EVALUATION OF HEALTHY LIVING CENTRES IN NORTHERN IRELAND

SUMMARY

THE INSTITUTE OF
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BACKGROUND

The Institute of Public Health in Ireland (IPH) was commissioned by the Department of Health, Social Services and Public Safety (DHSSPS) to evaluate Healthy Living Centres (HLCs) in Northern Ireland, to assist them in assessing the value of the work done by the HLCs and to make decisions about the support which might be offered to them in future in the light of competing priorities. The evaluation was carried out during 2006 by Siobhan Livingstone, Jorun Rugkåsa and Leslie Boydell.

The Bridge Consortium, led by the Tavistock Institute, carried out an evaluation of HLCs across the UK between 2002 and 2006. As a member of this consortium, the IPH undertook case studies of selected HLCs in Northern Ireland and the evaluation commissioned by the DHSSPS builds on this work.

HEALTHY LIVING CENTRES

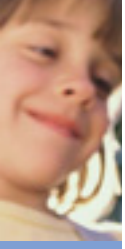
The HLC programme was set up by the New Opportunities Fund (now the Big Lottery Fund or BIG) in 1998 with the aim of promoting health in its broadest sense, targeting the most disadvantaged sectors of the community and addressing health inequalities. They were expected to provide innovative solutions to local needs, work in partnership with other organisations and engage with the community. A key feature was that the programme would work towards a vision of health that encompasses not only physical health but also wellbeing and enhances quality of life.

Some 350 HLCs were funded by the New Opportunities Fund between 1999 and 2003: 257 in England, 19 in Northern Ireland, 46 in Scotland and 28 in Wales. Most received funding for five years which means that funding for all will have expired by 2008. In Northern Ireland, two were funded in 2000, five in 2001 and the remainder in 2002.

There were some important variations in HLCs across the UK, for example in the type of lead organisation. Over 50% of HLCs in England and Wales were led by statutory organisations compared with only 5% in Northern Ireland. Most HLCs in Northern Ireland were led by a partnership or by a voluntary or community sector organisation. These differences are thought to reflect differences in regional policy context (Bridge 2007).

Due to the diversity in the organisation and activities of individual HLCs, it is hard to define them. The Bridge evaluation emphasised that HLCs are more than a collection of activities, that their activities are responsive to local communities' needs and that they harness the resources of HLC partners, ensuring that their work is imbedded within local infrastructures. The Bridge evaluation uses the concept of the 'platform for innovation' (DTI 2006), suggesting that HLCs provide a mechanism for the development of new initiatives, which they subsequently support or implement. They also play a key role in developing local communities.

Most HLCs in Northern Ireland operate from one physical location. However, there are also examples of HLCs which have activities being run by a number of different organisations from different sites. Some have built on existing organisations while others have started as new organisations. Most are steered or managed by a partnership and have a manager with a small team of staff and volunteers. Some HLCs focus on particular groups such as children, older people or people with disabilities, while others target the population of a geographical area or neighbourhood. Some focus on single issues such as physical activity while others



provide a range of services to address different needs. Despite the variation between HLCs, HLCs in Northern Ireland share some fundamental features:

- adoption of a social model of health with a focus on a wide range of social and economic determinants
- use of a community development approach
- empowerment and support for making healthy choices
- close links to mainstream service provision

HLCs in Northern Ireland have recently formed the Northern Ireland HLC Regional Alliance to promote the HLC model and to influence policy.

THE EVALUATION

Purpose

The purpose of the evaluation commissioned by the DHSSPS was to assess the local contribution of HLCs to the health economy in Northern Ireland, to capture lessons learnt and to explore their impact on health.

Methods

The Bridge evaluation highlighted the challenge of evaluating such a complex and diverse programme and in producing the kind of robust evidence required by policy makers. This evaluation faced similar challenges and builds on the UK wide evaluation, using the following methods and data sources:

- Case studies: in addition to six case studies of individual HLCs in Northern Ireland carried out as part of the UK wide evaluation, a further six case studies were undertaken for this evaluation. Each case study involved interviews with HLC managers, staff and stakeholders; interviews and focus groups with users and volunteers; review of documents; and observations of meetings and activities. Case studies were selected to ensure a spread in location and approach.

- Policy perspective: interviews were conducted with policy makers and managers from relevant government departments, Health and Social Services Boards and Trusts, and Investing for Health Partnerships. These explored their views of the local contribution of HLCs and the value of their work.

- SPEAK data: SPEAK (Strategic Planning Evaluation and Knowledge) is an evaluation tool introduced in 2006 as part of the support programme for HLCs being run by the Health Promotion Agency for Northern Ireland (HPANI). It records and reports on the operational environment of the HLC, resources used, activities, outputs and outcomes. It has the potential to produce annual reports for individual HLCs and for the HLC programme as a whole. So far 11 HLCs have entered data and early results from this have been included in this evaluation.

- Analysis of Annual Monitoring Reports: all HLCs produce annual monitoring reports for BIG and these have been analysed by the Northern Ireland HLC Regional Alliance, HPANI and Community Action Network (CAN). Data from this analysis has been used in this evaluation.

FINDINGS

Healthy Living Centres in Northern Ireland

(i) Users

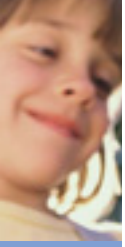
The HLC programme was originally expected to provide services for a catchment population of 20% of the UK population. In Northern Ireland, more than 25% of the population live within areas where HLCs are providing services. According to the analysis of annual monitoring returns, more than 60,000 people access services provided by HLCs in Northern Ireland (this figure may reflect number of visits rather than number of individuals using the services and therefore be an overestimate). However the number of users varies according to the type of services provided by each HLC. For example, one HLC providing rural transport has over 18,000 users while another which provides one-to-one counselling services has a much smaller number of users. The majority of HLC users are women (65%). Some 15% are over the age of 65 years and 22% are under the age of 16 years. These figures are similar to HLCs in other parts of the UK. Only 2% of HLC users in Northern Ireland are from black or minority ethnic groups compared to 10% in the UK as a whole. However, this may reflect the smaller population of people from these groups in Northern Ireland.

(ii) Activities

HLCs in Northern Ireland provide a wide range of different services. HLC managers and staff emphasised that services are provided in response to local needs. They include services to promote physical activity, healthy eating, smoking cessation, sexual health, reduction in substance abuse and help with addictions, general health information, screening, and complementary therapies. They also provide services to promote mental health and combat social isolation, including stress management and counselling. With regard to their contribution to government policies and targets, 14 of the 19 HLCs in Northern Ireland provide smoking cessation support; 15 promote physical activity; 13 provide dietary advice and support for healthy eating; and 12 provide sexual health services. Some 11 HLCs provide some counselling and managers reported that they saw this as an essential service to promote coping skills and that the service is often over-subscribed. Most HLCs also provide services indirectly related to health such as IT training, artistic activities and personal development. HLC staff view these activities as contributing to health in the broadest sense and in helping to engage people in activities which may then enable them to progress to the use of services with a more direct contribution to health. HLC managers emphasised the importance of building relationships with people who are 'hard to reach', enabling them to participate initially in activities such as coffee mornings or art classes before engaging them in activities related to health. Some of these people progress to become volunteers and ultimately find employment. According to SPEAK data, some 16% of the time of HLC staff is spent on enabling participation.

(iii) Costs

HLCs in Northern Ireland currently employ around 100 people. Total salary costs are just over £2,200,000. The majority of HLCs have an annual salary cost of £70,000 to £100,000. There is however, in addition to this, considerable contribution in kind from volunteers. Nearly 250 volunteers contribute up to ten hours per week and around 70 people more than 10 hours per week. Making a crude estimate of six hours per volunteer per week, this would amount to 2000 hours, which if paid at the minimum wage, would cost HLCs a further £500,000 per annum. This would suggest that the contribution of volunteers adds nearly 25% to the human resources of HLCs in Northern Ireland. This analysis in based on data from annual monitoring returns. Data from SPEAK suggests that this figure may be much higher. This is an important contribution to the health economy.



Analysis of annual monitoring returns indicates that the average cost per user for services delivered by HLCs is just under £80. This varies according to the services offered. Using estimates of the costs of services provided through HLCs compared with similar services provided by statutory service providers, for example for smoking cessation, counselling, dietary advice or promotion of physical activity, those provided by HLCs appear to be competitively priced. Obviously this analysis cannot take into account case mix or outcomes. However, it suggests that further economic analysis would be worthwhile.

The Bridge evaluation (2007) concluded that,

There is ample evidence of the potential effectiveness of the majority of activities found in HLCs. For physical activity programmes, lifestyle advice, mental health improving interventions for instance, evidence from studies in the UK and elsewhere indicate that they can have cost effectiveness levels well with the £30,000 per QUALY (quality adjusted life year) gained guideline for treatments funded by the NHS.

Impact of HLCs on individual health and wellbeing

The overall aim of the HLC programme is to improve health and wellbeing of people within the communities served. As already indicated, it is difficult to provide robust evidence of impact on health and wellbeing. The Bridge evaluation concluded that,

There is a considerable amount of information that, taken together, indicates that HLCs were able to have an impact on the lives of those who attended their activities regularly. There was also evidence that they were often reaching out to people who had little previous interest in taking part in health related activities, an essential prerequisite if they were not just to improve the general health and wellbeing of their communities but to reduce to the gap between the better and worse off.

As part of the Bridge evaluation, a survey was carried out of the perceived health and health-related behaviours of HLC users. This was carried out as a baseline, after six and then 18 months. It found that the physical and mental health of non-regular users and non-users deteriorated while that of regular users remained stable. Smoking decreased amongst regular users, physical activity increased and fruit and vegetable consumption increased. These changes were not found in non-regular users. These changes are known to have health benefits and should therefore be considered as evidence of the positive impact of HLCs on the health of their users. HLCs from Northern Ireland were included in this survey and we assume that the findings apply to HLCs here. (Regular users were defined as those who had used the HLC on a weekly basis in the six months previous to the follow up surveys.)

It is very difficult to produce hard evidence of impact on health and wellbeing for local HLCs. In interviews with managers from both HLCs and the statutory sector, claims were made for the beneficial impact of the HLCs on the health of local communities and in reducing health inequalities. One statutory manager stated that,

They can approach things in a different way, take the time to build up relationships with people who already know them and build up their confidence. They trust them because they know them and they take their time in a way that the statutory services could never do. There's a lot of work to do before you can get some people in the front door.

A manager of a HLC based in a rural area with over 6000 users, 60% of whom are regular users, said she could provide:

Endless examples of the impact the HLC has had on individuals which can be backed up with statistics: breast feeding rates have increased locally; home accident numbers reduced following home safety checks campaign; more families are supported; there is evidence from schools of improved attendance; the PSNI report fewer call outs to the area and social services fewer referrals; there has been an increase in the numbers nominated for Community Volunteer awards; increase in numbers attending courses; individuals are said to be more health aware with fewer pregnant women smoking and a number of people who attended the centre with mental health problems are now employed.

This response highlights the diversity of activities and potential mechanisms for producing health benefits. Several managers and users produced individual testimonies of the impact of their HLC on the lives of individual users.

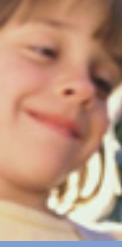
Impact on communities

A key element of the HLC programme is the engagement of users and local people in the activities of the centres. The Bridge consortium (2004) found that HLCs involve communities in many groups such as HLC partnerships and management committees, reference groups and consultations. They also found that HLCs provide a focus for local activity, with the HLC network or buildings acting as a community resource (Bridge 2007).

The evaluation of HLCs in Northern Ireland found that they engage communities in similar ways to HLCs elsewhere. Community participation includes the involvement of local people in volunteering, for example in youth work, crèche provision, leading walks, weight management facilitation or complementary therapy provision. The participation of local people does depend on their willingness to become involved and some HLC managers conveyed their disappointment that community involvement had not been as high as they initially hoped. Data from SPEAK indicates that the issue of encouraging greater community participation is a key challenge and goal as they go forward. For the 11 HLCs using SPEAK 190 volunteers were identified. These contribute in a variety of ways including management activities and programme support, for example in healthy eating, walking and physical activity coaching, smoking cessation, crèche and childcare provision, youth work, event planning and management. The Bridge Consortium (2007) drew attention to the success of the HLCs in Northern Ireland in engaging the community. In particular they highlighted the development of skills in local people as a way of engaging the community, demonstrated by one HLC in Northern Ireland.

For one HLC in Northern Ireland, this appears to have been a key way in which they have been able to reach out to the most invisible or 'hard to reach' members of the community. Through the training of Lay Health Information Workers they sought to encourage an ambassadorial approach which involved encouraging these workers, and then the people they work with, to identify and encourage other vulnerable individuals within their area to make use of HLC resources and activities.

A particular challenge for some HLCs in Northern Ireland is the need to develop trust in communities marked by sectarian division and conflict. There were some impressive examples where HLCs had helped to bring the two communities together to work collaboratively to address local problems. This is an important contribution to promoting social cohesion.



HLC staff emphasised the time-consuming nature of the work that they do helping to build community capacity, foster trust and nurture relationships. They expressed concern that this work is being threatened by uncertainty over future funding. Managers also recognised the strong connections that HLCs have made with their communities and the important role played by volunteers. The informal and friendly approach of HLCs, often facilitated by having local people engaged as staff or volunteers, enables people who might not otherwise do so to access services. Some HLCs reported that they are often approached by staff from statutory agencies to help consult with communities or to facilitate their work with communities because they are seen to be so closely in touch with local people.

Statutory sector managers endorsed this view of the contribution of HLCs in Northern Ireland to community development and to engaging 'hard to reach' individuals. They consider that HLCs are contributing to a reduction in health inequalities locally, and that they have demonstrated their ability to work in innovative and flexible ways in response to local needs.

Impact on service development and partnerships

HLCs try to improve the level of service available to local communities. They do this by identifying gaps in services; setting up new services by themselves or in collaboration with other organisations locally; encouraging other organisations to fill these gaps; and sometimes by lobbying on behalf of local groups. Through their partnerships with other agencies, they help to bring together diverse organisations to respond to health needs in their areas and to encourage other agencies to provide more appropriate, flexible and accessible services. HLCs in Northern Ireland work closely with Investing for Health teams, Local Health and Social Care Groups (up until their dissolution) and other relevant groups, aligning their work closely with local agendas. HLC managers feel strongly that they have been an important influence in the development of local services and in influencing policy locally. This view of the contribution of HLCs was endorsed by statutory sector managers.

CONCLUSIONS AND RECOMMENDATIONS

From this evaluation, we conclude that the HLCs in Northern Ireland are doing what they were set up to do, that is to address the health and wellbeing needs of disadvantaged communities and to contribute to tackling health inequalities. They can demonstrate a number of achievements:

- they are providing services to substantial numbers of people living in disadvantaged communities, many of whom would be considered 'hard to reach'
- based on rough estimates, they appear to provide good value for money
- they have mobilised an increase in volunteering in the areas where they work
- there is evidence that they have impacted positively on the physical and mental health of regular users and improved health-enhancing behaviours
- they have helped to build community capacity and increase community cohesion
- they have increased the range of services available to local people and provide services that are responsive and accessible
- through relationship building, they have established new partnerships and contributed to existing partnership arrangements

These achievements are all in line with government policy. A strong theme throughout the evaluation was the anxiety felt about the loss of BIG funding and the associated threat to HLC sustainability, not only their financial viability, but also the potential erosion of trust built up with local communities if services were to be withdrawn.

Based on this evaluation, we recommend that:

1. The HLC model implemented in Northern Ireland is recognised and supported by the DHSSPS, Health and Social Care Authority (HSCA) and Trusts and other relevant agencies, as a model of good practice in community development and health.

2. The Northern Ireland HLC Regional Alliance is recognised as an effective network across Northern Ireland providing an infrastructure through which the statutory sector can work to address health inequalities and progress regional and local health priorities.

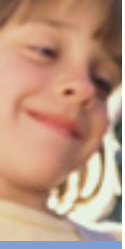
3. The HSCA and Trusts work in partnership with HLCs to develop and deliver a range of services designed to implement regional policies and address locally identified needs and priorities.

4. The HSCA, Trusts, Northern Ireland HLC Regional Alliance and other interested agencies work towards developing a comprehensive monitoring and evaluation system to meet their collective needs. SPEAK is a potentially valuable tool. Support for HLCs to use it over a longer period would be worthwhile. Evidence of increased uptake of healthy lifestyles, such as physical activity or healthy eating, should be accepted as beneficial outcomes since evidence for their impact on health already exists. Based on the preliminary evidence that HLCs provide good value for money, more in depth economic evaluation is recommended.

5. Because of their role in the local health economy and their knowledge of community needs, HLCs have an important contribution to make to local commissioning.

6. HLC staff and volunteers could make a useful contribution to the training of health professionals in community development and health.

7. In parts of Northern Ireland where there are no HLCs (such as the Northern Health and Social Services Board area), consideration could be given to identifying or promoting initiatives which work in similar ways to the HLC model.



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