym and swimming activities), as well as these dance sessions to improve her mental well-being, asthma and after having undergone several operations. She says:

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

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

Key themes this case study illustrates

- Referrals to dance exercise are broad and inclusive of physical, psychological and emotional problems.
- Attendance at dance sessions by, predominantly female, participants who have been referred is high.

- Many participants have progressed to an intermediate course in order to continue long-term physical activity.
- Referring agencies appreciate reports on the outcomes for participants. This information gives partner agencies confidence to continue recommending the well-being service.

8.3 Healthier Eating: supporting NHS dieticians through lifestyle coaching services

A one-to-one, personalised service to advise on lifestyle behaviours is an example of how SWWB funded services can help to both alleviate pressures on hospitals and provide the type of support that is welcomed by some people with weigh management issues.

Many people with weight management problems or dietary conditions are aware and prepared to make lifestyle changes. Often a major life event, such as a diagnosis of diabetes, prompts a change in their outlook. This SWWB service works from the premise that a short course of personalised coaching can make a major contribution in turning such people's intentions into reality.

Based upon positive feedback dieticians in the local hospitals and PCT have started to refer their patients to these SWWB coaching sessions. Dieticians typically see patients for a 30 minute consultation with two-three 15 minute follow-ups every two-three months. Nevertheless work with overweight patients can be a complex and challenging. The allocation of time available under the NHS contract is often insufficient to cover aspects of motivation, behaviour changes, willingness to change - as well as healthier eating advice. Dieticians have found that the SWWB lifestyle coaching service has been well placed to help patients with these wider motivational issues. The dieticians assess their individual patients' willingness to change, those who have already made changes to their diet and lifestyle but are still struggling and those who require weekly sessions to help keep them motivated but the NHS is unable to provide this level of service. The lifestyle coaching offers six individual sessions over a fixed period of three months but spaced according to the needs of each client.

Thirteen referrals have been received from the out -patient clinic of the acute trust in the last six months and none have been seen again by the dieticians since referral. These patients had either been discharged but further work was needed on behaviour change or they have not had any follow-up from this clinic. From the PCT, 7 patients have been referred in the last 5 months and been reviewed by the dietician: the service is seen as an additional service to that offered by the PCT. Recently, the facilitator has been invited and attended a review session of the acute trust's group-based weight loss programme. Patients will therefore be able to move into the coaching sessions, either during the weight loss programme or after it has finished, if they wish to.

Added value

Dieticians viewed the SWWB service as a valuable resource for overweight patients who need support to change their health behaviours. Evidence suggests, to facilitate health behaviour change in overweight patients, regular follow-ups are advisable such as, every week or second week. Whilst dieticians within the NHS are unable to

provide this follow-up service, the SWWB has been well-placed to offer this form of support.

> *'I have been very impressed with the pitch/theory but haven't had a chance to evaluate it yet. She [the facilitator] seems to be building on what our clinical psychologist has done with the groups but because of resource constraints, can't do anything with patients on an individual basis, so the Lifestyle Mentoring on offer seems to be highly appropriate'.*
>
> *'So far I am very impressed, I have heard good reports back, patients like it; She [the facilitator] lets them talk and she listens well.'*

Regarding the needs of the dieticians, the coaching sessions provide a service that the NHS cannot provide. The drawback seems to be that once the patients go through a programme (6 sessions), they then cannot attend any further so the long-term support aspects may still need to be addressed.

The SWWB facilitator reported that 'I'm currently seeing 3 clients, 2 of whom have lost 5 lbs by the 3rd session, and due to start seeing 2 new clients.' Some clients, however, are very keen to lose weight rapidly: 'One client, despite losing 1.5-2 lbs a week, found that it wasn't quick enough, so only had 3 sessions. Three clients didn't respond to calls and letter.'

Key themes this case study illustrates

- Third sector providers can offer an additional, highly valued service that complements what the NHS can offer.
- This service is able to offer an intensity of provision that NHS staff are not able to offer within their current workloads.
- Third and statutory sectors can work and liaise to the benefit of patients.

8.4 Mental Well-being: supporting primary care through personal and responsive community services

This SWWB project has developed good, close links with the GP practice which operates out of the same centre and is part of the same organisation. GPs have said for a long time that they have little to offer patients presenting in the surgery with low level depression or anxiety, often in response to issues and situations in patients' lives. Despite the recent development of a county-wide Primary Mental Health Service, GPs value the ability of the SWWB project to offer a local, rapid and flexible response to people referred to it. The co-location of clinical and well-being services, alongside other services such as a Children's Centre, a Day Centre for older people and a community café, allows the development of relationships which can link services and more effectively support the well-being of local residents.

Children's Centre staff, Health Visitors and other local workers also refer people to the SWWB project and organisations work together to ensure a consistent response. People can also self-refer into any of the services and activities which are open to all residents of the area, not just patients who are registered with the GPs.

The SWWB project offers an initial one-to-one assessment. This can be followed by an offer of extended one-to-one listening support or a supported link into a range of

activities. Some activities (such as walking groups, exercise and dance groups, drop-in, volunteering, gardening, psycho-educational courses, creative activities, social groups etc) are provided directly by a lead worker. They are designed to promote physical activity and learning opportunities for their impact on mental health, build social supportive networks and increase people's capacity to work out their own solutions and develop their own resilience. Others are provided by partner organisations (e.g. information and advice about housing, debt, employment, training, childcare etc) and are designed to address some of the issues affecting mental well-being.

The project pays attention to people's journeys through anxiety and depression to engagement, social networks, learning, growing resilience, confidence and self determination. The project offers an open door for people to return for reviews or links into other activities.

An example of this journey is provided by a single mother who moved from another area with her two daughters. She had suffered a bereavement, was isolated and described her mood as "very low". Her GP was concerned about her mental health and her lack of support for her bereavement and referred her for one-to-one support. She was supported by a project worker, able to talk about her grief, and given practical support around specific financial issues. She went on to join an exercise class, attended a "positive listening" course and she and her daughter became part of a group using the local sports centre. She said it was "very useful, someone being out there I could talk to"; she liked the "stepping stones to other services" and "felt more motivated".

The referring GP initially described his patient as "over eating, lacking energy, sleeping very poorly and anxious when leaving home". After working with the project lead he felt she was "reporting more social contact and feeling more positive".

Another group of people, with multiple difficulties, use the Centre regularly. After discussion with the project workers, they worked with a theatre group to adapt and update the story of Persephone, exploring issues (and archetypes) close to their own lives. When reviewing their work they said: "we all gathered together"; "we're a team now, we get on well"; "it's really confidence-building, we can forget our problems and just focus on what we're doing – it's like a pressure release". The daughter of one participant (aged 5) wanted to "be in a play like mummy" and the worker commented on the impact on aspiration.

Review and written feedback from participants of all activities include the following comments:

> *" I think more positively"; " I get out more and have improved my fitness"; " I'm working on my anger levels"; "I feel better since starting exercise"; "I have accomplished so much and really hope so much more that I know I am capable of doing".*
>
> *Another referring GP reported her patient saying "I'm stopping my anti-depressants… I've started making jewellery".*

Added value

This SWWB project is offering a local, rapid, flexible response which:

- Reduces use of primary medical services.
- Improves the effectiveness of appointments with GPs.
- Supports GP work to help patients living with chronic disease.
- Reduces the referral into secondary care (and the Primary Mental Health Service).

Key themes this case study illustrates

- The value of a local, flexible rapid response.
- The value of organisational roots in the community it serves.
- The value of alternatives to GP options of drug therapy or referral.
- The range of activities, services and opportunities which can have a positive impact on mental well-being.
- The social and emotional benefits, such as increased resilience and confidence, of social networks which can develop round group activities.

8.5 Key Points

- These case studies provide three illustrations of SWWB supported activities that benefit a range of local statutory agencies. They demonstrate how SWWB services have developed mature cross agency links in which the benefits to practitioners are evident in terms of the concept of 'added value'.
- The case studies highlight the breadth of referrals and the complexity of identifying the advantages for beneficiaries, both short and long-term, as well as the overall benefits to the partner agencies.

9. SWWB Project Unit Costs

9.1 Introduction

Economic analysis has become an increasingly important part of the evidence-base that is used to inform the development of health and social care policy and practice. Unit costing, calculating the costs of specific interventions, is one part of this process of economic analysis and has become a widely used tool for commissioning health and social care services. Indeed, commissioners are increasingly unwilling to purchase services without such information. Unit costs are also a key part of the Government's performance assessment framework for public sector services and forms the basis of a range of best value initiatives.

We have included unit costing as part of our evaluation in order to help demonstrate the value for money that the projects provide. The unit cost figures are not intended to provide a comparison between projects. This would not be comparing like with like because each project is providing a different and unique service to different groups of service users. We hope that projects will also find the unit costing approach useful for demonstrating the cost of their services to commissioners and others. This approach can be particularly useful for calculating the potential financial benefits of preventative approaches and therefore the added value that the projects contribute to local health and social care communities. For example, a recent research project demonstrated that providing a memory service across England at a cost of £220 million per year would eventually pay for itself through annual savings of £120 million in public expenditure on social care and £125 million in costs to service users and their families (Banerjee & Wittenberg, 2009).

9.2 The Unit Costing Model

The approach to unit costing used for this evaluation is based on a model developed by the Personal and Social Services Research Unit[4] (PSSRU) for the Department of Health, which has been widely applied to services across health and social care. The model calculates the real cost of providing a service by adding up the costs of each service component and dividing this by the number of service users. Its application is summarised by the PSSRU as follows:

1. Describe the ingredients of the service;
2. Identify the activities and a unit of measurement;
3. Estimate the cost implications of the service elements;
4. Calculate the unit cost.

[4] http://www.pssru.ac.uk/

For our evaluation we asked each project to provide the raw costing and service use data using a template spreadsheet (see Appendix. In most cases we followed this up with requests for clarification and additional information as appropriate.

We have distinguished between two types of project in our evaluation: the 11 that started in 2008 and four 'seed corn' projects that followed in 2009. For the former, financial information covered the delivery of established services while figures for the latter spanned their start-up period when costs were inevitably higher. It was therefore decided that unit costing would be applied to the earlier 'maintenance' projects but not to the later start-up ones.

In presenting the unit costing data below we have distinguished between those projects that provide one-to-one activities and those that are characterised by group-based delivery. Inevitably some provide a combination of the two. Some projects have provided separate financial data for different elements of their project and therefore have two entries on the list.

1. Fitness group for younger people

This service is an instructor-led 2 ½ hour dance and exercise session for young people who may be overweight or who do not normally do vigorous exercise. The service is offered weekly.

Data Period: 3 months	
Activities delivered on a group basis (average 18 participants)	
Average service costs per week:	£59.27
Number of activity units per week:	18
Cost per service user/client:	£3.29

2. Gentle exercise group for older people

This service is an instructor-led 1 ½ hour exercise session for older people who may be overweight or have health conditions that would benefit from improved regular physical activity. The service is offered weekly.

Data Period: 12 months	
Activities delivered on a group basis (average 16 participants)	
Average service costs per week:	£59.00
Number of activity units per week:	16
Cost per service user/client:	£3.69

3. Befriending group for older people

This service is a community worker-led 1 ½ hour social group for older people who may be isolated or changing residence to supported accommodation. Most participants have longer term health conditions. The service is offered weekly.

Data Period: 12 months	
Activities delivered on a group basis (average 12 participants)	
Average service costs per week:	£73.93
Number of activity units per week:	12
Cost per service user/client:	£6.16

4. A multiplex well-being service for a wide range of target groups

This service provides a wide range of small group-based activities including health walks, exercise classes, community gardening, healthy eating courses, family obesity support and falls prevention. The service works with people with low level mental ill health, people aged over 45 with sedentary lifestyles and families from deprived communities.

Data Period: 3 months	
Activities delivered on a group basis (average 7 participants)	
Average service costs per week:	£1,306.25
Number of activity units per week:	175
Cost per service user/client:	£9.38

5. A service to promote active community participation and healthier eating

This service runs a variety of food growing programmes to engage families, socially isolated people and older people in activities that directly support their dietary, physical and mental health. It seeks to encourage sustainable activities that are accessible in settings where existing health and leisure services are very limited.

Data Period: 12 months	
Activities delivered on both a group (65%) and individual (35%) basis	
Average service costs per week:	£1825.48
Number of activity units per week:	160
Cost per service user/client:	£11.41

6. A flexible, rapid response service for people with low level mental ill health

This is a rapid response service offering both group and one-to-one activities. It is designed for people experiencing mild anxiety or depression and concentrates on promoting protective factors such as social networks, participation and self esteem

Data Period: 9 months	
Activities delivered on both a group (60%) and individual (40%) basis	
Average service costs per week:	£2356.44
Number of activity units per week:	144
Cost per service user/client:	£16.38

7. A combined one-to-one and group-based service for isolated older people

This service provides one-to-one support for a limited time for isolated people and others who are disengaged from their communities. In addition the service runs group activities intended to stimulate creative, social, learning and physical activities in order to support people's well-being and lifelong independence. The service is generally for older adults but there are also intergenerational projects.

Data Period: 24 months	
Activities delivered on both a group (95%) and individual (5%) basis	
Average service costs per week:	£1237.53
Number of activity units per week:	81
Cost per service user/client:	£15.28

8. Personal exercise coaching and motivational support for a healthier lifestyle

This service offers one-to-one health assessment sessions with a mentor or coach to help people improve their overall health and well-being. Some sessions take place in the community gym. Individuals taking part are often referred by health and social care practitioners.

Data Period: 3 months	
Activities delivered on an individual basis with occasional small group work	
Average service costs per week:	£870.83
Number of activity units per week:	33
Cost per service user/client:	£26.39

9. A service to develop small-scale community groups and volunteer initiatives

This service promotes the engagement of local people in health and well-being activities through a combination of community group development and one-to-one support. It works with individuals at risk of poor health through the promotion of personal confidence, motivational support and group facilitation.

Data Period: 12 months	
Activities delivered on both a group and an individual basis	
Average service costs per week:	£2124.47
Number of activity units per week:	78
Cost per service user/client:	£27.24

10. An integrated motivational guidance and massage therapy service

This one-to-one service offers an integrated package of motivational guidance and massage therapies for people with poor physical health or weight management issues, people with low-level mental ill health, or people with diet-related health risks. Structured sessions are delivered on up to six occasions.

Data Period: 3 months	
Activities delivered on an individual basis	
Average service costs per week:	£309.63
Number of activity units per week:	10
Cost per service user/client:	£30.96

11. A hub-and-spoke well-being information, support and recommendation service

This is a central information and volunteer support service for a wide range of local well-being activities working in partnership with primary healthcare services to promote a GP recommendation scheme. This is mainly a one-to-one service that works with individuals from deprived communities and families, people with low-level mental ill-health and people aged over 50 to overcome their barriers and assist them to improve their health and well-being.

Data Period: 12 months	
Activities delivered on both a group (20%) and individual (80%) basis	
Average service costs per week:	£2920.98
Number of activity units per week:	64
Cost per service user/client:	£45.64

12. A one-to-one intensive mentoring service for people with weight management difficulties and high level diet-related health risks

Qualified practitioners deliver this one-to-one intensive service. The course is offered over up to six sessions. Participants have clinically defined needs and take part in a structured course of lifestyle behaviour change activities.

Data Period: 8 months	
Activities delivered on an individual basis only	
Average service costs per week:	£1829.78
Number of activity units per week:	19
Cost per service user/client:	£96.30

9.3 Discussion

The unit costing figures presented above provide a useful indication of the cost per service user of the activities provided through the South West Well-being programme. It is important to note that we are not comparing like-with-like here. As the project descriptions indicate, services differ considerably in what they are offering, who to and over what period. However, we can see that costs per service user range from £3.29 to £96.30 and, as would be expected, those projects that provide services solely or largely on a group basis (projects 1 to 6 in the list above) have a lower unit cost than those that focus on one-to-one work (projects 7 to 12). Moreover, projects delivering preventative services on an open access basis also tend to be lower cost than those offering therapeutic interventions targeted at individuals with higher levels of health need.

It can be useful to view local unit costing figures in the light of national data. The PSSRU provide figures, updated annually, to show the unit costs of a wide range of public sector services. Below are some examples from 2009. These are not directly comparable with the services provided through the well-being projects, largely because they don't provide a figure per service user, but they do provide useful context.

- Voluntary sector residential care for people with mental health problems: £344 per week
- NHS Trust day care for people with mental health problems: £66 per day
- Local authority social services day care for people with mental health problems: £43 per day
- Cognitive Behavioural Therapy: £64 per hour of face-to-face contact

It is important to note that providing the data for calculating unit costs was not a simple task for most projects. The costing template is inevitably generic and some projects had difficulty fitting their costs into pre-defined categories. Others felt unable to quantify accurate numbers of service users/clients. This meant that we were not able to produce a unit cost for some projects. This highlights the main limitation of the unit costing approach – it is difficult to apply a single model to a range of projects that differ greatly in terms of the type of service provided, the characteristics of direct beneficiaries and the level of contact provided. Another limitation is the fact that the model relies on a level of detailed information concerning service delivery at project level. This can make it difficult to provide accurate figures, particularly where activities funded by the Big Lottery grant are one part of a wider service provision. Finally, it is important to note that while the model calculates the cost of delivery per service user, it doesn't take into account activity length.

9.4 Key Points

- There are considerable advantages to using a single, transparent model to calculate the cost per service user of providing the full range of activities that form the SWWB programme.
- SWWB activities show a wide range of unit costs. These reflect the level of specialism, intensity and personalisation of the service. Higher costs services also reflect the levels of need and potential benefits intended. A key potential benefit offered by SWWB services includes their role in preventing the need for individuals to use more costly health and social care services.
- Unit costs for multiple aspects of provision give an insight into 'whole service' operations whilst costing for individual services offer a platform for developing a detailed understanding. These levels of analysis are different and are likely to be of value when internal and external stakeholders wish to consider options for developing services.
- Simple comparisons with statutory sector provision are not advisable owing to the complexity of factors that need to be taken into account when unit costing. Nevertheless, it appears evident that some aspects of SWWB service provision represent good value for money.

10. Discussion

This report, by drawing upon a range of sources, presents a number of perspectives on how SWWB projects add value in the context of their local service delivery. Profiles of direct beneficiaries based upon project records highlight a wide demographic make up and the multiple routes through which people come to participate in activities. The regional survey of practitioners in local agencies has provided a rich set of feedback on perceptions of, and links with, SWWB activities. Case studies provide selected accounts on how SWWB projects can support local statutory sector organisations. Finally the unit cost analysis helps provide an economic perspective on the service delivery.

Whilst each section addresses a different set of issues, some common themes emerge. Firstly, SWWB project activities work with local social networks that are often outside statutory referral systems. Practitioners in partner agencies value and appreciate SWWB activities, in part because of these strong community bonds and linkages. Clearly SWWB projects are perceived to help develop local community connections and operate in areas where no other services are available. Unit costs for some SWWB activities also appear low in comparison to other community-based human services (although the lack of robust, national, data in this field make comparisons difficult). Some of these low costs are likely to be due to the group-based format of activities, the use of sessional staff and small community venues.

A strong majority of practitioners feel that SWWB activities deliver benefits for their statutory sector partners. Some of these dividends include their role as preventative services that can offset demands on acute, primary care or more specialised services. The case studies illustrate how some SWWB projects have developed formal relationships with their statutory partner agencies and are documenting evidence of outcomes for service users. Some of the more specialised SWWB activities deliver intensive one-to-one services to meet the needs of clients with higher-end health and well-being needs. This form of work is reflected in the higher unit cost services identified in the economic analysis. Here, comparisons with statutory therapeutic intervention become more pertinent for local commissioners.

Partner agencies clearly believe that SWWB activities do not duplicate or substitute for other local provision. They also report positively on the general health and well-being outcomes for service users. However, there is some way to go in terms of providing evidence that this is the case in all SWWB service settings. Practitioners tend to rely on feedback from individual clients and personal observations. Only a minority receive reports from SWWB projects on service outcomes. This may contribute to the perception of a significant minority of practitioners who do not report being well-informed about the outcomes for beneficiaries. It should be emphasised that this perception was not so much a general reflection on SWWB activities: a strong majority of partner practitioners report positively on the overall effectiveness of projects in terms of communication, working relationships and local

engagement. Given issues of data protection and other organisational obstacles, a significant minority of respondents in the practitioner survey also report joint working practices in terms of services delivery, information sharing and so forth. It is evident, therefore, that SWWB organisations often have in place the links for giving routine data on outcomes.

SWWB projects have a remarkable range of links with agencies and these span statutory, community, voluntary and social enterprise sectors. Whilst each SWWB project tends to specialise in their client groups and link agency , as a whole programme we see a network of organisations promoting the well-being agenda on a wide range of fronts. At the local community level, there appears to be great potential. Mainstream and statutory professionals are often working with those who could most benefit from informal, friendly grassroots services. Current patterns of uptake indicate that there is further scope for actively promoting SWWB activities to people using the health and welfare services of partner agencies. Whilst there are barriers – particularly in terms of resource and capacity – our regional survey indicates that partner practitioners clearly see the opportunities for closer working practices.

11. Conclusions & Recommendations

1. As a group of historically separate organisations, SWWB portfolio partners have made considerable advances in developing common approaches towards delivering well-being services. With Westbank Healthy Living Centre as lead agency, agencies increasingly share common standards for planning and recording their take up of services and the characteristics of their beneficiaries. External stakeholders clearly appreciate information on the progress of individuals they refer or recommend to SWWB services. We recommend that SWWB continue to strengthen and consolidate their records on beneficiaries and use this information as a basis for feeding back to partner agencies.

2. Partner agencies engaged in referring and recommending SWWB activities to their service users would benefit from greater evidence of SWWB service outcomes. SWWB projects should ensure that they are well placed to provide outcome data from SWWB Well-being questionnaires, self report outcomes and service feedback assessments. This will help SWWB agencies achieve the vision of 'local health collaboration' set out in the Well-being in the South West 2006 strategy.

3. Whilst further evidence on statutory sector referrals and recommendations needs to be gathered, there is some evidence that such links are likely to be an effective route for reaching individuals who experience higher levels of health need and other forms of inequality. Evidence from practitioners in partner agencies indicates that there remains further scope for promoting recommendations and referrals from these organisations. Work to consolidate and build links should therefore continue to be a priority for SWWB organisations and should be actively supported by local strategic partnerships.

4. Partner practitioners raise the ongoing need to SWWB organisations to market their 'service offer' effectively to local providers as well as direct approaches to target groups.

5 The breadth of services and activities on offer and the diversity of beneficiaries may make it difficult for external stakeholders to grasp the essential or core characteristics of SWWB services. Ongoing work to refine the theory and value base of one-to-one and group-based services continues to be an important opportunity for local providers working within the SWWB programme.

6 Unit costing is a useful and well-established technique that enables projects to demonstrate the cost and value of their services to commissioners and other partners in the local health and social care community. Collecting information and performing these calculations on a regular basis will help projects to identify and understand any changes in the costs of the services they deliver and to ensure that they continue to provide added value.

7 Some projects found it challenging to produce accurate information on which to base the unit costs in this report. Maintaining up-to-date records of the costs of service delivery and the patterns of service use is crucial to demonstrating that projects are delivering the levels of service activity that they are funded to deliver in a cost effective way.

8 The project case studies presented in this report illustrate just some of the SWWB initiatives that are adding value to local service delivery. Other case studies that focus on specific issues such as savings to acute care services, the less tangible benefits of volunteering or co-located service delivery, could be developed as part of the next SWWB evaluation programme of work.

9 Examples of innovative local work taking place under the SWWB programme clearly have the basis for innovative transfer to other locations in the south west region. Commissioners could benefit from examining the scope for reconfiguring current provision to accommodate aspects of SWWB type services alongside their mainstream provision.

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Appendix A: Copy of the Practitioner Survey

South West Well-Being Evaluation
Project Links Questionnaire

Your job title

…….

Your organisation

…….

SWWB project details here

1. **Have you heard of the [SWWB] project?** (Please tick)

Yes ☐ No ☐

If **No** there is no need to complete the rest of this questionnaire.

Please return it in the freepost envelope provided. Thank you for your help.

2. **Have you had any contact with the [SWWB] project?**
This can include any forms of direct or indirect contacts (Please tick)

Yes ☐ No ☐

If yes:

Less than 1 year ☐ More than 1 year ☐

3. **What are the links between your agency, or area of practice, and the [SWWB] project?** (Please tick any that apply)

You recommend SWWB project activities to individuals ☐

You refer clients to SWWB activities ☐

The SWWB project recommends individuals to your agency ☐

The SWWB project refers clients to your agency ☐

You share information about service users ☐

SWWB is contracted to deliver services for your agency ☐

SWWB contracts your agency to deliver services ☐

You collaborate or share venues for service delivery ☐

You collaborate on joint funding proposals ☐

If you have other links please specify……..……..

4. In your view…

How effective is communication between the SWWB team and yourself/your agency? (Please tick one option)

Excellent ☐ Poor ☐ Don't know/Not applicable ☐

How effective has your working relationship been with the SWWB team?

Excellent ☐ Poor ☐ Don't know/Not applicable ☐

How effective is the SWWB project in identifying people's needs?

Excellent ☐ Poor ☐ Don't know/Not applicable ☐

How effective is the SWWB project in identifying local community needs?

Excellent ☐ Poor ☐ Don't know/Not applicable ☐

5. How well informed do you feel about the SWWB project in terms of… (Please tick one option)

	Very well informed 5	4	3	2	Not well informed 1
The target, or priority, groups for the service/activities?	☐	☐	☐	☐	☐
What the service/activities aim to achieve for individuals?	☐	☐	☐	☐	☐
The outcomes for participating individuals?	☐	☐	☐	☐	☐
Availability and accessibility of service/activities?	☐	☐	☐	☐	☐
How service/activities fit with existing local services?	☐	☐	☐	☐	☐
What the project aims to achieve overall?	☐	☐	☐	☐	☐

6. To what extent do you agree with the following statements on potential benefits and drawbacks of the project?
(Please tick one option)

	Strongly agree 5	4	3	2	Strongly disagree 1 / Don't know
The project supports the NHS by providing preventative and/or alternative services	☐	☐	☐	☐	☐
The project supports other statutory services by providing preventative and/or alternative services	☐	☐	☐	☐	☐
The project appears to lack clear outcomes for participant	☐	☐	☐	☐	☐
The project addresses local priorities for promoting health and well-being	☐	☐	☐	☐	☐

The project appears to duplicate other locally available services	☐	☐	☐	☐	☐
Local communities / target groups have a good awareness of the project's services	☐	☐	☐	☐	☐
Local statutory bodies have a good awareness of the project's services	☐	☐	☐	☐	☐

7. Do you have evidence that the SWWB project supports the health and well-being of your service users? *The evidence may be in the form of client self evaluation, practitioner feedback, clinical indicators etc. You may not necessarily have evidence for all service users.*

Yes ☐ No ☐ Don't know ☐

Please comment further

……
……

8. Are there any barriers to closer working links between the SWWB project & your agency?

Yes ☐ No ☐ Don't know ☐

Please give details

……
……

9. Are there any opportunities for closer working links between the SWWB project & your agency?

Yes ☐ No ☐ Don't know ☐

Please give details

……
……

10. Would you be willing to be contacted by a member of the research team for further details?

You will be asked for written consent and any reporting of your views will be anonymised

Yes ☐ No ☐

If yes, please give your telephone number……

… and your email……

Thank you for taking time to complete this questionnaire. Please return your completed questionnaire in the FREEPOST envelope provided by **18th December 2009**, or at your earliest convenience.

Appendix B: Unit Costing Example

South West Well-being Evaluation: Unit Costs		
Please enter Project Name: [Example Project]		
Period for which costs apply:Year2 (Jan - Jun 2009)		
Project Management Costs		
Finance, admin, management staff		£ 1,322.00
Photocopier		£ 250.00
Office Running Costs		£ 1,136.00
Information and Publicity		£ 460.00
Other		£ 1,582.00
Sub Total		£ 4,750.00
Project Staff Costs		
Salaries and expenses		£ 12,705.38
Project Activity Delivery Costs		
Providers		£ 10,046.62
Venue Hire		£ 300.00
Materials		£ 152.00
Transport		
Refreshments		
Other		£ 126.00
Sub Total		£ 10,624.62
Total Service Costs for Period		£ 28,080.00
Number of weeks service is available during period		13
Average total service cost per week		£ 2,160.00
Number of activities per week		41
Average number of participants per activity		5
Number of Activity Units per week		205
Cost per Activity Unit (service user)		£ 10.54