The North Lewisham Health Improvement Programme
2008/14

Evaluation Report (2008/12)
Acknowledgments

Members of the North Lewisham Health Improvement Programme Stakeholder Group

Jane Miller – Deputy Director of Public Health, Public Health Lewisham

Alfred Banya – Assistant Director of Public Health, Public Health Lewisham

Chris Baguma – Health Improvement Programme Manager, Public Health Lewisham

Keji Kazzim – North Lewisham Health Improvement Officer, Lewisham Healthcare NHS Trust

Susan Robinson - Knowledge Management Research Officer, Public Health Lewisham

Meic Goodyear - Public Health Intelligence Specialist, Public Health Lewisham

Danny Ruta – Director of Public Health Lewisham

Oliver Kempton – Independent Consultant

Ron Houston – Public Participation Consultation and Research (PPCR)
Contents

1. Introduction
2. Background about the programme
3. Evidence base for community development
4. Evaluation methodology and framework
5. Findings
6. Conclusions
7. References
8. Appendices
1. Introduction

This evaluation is about the North Lewisham Health Improvement Programme (from 2008 to 2011), described in more detail in section 2. The North Lewisham Health Improvement Programme (NLHIP) was developed as part of the Health Inequalities Strategy for Lewisham. For the purposes of the Programme, North Lewisham is defined as New Cross and Evelyn wards, which are situated in the north of the London Borough of Lewisham. North Lewisham was selected because Evelyn and New Cross were 2 of the 4 wards in Lewisham with the lowest life expectancy for both men and women; had 2 of the 5 highest ward death rates for people under 75 in Lewisham; and had the highest death rates for people under 75 from cardiovascular disease.

The evaluation of this programme is important for two main reasons; one to measure the effectiveness and impact of the programme and the other to disseminate the learning from the programme to inform other initiatives aiming to reduce health inequalities. When Lewisham Primary Care Trust decided to invest in the programme, it was envisaged that the evidence and learning would be shared so that the programme and its approach would inform health improvement in other parts of the borough.

The evaluation was one of the actions identified in North Lewisham Health Improvement Programme delivery plan. It was undertaken to provide the NLHIP Stakeholder Group, communities in North Lewisham, as well as NHS Lewisham and local authority commissioners with an assessment of the progress made in the implementation of the plan.

This report provides some background information about the programme, a summary of the evidence for using a community development approach, the evaluation methodology used, a summary of the findings, (encompassing findings about specific projects within the programme), and some conclusions.
2. **Background about the programme**

2.1 **Aims and objectives**

The North Lewisham Health Improvement programme aims to reduce the gap in premature mortality between Evelyn and New Cross wards and the rest of the borough through improving health in a number of different ways. The outcomes, which the programme was intended to contribute to were:

- Increased life expectancy
- Decreased rates of premature all cause mortality
- Decreased rates of premature mortality due to circulatory disease

The objectives identified when the plan was first developed were as follows:

- To undertake a detailed analysis of health data regarding Evelyn and New Cross wards in comparison with Lewisham as a whole.
- To work with key stakeholders to understand the factors contributing to the health inequalities and to identify ways to reduce them.
- To build on current initiatives to promote health and reduce health inequalities.
- To develop new health promotion programmes and primary care initiatives.
- To improve the uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness.
- To identify opportunities to target investment towards Evelyn and New Cross wards.
- To identify resources and delivery mechanisms for working in a different way.

2.2 **How the programme was developed**

The plan recognized the need to do things differently. The programme was innovative, dynamic, ambitious and challenging. The rationale was that strengthening community engagement would be a catalyst to promoting health and reducing health inequalities. In addition to targeted increased investment in the area, the programme was to be both ‘bottom up’ and ‘top down’ (linked to the health inequality strategy and long term outcomes and using a community development approach, with a strong emphasis on stakeholder engagement).

The intention was to involve a broad range of stakeholders who lived and worked in Evelyn and New Cross wards in both the development and the
implementation of this plan. When the plan was first conceived the stakeholders included: Cluster 1 Practice Based Commissioning; Evelyn Neighbourhood Management Panel; New Cross Gate New Deal for Communities Programme; Lewisham Council Community Services Directorate; Pepys Community Forum; Deptford Community Forum; and Voluntary Action Lewisham.

In addition to regular discussions with key stakeholders a Steering Group was established to oversee the Health Improvement Programme, with membership drawn from the above stakeholders.

It was envisaged that a health profile for each ward would be undertaken, and that an action plan would be developed, building on current initiatives in addition to new programmes, working together with the key stakeholders and through the Steering Group.

The NLHIP Stakeholder Group was formed in 2008 to oversee the development, implementation, monitoring and evaluation of the Health Improvement Plan. The Plan underpinned the vision and priorities of the Lewisham Strategic Partnership (LSP).

The Plan targeted New Cross and Evelyn wards because these were two of the four wards in Lewisham with the lowest life expectancy for men (2002-2006). New Cross was one of the two wards with the lowest life expectancy for women (2002-2006). New Cross and Evelyn had the highest premature mortality for CVD in Lewisham (2000-2004) and were in the highest five wards in Lewisham for premature mortality (under 75 years) in 2002 to 2006. They also had the highest premature mortality for cancer in 2000 to 2006 in Lewisham. More than 50% of the population of both wards was from black and minority ethnic groups (Black African and Black Caribbean groups are at increased cardiovascular disease). Both wards were in the 20% most deprived in England (Index of Multiple Deprivation 2007). Evelyn ward had a population of 14,500 and New Cross a population of 15,100 according to the ward profiles published March 2004.

The NLHIP Stakeholder Group was also to provide a forum in which representatives from community and voluntary sector groups, GP Practices, the local authority and the PCT share their knowledge, skills and expertise to aid better understanding of the factors contributing to health inequalities in North Lewisham and to identify ways to reduce these.

Additional resources were targeted at both wards. Lewisham Primary Care Trust committed £190,000 Public Health/Choosing Health monies per annum to the programme. In addition, one off external funding from the Department of Health (DH) was directed to both wards: £50,000 from the National Social Marketing Centre/DH for the Evelyn Stop Smoking Social Marketing project;
£100,000 from DH for the Communities for Health – Evelyn Chooses Health; and £160,000 from DH for the Cardiovascular Disease (CVD) & Cancer Healthy Communities Collaboratives.

2.3 **Scope of the programme**

The scope of the programme is wide ranging including many projects and initiatives, which are inter-related. These include: community health projects; primary care interventions; health promotion initiatives; participatory budgeting and small grants to community groups; social marketing; needs assessments and health impact assessments.

Projects were developed which contributed to the objectives of the programme and were underpinned by a community development approach.

Given the limited resources available to support the delivery of the programme, a number of externally funded projects (as described above) were earmarked for Evelyn and New Cross wards, rather than other parts of Lewisham, in addition to projects funded by the Lewisham Primary Care Trust. These projects included the Cardiovascular Disease Healthy Communities Collaborative; the Stop Smoking Social Marketing project; the Communities for Health programme and the Cancer Healthy Communities Collaborative.

A key role of the programme was also to link with other existing local programmes, such as the New Cross Gate New Deal for Communities Programme, which funded a number of health promotion projects during its lifetime from 2001-2011 and the Older People’s Well Being LAA\(^1\) project.

It was also the intention that plans for use of the newly built Waldron Health Centre would dovetail with the programme as it developed in order to optimise the use of the space and facilities provided by the building. Table 1 provides examples of projects and activities within the programme under each objective.

**Table 1: Scope of the programme**

<table>
<thead>
<tr>
<th>Health needs assessment</th>
<th>North Lewisham Health Needs Assessment</th>
<th>Vietnamese Focus Group</th>
<th>New Cross Gate New Deal For Communities Exit Strategy</th>
<th>Evelyn Stop Smoking Social Marketing Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased partnership working</td>
<td>Stakeholder events 2008 &amp; 2009</td>
<td>Bi monthly stakeholder group meetings</td>
<td>Healthy Community Collaborative steering groups</td>
<td>Community Health Forum</td>
</tr>
</tbody>
</table>

\(^1\) Local Area Agreement
A description of the main projects within the programme is provided below.

### 2.3.1 North Lewisham Needs Assessment

This needs assessment (Miller et al 2010) examined and drew out knowledge about the health needs of people living in the north of the borough of Lewisham. It considered data on demography, risk factors for disease, use of primary care and secondary care services as well as outcome data on death, disease and patient satisfaction. Qualitative interview data from general practitioners and other health care professionals were also considered. In addition a range of secondary sources of data were used about the health of north Lewisham residents, including a report on findings from a series of focus groups with members of the Vietnamese community living in North Lewisham in 2009 (Paton 2009).

### 2.3.2 Vietnamese Focus Groups

The Vietnamese community had been identified as one of the population groups in North Lewisham experiencing health inequalities. In Lewisham, the Vietnamese population is estimated to range between 3,500 to 4,000 people. Most of this community lives in the Deptford and New Cross areas.

The information on the experience of health inequality by this population was gathered using a series of focus groups with different sections of the Vietnamese community (people from Vietnam, and second generation Vietnamese people who have Vietnamese parents and have been raised in a country other than Vietnam) living in North Lewisham. The three objectives for the focus groups were:

- To identify perceived health needs among people from Vietnam and second generation in Lewisham;
- To identify perceived gaps in support and service provision;
• To identify issues surrounding access to and experience of health and related services.

2.3.3 Mental Well-being Impact Assessment

The NLHIP stakeholder group decided to use Mental Well-being Impact Assessment (North Lewisham Stakeholder Group 2009) as a way of integrating the promotion of mental well-being into the plan and also to provide possible measures for the impact of the programme on the mental well-being of the local community.

Mental Well-being Impact Assessment (MWIA) uses a combination of methods, procedures and tools to assess the potential for a policy, service, programme or project to impact on the mental well-being of a population. MWIA makes evidence based recommendations to strengthen the positive and to minimise the negative impacts.

The NLHIP Stakeholder Group recognised that while the plan had focused mainly on reducing the levels of premature death particularly from cardiovascular disease and cancer, mental health well-being played a crucial role in determining how people access and respond to healthy living initiatives locally.

The following process was used:

Screening – Deciding - Should you carry out an MWIA?
Identifying from a range of proposals that are most suitable, and those that you wish to assess in more depth

Appraisal process – gathering & assessing the evidence
Community profiling; Stakeholder and key informant – MWIA workshop; Research such as Literature Review

Identification of potential positive or negative impacts

Identification of recommendations and report

Identification of indicators
For monitoring impacts of proposal on mental well-being and implementation of recommendations

A desktop screening meeting was held in August 2009 with a number of stakeholders involved in the North Lewisham Health Improvement programme.

2.3.4 Evelyn Social Marketing Stop Smoking Project
Lewisham Primary Care Trust (PCT) worked with the National Social Marketing Centre as one of 10 Learning Demonstration Sites from April 2007 to pilot a social marketing initiative to address smoking quit rates in Evelyn ward (National Social Marketing Centre 2010). Funding for this Smoking Social Marketing Project from the DH was targeted at Evelyn ward, following a visit from the DH Tobacco Control National Support Team.

Social marketing is an approach to behaviour change that uses commercial marketing techniques to change behaviours for the social good. Commercial marketers have had decades of success in changing our behaviours and evidence suggests that social marketing ideas and techniques can successfully modify patterns of exercise, drinking, smoking and drug use and other behaviours. Like marketing, social marketing requires rigorous consumer insight in order to be successful (4). National Social Marketing Demonstration Scheme aimed to:

- Stimulate the use and integration of social marketing approaches into existing local programmes and strategies
- Increase understanding and development of skills at the local level in using and applying social marketing concepts and approaches
- Test out and contribute to the further development of the NSMC’s practical resources and tools on social marketing;
- Capture learning and promote best practice
- Develop an evidence-base for social marketing in England

The key aim of the Evelyn Stop Smoking Social Marketing Project was to double the number of four week quits amongst smokers in the ward through an increased understanding of the barriers to stopping smoking and what might motivate them to stop.

Three segmented groups of smokers were identified, (adults in manual employment; parents of primary school-age children; adults aged 35-44 years old) following the production of a scoping report by the National Social Marketing Centre.

Data was collected between December 2007 and March 2008 from four focus groups with 32 smokers and semi-structured interviews with six health professionals providing the service in Evelyn Ward, a PCT commissioners and a manager of the Lewisham Stop Smoking Service, on the knowledge and attitudes about the stop smoking service, to inform the development of the social marketing intervention.

The key messages from the research were:
• Stress: smoking helps to manage stress
• Access: support should be available like a supermarket 24/7
• Expectation of being told off and judged
• Service experiences: too little time, too short, mixed views about group support
• Advisors do not see themselves as part of the Lewisham Stop Smoking service
• Customers do not see this as an integrated service (Robinson 2009)

Interventions chosen by the Evelyn Social marketing steering group, following a stakeholder day to consider the research findings were as follows:

**Table 2: Response to research findings**

| Mapping services in detail shows up gaps | GP practices limited time or no advisor  
No pharmacy advisor on Saturday  
No community based service in north of ward |
| Increase investment and access | GP practice based services increased  
Outreach to inform and recruit smokers  
Drop in at Waldron extended and run by outreach advisors  
Millwall endorsement, Smokefree match, bus and market stall  
‘One deep breath’ marketing company - publicity |
| Stress management | Encourage physical activity  
Trial relaxation sessions run at Waldron  
Advisors to give information about other support services |
| Knowledge and referrals to other support services | Gap for most advisors |

### 2.3.5 New Cross Gate New Deal for Communities Programme 2001/11

This ten year regeneration programme, based in New Cross Gate, was nearing the end of its life when the North Lewisham Health Improvement Programme was established. It had developed a strong health improvement element as part of its programme as a result of a Health Impact Assessment (Cooke & Beckingham 2002). The New Deal for Communities Programme (NDC) strategic health outcomes that emerged from the Health Impact Assessment were based on the most pressing issues for people in New Cross Gate:-

- Improve the accessibility and quality of local health and leisure services
- Reduce the incidence of teenage pregnancies and improve the understanding of sexually transmitted diseases and the need for early treatment.
• Improve mental well being of community members through a combination of professional services and informal networks

• Enable local people to make healthy life style choices, including increased physical activities, healthy eating and reduce smoking.

To meet these outcomes the NDC funded a wide range of projects associated with health, including a food co-op, and an older person’s social group promoting physical activity and well being through a range of activities including Tea Dances and Tai Chi. The health theme of the New Deal for Communities Programme became an integral part of the delivery of the North Lewisham Health Improvement Programme.

2.3.6 Cardiovascular Disease Healthy Communities Collaborative

The Cardiovascular Disease Healthy Communities Collaborative, funded by Department of Health, with a dedicated team from 2007-2009, managed by Public Health Lewisham, aimed to raise awareness and to promote the early identification of people aged 40 years to 74 years, at risk of cardiovascular disease.

The project consisted of two teams of volunteers and health professionals, a steering group of stakeholders, and a project manager/CVD support officer. The budget for this two-year project was £89,402, including a project manager, volunteers, events and training. Several work streams developed within the Healthy Communities Collaborative such as; raising awareness in the community and health checks; at risk registers in primary care; and a community pharmacy pilot project.

The community engagement element of the CVD Healthy Communities Collaborative occurred through the activity of volunteers, recruited through networks of local community groups and a number of community events. The events helped to enhance social networks and messages about CVD awareness were conveyed.

More than 30 community venues were tested (using the Plan, Do, Study, Act methodology) by volunteers as outreach points for health checks and raising CVD awareness: Pepys Community Forum information event; Chinese New Year organised by the Deptford Vietnamese community; Woodpecker Time Bank event; Action 2000 Community Centre; Edmund Waller Primary School; Deptford market; Albany Theatre; New Cross Gate residents AGM; Deptford Green School; Post Office at New Cross Gate; 999 Club; NDC health fair at All Saints Church; Somali Community Centre; outside the John Evelyn Pub ("Evelyn Triangle"); Lewisham Shopping Centre; Methodist Church Hall; New Cross Library; Deptford
Blood pressure measurement was usually done by a health professional. Two readings were recorded. All volunteers were trained to know the reference values for BP and the guidelines from the British Hypertension Society were always available. All cases with two high blood pressure readings were referred to their GP.

Those having health checks were signposted to a range of services, including the stop smoking service, the health trainers and a range of physical activity options including Healthy Walks and exercise classes provided by community groups in the north of the borough.

In the absence of a 'local enhanced service' to develop CVD at risk registers within primary care, a pilot project was established. A letter was sent out to 13 practices to encourage expressions of interest to become pilot sites for the CVD risk register. Eight expressions of interest were received. A panel met to select the practices. Six practices were selected. Funds were made available to support these practices, which were contingent upon practices meeting the following requirements:

- catchment population in Evelyn or New Cross wards;
- commitment and clear action plan for developing the at risk register within the specified time scale in line with the PCT guidance, including a risk assessment with a risk tool (either Framingham or JBS);
- patients 'at risk' are assessed in the practices with a view to modifying lifestyle behaviour or initiating appropriate therapy;
- agreement to select a professional lead on CVD within the practice;
- champion CVD work within practice and link with community and other services;
- encourage staff and provide peer support; monitor progress against agreed action plan;
- develop partnership referral arrangements to and from local healthy lifestyle services;
- release designated practice staff to attend local CVD team meetings;
- attendance at the New Cross or Evelyn monthly team meetings of the Healthy Communities Collaborative (Perez- Ferrer, Lewisham PCT 2009)

A third element of the collaborative was a pilot in three community pharmacies
for CVD risk screening was launched in April 2009 and it was evaluated (Lewisham PCT 2009).

2.3.7 Cancer Healthy Communities Collaborative

The aim of the programme was to promote the early presentation and diagnosis of breast, lung and bowel cancer symptoms. The programme was delivered in two areas of Lewisham, New Cross & Evelyn wards and Bellingham ward with the strategic goals of raising public awareness on the early cancer symptoms and engaging GP’s Practices.

The purpose of the GP engagement was twofold; firstly to increase the awareness of GPs about the signs and symptoms of bowel, breast and lung cancer and the importance of early diagnosis. Secondly, to collect data on the number of referrals to secondary care for investigation of cancer, in particular recording the numbers referred within the recommended two weeks from having been seen by the GP. Practices were also asked to make sure people with concerns or symptoms of lung, breast or bowel cancer were able to access services easily. They were also asked to use the 2 week referral route, as well as provide and display cancer promotional resources such as leaflets, posters & flyers. Practices were requested to send the monthly data on 2 week referrals to the HCC.

An action plan was set up for delivering and achieving the above two core strands. Publicity information on cancer awareness was distributed to 10 GP practices in the North of the borough

Volunteers were recruited from local communities and given training to improve their knowledge in raising awareness on cancer risk through informal talks, presentations and facilitation of public events on Breast, Bowel and Cervical cancers. The volunteers carried out a mapping of the potential community groups and venues to run cancer awareness sessions for local people from different ethnic and cultural backgrounds. The volunteer teams met on a monthly basis. Two celebration events for volunteers were held when certificates were awarded.

2.3.8 Deptford and New Cross Health Forum

The forum was established in November 2009 and was set up and is supported by the 170 Health Project Community Development for Health Worker. The main focus is to provide an environment, which fosters trust among groups, encourage sharing of information, resources and ideas and a seedbed for the development of effective partnerships on health improvement.
2.3.9 North Lewisham Stakeholder Group, events and ward assemblies

The stakeholder group was established at the inception of the programme in 2008 (at a stakeholder event) to oversee the development, implementation, monitoring and evaluation of the Health Improvement Plan. It meets every two months. It is chaired by a voluntary sector member and supported by the public health programme manager and the North Lewisham Health Improvement Officer, Lewisham Healthcare Trust. The purpose of the group is to increase partnership working, accountability, engagement and involvement by the wider community in identifying ways to reduce health inequalities in North Lewisham. A key role of the group has been to make prioritise expenditure of the programme budget.

The core group membership is made up of service users, key statutory, voluntary and community sector providers, who also serve on designated working groups to take forward the implementation of plans and recommendations from the stakeholder group meetings.

Stakeholder events have been held every year since the programme started and have been attended by 70 and more stakeholders each time. The purpose of the events is to: engage the wider community in finding local solutions; share progress in delivery of the Programme and involve and consult the local residents on priorities and projects to support and deliver those priorities. It is also a platform for raising and responding to key issues to ensure they are resolved through the stakeholder process.

Links have been established with the Evelyn and New Cross ward assemblies. The ward assembly co-ordinators attend the North Lewisham Stakeholder group meetings regularly and the North Lewisham programme manager and health improvement officer make regular presentations to the assemblies.

2.3.10 Reducing Alcohol Harm

The programme was aligned with the Lewisham Alcohol Delivery Plan.

A number of initiatives have been undertaken in the north Lewisham area including: brief intervention training for community groups (increased awareness of the issues surrounding alcohol misuse; understanding some of the consequences of alcohol use, alcohol dependence, relapse and withdrawal; increased confidence in dealing with alcohol related issues and incidents; more knowledge of the help available locally for people with alcohol problems); the development of referral pathways with CRI, New Direction the specialist alcohol service; the inclusion of alcohol awareness in health events in Deptford market and a number of alcohol seasonal awareness campaigns in the New Cross area, aimed at young people.
2.3.11 Small Grants to Communities

There has been a range of small grant programmes during the lifetime of the overall programme: Evelyn Chooses Health (ECHF); Deptford/New Cross Choose Health and the Supporting Communities Fund.

**The ECHF** was part of the Communities for Health Programme, launched by the Department of Health, with the aim of piloting approaches to working with the most deprived communities to tackle health inequalities by bringing together Local Authorities, the NHS and the community and voluntary sector. Lewisham Council was granted £100,000 non-recurrent funding by the Department of Health, to be spent by March 2008.

Evelyn ward was targeted for funding by Lewisham Council and Lewisham Primary Care Trust because it met the criteria of being one of the areas with the worst deprivation and poorest health outcomes in the borough, but which also had an adequate community infrastructure to facilitate delivery of the programme within the year. New Cross was not targeted because much of the ward benefited from investment through the New Deal for Communities Programme. The EHCF was to contribute to the delivery of the North Lewisham Plan. In addition, Evelyn had recently been one of two neighbourhood management areas selected by the multi-agency Community Development Strategy Steering Group to pilot participatory budgeting, using funding from the Neighbourhood Renewal Fund.

The main aim of the ECHF was to improve the health and well being of people living in the Evelyn area. The EHCF was intended to deliver interventions that would support individuals in making lifestyle changes in relation to smoking, eating and physical activity, using a community development approach (2008).

The participatory budgeting approach to allocating funds to groups to improve health and well-being was a different way of working between community groups and statutory agencies. The stakeholders saw it as a positive way of involving local people in making decisions. The learning from the evaluation of Evelyn Chooses Health has informed the development of subsequent participatory budgeting rounds (Deptford/New Cross Choose Health).

**The Supporting Community Fund** was a similar grants scheme aimed at local communities in North Lewisham, Evelyn Ward and New Cross Ward. The scheme was funded by the Lewisham Primary Care Trust. Grants up to £5000 funded activities that contributed to promoting healthy eating, stop smoking and physical activities. A Participatory Budgeting approach was not used in this instance.
The funding was publicised through letters and emails sent to known community organizations in North Lewisham. Applications from 18 projects were received, 14 projects were allocated funding. Most organisations were well established and had been running between 5-10 years and had experience in being funded by other Public Sector organisations, whilst a small number were recently established with very little experience in managing and delivering healthy living programmes. Four organisations were based outside the wards but had well-established activities within the wards. All project activities were delivered within the two wards, with the exception of Age Concern who also delivered their activities in Southwark Park in the borough of Southwark. 10 projects proposed to run over 6-12 months and four ran between 5-8 weeks. The most popular times for delivery of projects were weekday mornings and afternoons. The activities were aimed at: Children and Parents; Young people aged 13-25 yrs; Older Adults; Men; BME groups; Asylum Seekers and Refugees; People with long-term illnesses; Wider Community.

Objectives of the funding were met through different activities such as; dancing, cooking skills, creative arts, exercise classes, gardening skills, sewing classes, health walks, day trips to name but a few. No project focused on this objective; however it was addressed through raising awareness of the Stop Smoking Service.

**DeptfordNewCross Choose Health** was another small grants programme with three funding rounds in 2009, 2010, and 2011, using a participatory funding approach.

There were 42 applications received for the DeptfordNewCross Choose Health 2011 funding. Thirty of these groups were shortlisted and invited to the Participatory Budgeting event held in December 2010. A total of 16 projects were allocated funding from the £70,000 available. Six of these groups had never received funding through the North Lewisham Health Improvement Plan.

The groups proposed to deliver a variety of healthy living activities to meet the following priorities for the funding: increased consumption of fruit and vegetables; increased levels of physical activity; improved mental wellbeing; support people to stop smoking; raised awareness of alcohol consumption. Some groups proposed activities to directly meet the priorities; they would directly raise awareness of health issues by putting on nutrition workshops, healthier cooking skills, exercise classes, dance classes or walking groups. Other projects would use an indirect approach to engage and encourage clients to live more active lifestyles, uptake of fruit and vegetables or to improve mental wellbeing by encouraging people to participate in gardening, creative arts, days out or sowing classes.
2.3.12 Community Development for Health 170 Project

This project was established in 2009 and a Community Development worker was funded from the programme budget. The project aimed to enable groups to develop health benefits in: improved diet and nutrition; increased physical activity; positive mental wellbeing and supporting people to stop smoking. The anticipated outcomes were:

- Increased awareness of health and behaviour change
- Evidenced bases healthy lifestyle activities
- Increased sustainability of behaviour change
- Increased partnership working between groups
- Increased engagement of people in the community in improving their health

This is a community development project. The core funding is for a Community Development post, whose role is to provide support to local groups to develop and deliver health projects in north Lewisham (Evelyn and New Cross wards). The post works alongside the PCT North Lewisham Health Improvement Officer to support the work of north Lewisham groups, especially those funded through the participatory budgeting.

The worker has delivered training workshops, health promotion events, cookery and nutrition workshops and provided support with funding applications. The worker established the Deptford and New Cross Health Forum, bringing together community groups on a regular basis to share good practice and network with each other. She also arranged for other organizations to deliver workshops and information sessions to the groups such as bowel awareness, and stop smoking.

2.3.13 New Cross Gate Food Co-op

The key aims of the co-op are to promote healthy eating through the provision of affordable good quality fruit and vegetables in New Cross Gate and to increase the consumption of fruit and vegetables. The long-term sustainability plan is to develop the New Cross Gate Food Co-op into a social enterprise.

This is a community-based project that emerged as a result of an earlier health impact assessment conducted in New Cross Gate (Cooke & Beckingham). The health impact assessment had previously established that limited access to healthy foods, such as fruit and vegetables of an acceptable quality and cost was a major health issue in New Cross Gate. Consequently, the Eating for Health Project was established to increase awareness of eating healthily and to improve access to information and opportunities for healthy food choices. In 2005, the Eating for Health project worked with local residents and established the Food Co-operative, which ran a weekly stall as an outlet for affordable fresh fruit and
vegetables. It also reached out to the local sheltered housing for older people. It was funded by New Deal for Communities for three years.

The co-op has grown from strength to strength, originally managed by Building Healthier Communities and now run by 170 Community Project, funded under the programme, by Public Health Lewisham. It provides a fruit and vegetable stall outside the New Cross Gate Post Office three days a week, supported by local volunteers. In addition to providing increased access to healthy food for local residents, the stall acts as a focal point for health promoting activities such as health checks.

2.3.14 Spatial planning

The stakeholder group established a planning and health group soon after the programme was established. The purpose of the group was to ensure that the environment and infrastructure provision in the area encouraged and enabled healthy lifestyles. The agreed model of work was to use the stakeholder process to consult the local community and residents on key developments in the area. Liaison with the planning department was established and various planning officers have visited the stakeholder group to discuss various developments and planning schemes.

2.3.15 Waldron Health Centre

It was the intention that plans for the use of the newly built Waldron Health Centre would dovetail with the programme as it developed in order to optimise the use of the space and facilities provided by the building.

A PCT manager, with responsibility for the Waldron Health Centre, attended the stakeholder meetings from 2008 until 2010 to brief and update the group on evolving plans and improvements. In return, the stakeholders commented and fed back on issues of access.

The stakeholder group was also represented on the Waldron Health Centre User Group, through the Programme Manager. The purpose of the user group was to facilitate local engagement and involvement in shaping the use of the building and space, reviewing access to services and increasing joined up working between service providers. This group ceased to meet when the PCT manager changed role and the stakeholder group was no longer involved.
3. Evidence for a Community Development approach to Health Improvement

3.1 Introduction
In order to address effectively the poor health outcomes identified in north Lewisham, a community development approach was chosen as the most effective way to improve the health and well being of the residents of New Cross and Evelyn wards. This chapter focuses on the evidence about a community development approach for health improvement. It begins by presenting a brief background to community development, goes on to illustrate three models of community development and health, and finishes by providing evidence that demonstrates that community development can successfully be employed to address health issues.

3.2 Background to Community Development and Evidence of Health Improvement through Community Development
Community development has been an important element of UK public policy since the 1960s, used in central and local programmes across the fields of health, education, housing, social services and regeneration. Community development has been a central plank of the World Health Organisation’s strategy for improving health and reducing health inequalities since the early 1980s. Community development is an approach whereby communities are supported to identify and find ways to address their problems and concerns. It is anchored in the principles of social justice and engagement and is committed to building capacity within and for that group, while respecting, harnessing and cultivating its power, networks and assets (WHO 2002). The World Health Organisation (WHO) linked community development to health by stating that ‘the aim of community development is that of achieving personal, collective and social change, all of which is usually associated with improved health status.’ As a means of reducing health inequalities, the WHO considers the empowerment of both individuals and communities to be essential (WHO 1997). It further makes the connection between community development and participation, explaining that community development is an empowering developmental process that is a pre-requisite for community participation. Accordingly, ‘participation is the ‘product’ and community development the ‘process’ of a methodology that can be utilised to involve individuals and groups in looking after their health.

Participation has also been cited by writers, such as Putnam (1993) as one of the elements of social capital that can enable people to connect with each other, hence develop social support networks often resulting in health outcomes. The
health benefits of social support have been documented. Berkman et al (1992) for example compared the survival rates of elderly patients suffering from acute myocardial infarction between those who have support and those who do not. They found that lack of emotional support was associated with death within six months after myocardial infarction for those that lacked support. Berkman (1979) also argued for inclusion of social support, family and community strengths, when exploring new paradigms for disease and disability prevention. This was on the basis of a population-based research, which reviewed mortality risk over two decades and showed that people who are isolated were at risk of mortality from a variety of causes. Similarly Kawachi et al (1996) showed that, compared to people with strong social networks, individuals who were socially isolated were over six times more likely not to survive stroke, over three times more likely to commit suicide and also less likely to survive coronary heart disease. In an earlier study Kawachi et al (1999) found that fair or poor self-rated health was associated with living in areas with the lowest levels of social trust.

Community development represents a paradigm shift in the principles and practice of health promotion, as the focus moves from individuals to communities (Shediac-Rizkallah M and Bone L 1998). This shift is based on the tenet that changes in norms of acceptable behaviour at the level of the community as a whole is the best way to achieve lasting, widespread behavioural change, and that such change is more likely to occur when the people it affects are involved in the change process (Robertson and Minkler 1994). For example, within community development, people with shared needs living in a defined geographic area are viewed as active participants in the process, identifying their needs, taking decisions and shaping solutions to address those needs, in partnership with health professionals (Rifkin, Muller, and Bichmann, 1988).

In practice, community development covers a spectrum of approaches to interacting with local communities and community involvement, from working with established health programmes such as smoking cessation groups to facilitating community needs outside of mainstream NHS services. Therefore, while it could mean that communities decide for themselves what the problem is, it could also involve the health care services establishing the problem and providing a framework for community input. However, a key philosophy underpinning most community development approaches is that projects take a broad-based positive view of health and do not focus solely on illness (Royal College of Nursing 2002).

To assist an understanding of its role in health improvement and tackling health inequalities it is useful to conceptualise community development. Smithies and Adams (1993) have described community development for health as consisting of three basic elements: a theory of health; a set of core values; a practice. The theory considers health as socially as well as biologically constructed. Inequalities
in health are therefore seen as reflecting wider inequalities in society. The core values of community development for health are social justice and equity. The practice of community development for health is being focused on the disadvantaged and marginalised groups with the aim of increasing their confidence, self esteem, knowledge and skills, thereby empowering them as individuals and communities so that they can define and participate in addressing their own needs.

Popay (2006) identified a number of proposed pathways that aim to explain how community development works to improve health. These are:

1) **Information flows**: The community provides information of their needs and views of existing service provision so that services and interventions can be redesigned to improve uptake.

2) **Governance and guardianship**: The appropriateness and accessibility of services and interventions can be improved, and thus uptake increased, through the promotion and support of community involvement and/or co-production of a service.

3) **Social capital development**: Relationships of trust, reciprocity and exchange within communities can be developed through community development approaches.

4) **Empowerment**: The conditions for communities to act to change their material and political environments can be fostered by community development approaches. In effect, power relations are transformed, and health improvement theoretically evolves from the increased capacity, competency and skills of individuals to exercise choice, increase self-efficacy and control, and for their communities to improve material conditions.

There are many examples of programmes using a community development approach to achieve a variety of outcomes, of which some of those most closely related to the objectives of the North Lewisham Health Improvement Programme are presented here.

A community health animateur project (South Yorkshire Coalfields Health action Zone 2003) was implemented to spearhead a radical and integrated approach to training community health activists, community groups, voluntary sector groups and individuals, as a step to changing the way health promotion and healthcare are delivered at a community level. Community health animateur trainees undertook training in community work and health promotion, and spent three days a week on community health related work placement in their own communities. They were recruited from the communities that made up the South Yorkshire Coalfields Health Action Zone (HAZ) and were paid at a rate equivalent to the national minimum wage. Through this programme, 39 community health animateurs were trained and 26 gained employment. Two
entered further or higher education and two continued as volunteer workers within the community (in addition to the establishment of various community initiatives).

A community development approach was used in Bradford to increase breast and cervical cancer screening among Bradford’s minority ethnic women, reduce social exclusion and enabling marginalised groups to influence services. This resulted in an increase in cervical and breast screening uptake among women from ethnic minority communities (Kernohan 1996).

More recently, a rapid review of the effectiveness of community engagement approaches and methods for health promotion interventions was undertaken in the UK (Swainston and Summerbell 2008). It found that a number of different approaches can have a positive impact on health objectives similar to those in the North Lewisham Health Improvement Programme. For example, neighbourhood or community committees, when used in the planning and design of an intervention, may be effective in contributing to improving diet. Community coalitions were associated with the integration of a healthy lifestyle into a community norm, and appear to contribute to effective promotion of walking as physical activity. Finally, community workshops, when used in the design and delivery of an intervention, can maintain a high level of participation, and therefore contribute to the development of a sustainable healthy community by providing awareness and the adoption of healthy lifestyles.

Probably the seminal, and most thoroughly evaluated, public health improvement project to use a broadly-defined community development approach was started in Spring 1972 in the North Karelia area of Finland. The North Karelia project was set up to address the burden of heart disease in the region, and aimed to carry out a planned, comprehensive community program for control of CVD, especially CHD, in respond to the petition of the population (McAlister et al, 1982).

The main objectives for the project were:

- Improved preventive services to identify persons at abnormal risk of disease and provide appropriate medical attention;
- Information to educate people about their health and how it can be maintained;
- Persuasion to motivate people to take healthy action;
- Training to increase skills of self-control, environmental management, and social action;
- Community organisation to create social support and power for social action;
- Environmental change to create opportunity for healthy actions and improve various unfavourable conditions.
The project was evaluated after both five and ten years. After five years, a clear relative reduction in cardiovascular disease was observed in North Karelia as compared to the reference area. After ten years of the program, the reductions in risk factor levels observed in North Karelia were substantial: for men, 36% in smoking, 11% for mean serum cholesterol concentration, and 5% for mean diastolic blood pressure. The changes of this magnitude in risk factors may be small for an individual, but they represent mean changes for the whole population and should thus be important for population disease rates (Puska, Nissinen, Tuomilehto 1985).

The recent NICE Guidance (2008) emphasises the importance of involving communities in priority setting, funding decisions, designing, delivering, improving and managing health related projects and activities.

Overall, some gaps remain in the evidence for health improvement through community engagement and development, including costs and effectiveness, constraining and facilitating factors, and participants’ experiences of community engagement initiatives. However, there is a growing body of evidence internationally that community development is an effective approach to health improvement. The examples that have been discussed in this section show that community development is a relevant and useful approach. This approach is illustrated further in the models described below.

3. Models incorporating community development for health

The first model (Figure 1), the Beattie (1991) model of Health Promotion places community development in the context of different types of action that can be taken to improve health. This model has four quadrants; each quadrant conveys the means by which health may be promoted. Importantly, each quadrant is infused with its own philosophies, beliefs and values and outcome measurements in relation to health promotion. The methods can be directed at an individual or at population level. The manner of delivery can be ‘authoritarian’ and therefore top down or ‘negotiated’ and bottom up. The top-down approaches are termed health persuasion techniques for health and legislation/policy for health, the bottom-up approaches are named personal counselling for health and community development for health. The aims of the top down approaches are to redirect unhealthy behaviours; the bottom-up approaches are aiming to increase individual and community empowerment (see figure below).
The model in Figure 2 shows how to achieve change and reduce health inequalities at a population level in three main ways, at a personal health level, a community health level and a population health level. This model includes four key components: systematic and scaled interventions by frontline services; systematic community development, rather than ad hoc, targeting engagement and support to the weakest and least capable of responding; a range of processes to connect frontline services into the heart of communities, reaching out to seldom seen, seldom heard groups and individuals; and driven by committed leadership fostering engagement, effective local strategic partnership and a locally owned coherent vision and strategy (Bentley 2010). This model has been used as a framework to assist in the evaluation of the North Lewisham Health Improvement programme.
The third model (Figure 3) proposes that the level at which communities and local people are involved is considered critical to actually achieving improved health outcomes. It proposes a theoretically driven representation of how different levels of community engagement may directly and indirectly affect health in both the intermediate and longer term. Those initiatives with the least community input and direction, such as informing and consulting, are expected to have little impact compared with those in which the community acts as a co-producer or has delegated power or control (NICE 2008).

The model suggests that the engagement designs in which the community is most involved and has the most devolved power can also contribute to improved community bonding or social capital, which may have further beneficial effects on well-being. Such approaches do this by invoking knowledge gained through experience of non-professional participants, increasing people’s belief in and ability to assume control (Attree P, French B 2007).
Figure 3: Pathways from community participation, empowerment and control to health improvement
4. Evaluation methodology and framework

4.1 Design considerations and strategy

The North Lewisham Health Improvement Programme (NLHIP) is a complex intervention (MRC 2008), with numerous projects and interventions leading to various desired outputs and impacts. Complex interventions, particularly those involving community-based activities, are widely used in public health practice, but are difficult to evaluate because of their complexity, size, and the multiple problems they try to address (RCN 2002).

On the whole, strict experimental evaluation designs, such as randomised controlled trials (RCT), are not feasible when evaluating community programmes, as the ‘real life’ context of these programmes prevents the control of many variables required in an experimental design (HAZ 2003). Further, conventional cost effectiveness analysis can rarely be carried out on community engagement work, as the effects of such approaches are often diffuse, occur far into the future and are not easily measured (RCN 2002). Overall, a range of methods is needed to evaluate the diverse nature and intended outcomes of complex community interventions Swainston K and Summerbell C. (2008).

The approach to this evaluation is based on an understanding that health promotion represents mediation between people and their milieu. In other words, the role and actions of health promotion involve looking at the total environment, which enhances health. Therefore, health promotion activities not only include improvement in food, income, housing and building of skills but also creating supportive environments resulting in personal and community empowerment (Dines & Cribb, 1993). The programme was compared with two of the models described in the previous section, the Beattie model and the Health Inequalities National Support Team Intervention Model.

For this interim stage of the evaluation, an embedded design was developed to capture the changes that occurred since the implementation of the plan (Parry C, Berdie J, 2004). For the purposes of this project, embedded evaluation entails assessing how far the constituent parts of a programme met its individual objectives, and then looking at these, both separately and together, to assess their contribution to the process and outcomes of the whole programme. Embedded evaluation is therefore most appropriate when the initial goal is to ascertain that actions were undertaken, to understand how they were conducted and to document the outputs and impacts deriving from them, before then evaluating their contribution to the objectives of the broader programme. Such a design is particularly apposite for this plan, as five years is not a long enough
period of time to achieve aims such as reducing cardiovascular morbidity and mortality, but changes that contribute to these may still been observed (Swainston K, Summerbell C 2008).

From the breadth of NLHIP interventions described in Section 2, it is clear that their diverse nature and the different levels at which they operate require different methods, both qualitative and quantitative, to evaluate them. Using embedded evaluation provides the scope for employing different evaluative strategies, tailored to measuring the outputs, outcomes and process of interventions. Outputs are defined as the products of projects or initiatives, such as meetings, documents, groups established, money distributed, number of people or population groups benefitting. Outcomes are defined as the effects, both intended and unintended, of the products. On the whole, outputs and intended outcomes should correspond to the objectives of the project or initiative. Process looks at how a project or initiative is working, including the unexpected challenges, opportunities and barriers encountered in running it.

Overall, the embedded evaluation was designed to answer four main questions:

What projects or initiatives were established?
What objective[s] of the programme did they meet?
What was learned about the process of the projects or initiatives?
What were the outputs and outcomes of the projects or initiatives, and how did they contribute to improvements in the four overarching areas of the plan: knowledge, behaviour, disease prevalence and premature death?

4.2 Data Collection

Six different methods of quantitative and qualitative data collection were used to evaluate the various projects within the overall programme:

- **Focus Groups:** Specifically chosen groups of people were asked about their perceptions, opinions, beliefs, and attitudes towards particular topics or aspects relevant to the project. Questions are asked in an interactive group setting where participants are free to talk with other group members.

- **Semi-structured Interviews:** Unlike a structured interview, which has a formalised, limited set of questions, a semi-structured interview is flexible, allowing new questions to be raised during the interview as a result of what the interviewee says. The interviewer in a semi-structured interview generally has a framework of themes to be explored.
• **Surveys:** Surveys involved the administration of questionnaires to a sample of a group or whole group to collect information that could be analysed using quantitative (numerical or statistical) methods.

• **Document Search:** Information from documents such as reports, minutes, plans, reviews, or records of any kind to extract information relevant to the inquiry were collected.

• **Database Search:** Databases of information from online sources, such as articles in academic journals, reports from academic or charitable organisations’ websites, or other collections of scientific and other articles were systematically searched according to pre-agreed search criteria.

• **Desktop Screening (Mental Well-being Impact Assessment only):** Identification of the most suitable proposal that merits the undertaking of a more in-depth assessment.

### 4.3 Data Analysis

Seven different quantitative and qualitative methods of analysis were applied to the relevant sources of data:

• **Thematic analysis:** Thematic analysis is one of the most commonly used methods of qualitative analysis. The researcher identified a limited number of themes which adequately reflect the data collected through interviews, focus group discussions or other sources of qualitative data.

• **Framework Analysis:** Framework analysis is a qualitative method that is used with research that has specific questions, a limited time frame, a pre-designed sample and a priori issues (issues known ahead of time) that need to be investigated. Data were sifted, charted and sorted in accordance with key issues and themes.

• **Descriptive analysis (statistical):** Descriptive statistics were used to describe the basic features of the data in order to present quantitative descriptions in a manageable form. Where appropriate, tests of statistical significance were undertaken to account for the effects of chance.

• **Document analysis:** This social research method involved the extraction and interpretation of information relevant to the current project.

• **Secondary data analysis:** This involved the re-use of pre-existing qualitative data for research purposes and corroboration. Data collected by others
provided larger and higher-quality databases that would be unfeasible for researchers to collect.

- **Comparative analysis**: Involved comparison of two or more comparable sets of data to ascertain what differences and similarities there are or to judge performance against another set of data.

- **Interrupted Time-Series**: This design, whereby a single group of participants (such as those living in a specific area) is tested repeatedly both before and after a manipulation or a natural event (such as prescribing rates after GP training). Essentially, it involved a single-group, pre-test/post-test design with multiple before and after measures.

The different sources of data, and the application of the various data collection and analysis methods used to evaluate each initiative within the overall programme, are listed in Table 4 below. The table also indicates which specific project objectives were being evaluated by each data source and method of collection/analysis.

4.4 **Overall Assessment of the North Lewisham Health Improvement Programme**

The framework developed by the National Health Inequalities Support Team (Bentley C, 2007) and the Beattie model of health promotion (1991) were used to assess the approach used by the overall programme.

4.5 **Overall Assessment of the Impact of the North Lewisham Health Improvement Programme**

In order to provide an overall assessment of the impact of this complex public health intervention on health and wellbeing in North Lewisham, a panel of four public health specialists (the Lewisham Director of Public Health, the Deputy Director of Public Health and initiator of the programme, the Assistant Director of Public Health, and the Programme Manager) reviewed all the findings and results from the evaluation and arrived at a consensus summary assessment.

The findings and results reported in this evaluation report, for each of the projects in the North Lewisham Health Improvement Programme were reviewed independently by panel members. Evidence of an impact on health and wellbeing was assessed against the four overarching outcomes (Knowledge, Behaviour, Disease Prevalence, and Premature Deaths) and eight programme outcomes (health needs assessment, increased partnership working, health promotion initiatives, increased community engagement, improved primary care uptake, increased resource allocation, working in a different way, identified local targets).
Each panel member was asked to assign a rating to each project against each relevant outcome, on a Likert (Likert R, 1932) whole number scale from 0 to +3, where a score from >0 to 1 indicates a small effect, a score from >1 to 2 indicates a moderate effect, and a score from >2 to 3 indicates a large effect.

A Delphi process (Brown B. B, 1968) was then used, whereby after initial scoring, the panel's results were compared and discussed, and panelists were given the chance to change their scoring having heard the opinions of the other three members. The final (post-Delphi) scores were then averaged to arrive at an overall score between 0-3 for each project against each outcome.

Individual panelists’ final (post-Delphi) scores were analysed for inter-rater reliability. There are many different measures or indices of inter-rater reliability (Popping, R. 1988). There is little consensus as to which is preferable, though there is widespread agreement that some commonly used measures are inappropriate (Lombard M, Snyder-Duch J, Campanella-Bracken C 2010). After consideration of available methods, Fleiss's kappa (1971), a multiple-rater generalisation of Cohen’s kappa was used. This measure calculates the degree of agreement between raters over that which would be expected by chance. It is scored as a number between 0 and 1. A value of 0 represents no agreement, while a value of 1 indicates complete agreement. There is no universally accepted measure of significance for Fleiss’s kappa, or scale of interpretation. The most frequently used is that of Landis and Koch (1977), and that is used here. Table 3 shows how the measure is interpreted.

**Table 3: Landis & Koch criteria for reliability**

<table>
<thead>
<tr>
<th>kappa</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 0</td>
<td>Poor agreement</td>
</tr>
<tr>
<td>0.01 - 0.20</td>
<td>Slight agreement</td>
</tr>
<tr>
<td>0.21 - 0.40</td>
<td>Fair agreement</td>
</tr>
<tr>
<td>0.41 - 0.60</td>
<td>Moderate agreement</td>
</tr>
<tr>
<td>0.61 - 0.80</td>
<td>Strong agreement</td>
</tr>
<tr>
<td>0.81 - 1.00</td>
<td>Very strong agreement</td>
</tr>
</tbody>
</table>

Kappa reliability coefficients were calculated for average agreement between panelists for each outcome.
4.5 Social Return on Investment (SROI)

Lastly the Social Return on Investment (SROI) cost benefit analysis tool was also applied to a number of the projects. This is a cost-benefit analysis tool, developed primarily by the new economics foundation and the SROI Network (UK Cabinet Office, 2009). It is designed to help organisations better understand the impact and value-for-money of projects or activities, and to provide tools to help decision-making. The model as it stands allows for a calculation of social value created by the programme. It was used to measure the change for the identified outcomes of some of the projects within the programme, such as the Stop Smoking Service and the Participatory Budgeting Small Grants Scheme and placed a monetary value on each of these outcomes. It also allowed a comparison against the original investment. See Appendix 1 for more information on the methodology used.
### Data sources, data collection and data analysis

**Table 4: Methods used to evaluate each initiative**

<table>
<thead>
<tr>
<th>Programme objective(s)</th>
<th>Project/Initiative</th>
<th>Specific project objective(s) to be evaluated</th>
<th>Data Collection Method</th>
<th>Data Source(s)</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed needs</td>
<td>North Lewisham</td>
<td>Knowledge about health needs</td>
<td>Semi-structured face</td>
<td>GPs (2) GPs (4) &amp; 4 other health professionals Vietnamese Focus Groups' Report</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>assessment</td>
<td>Health Needs</td>
<td></td>
<td>to face interviews</td>
<td>2009; NDC report from MORI Survey Demography, risk factors for disease, use of primary care</td>
<td>Secondary analysis</td>
</tr>
<tr>
<td></td>
<td>Assessment</td>
<td></td>
<td>Online survey</td>
<td>services and use of secondary care services as well as outcome data on death, disease, lifestyle and patient satisfaction.</td>
<td>Descriptive analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Document search</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Database search</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed needs</td>
<td>Vietnamese Focus</td>
<td>Knowledge about health needs, access and gaps</td>
<td>Six focus groups</td>
<td>1. n= 43: 32 Vietnamese (men; women; elderly (60 years and over); Indochinese; 2nd generation (16-25 years old); and 11 professionals working with Vietnamese community 2. Total n= 5: four Vietnamese and one GP</td>
<td>Descriptive and thematic analysis</td>
</tr>
<tr>
<td>assessment</td>
<td>Groups</td>
<td>in services</td>
<td>Five interviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme objective(s)</td>
<td>Project/Initiative</td>
<td>Specific project objective(s) to be evaluated</td>
<td>Data Collection Method</td>
<td>Data Source(s)</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
</tbody>
</table>
| Completed a health needs assessment of New Cross and Evelyn wards                      | Mental Health & Wellbeing Impact Assessment | Assess potential for NLHI to impact on the mental well-being of Evelyn and New Cross population              | Desktop screening MWIA Workshop (word association; discussion; small group work) | 1. Stakeholders involved in NLHIP  
2. Total n= 18: 5 community wardens; 1 resident; 5 voluntary & faith organisations; 1 children’s centre; 5 NHS Lewisham staff; 1 Local assembly member | Document and database analysis  
Thematic and content analysis       |
<p>| Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham | | | |  | |</p>
<table>
<thead>
<tr>
<th>Programme objective(s)</th>
<th>Project/Initiative</th>
<th>Specific project objective(s) to be evaluated</th>
<th>Data Collection Method</th>
<th>Data Source(s)</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed a health needs assessment of New Cross and Evelyn wards.</td>
<td>Evelyn &amp; New Cross Stop Smoking Social Marketing Project</td>
<td>1. To assess whether activity on the project was accompanied by changes in: awareness of stop smoking services; interactions with stop smoking services, smokers motivations to quit; perceived barriers and incentives to quitting. 2. To explore the extent to which the operational and implementation plans have been developed and carried out according to the aims of the project; to assess the acceptability of the intervention to those involved; to assess the level of engagement of key partners; and to examine what factors may have enhanced or hindered progress. 3. To explore the extent to which the intervention had an impact on numbers entering the service and quit rates in Evelyn and New Cross Wards.</td>
<td>External evaluation study: (Reducing smoking in the borough of Lewisham, National Social Marketing Centre Demonstration Site, NSMC, Spring 2010): 1. a cross sectional survey with a qualitative interviews 3. Analysis of Stop Smoking service data for 4 years (2008/11)</td>
<td>1. pre sample of 209 and post sample of 204 people living and working in the Evelyn ward area 2. eight key stakeholders 3. 1474 smokers living in Evelyn &amp; New Cross wards</td>
<td>Document and database analysis Descriptive and thematic analysis Quantitative analysis</td>
</tr>
<tr>
<td>Programme objective(s)</td>
<td>Project/Initiative</td>
<td>Specific project objective(s) to be evaluated</td>
<td>Data Collection Method</td>
<td>Data Source(s)</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
</tbody>
</table>
| Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham. | New Cross Gate New Deal For Communities Programme 2001-2011 | Assess if achieved strategic outcomes and performance of NDC Partnership. Identify strategic outcomes for NXG Trust. | 1. Document search  
2. Semi-structured interviews  
3. Surveys | 1. Delivery plans, reports, submissions, programme review; Administrative data for NDC areas  
2. n=15 stakeholders in NXG Partnership & partner organisations  
3. Households in NDC areas | Document analysis  
Comparative analysis  
Descriptive statistical analysis  
Thematic analysis |
<table>
<thead>
<tr>
<th>Programme objective(s)</th>
<th>Project/Initiative</th>
<th>Specific project objective(s) to be evaluated</th>
<th>Data Collection Method</th>
<th>Data Source(s)</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness</td>
<td>CVD Healthy Community Collaborative</td>
<td>Research questions: 1) These health checks may be raising people’s awareness of CVD and the risk factors but are they successful in getting them to their GP if they have risk factors? 2) Are the GPs subsequently managing these patients appropriately once they’ve had the health check?</td>
<td>Health Check data was provided by a volunteer organisation (BHC) and the HCC Project Manager. Those people who were referred to their GP in North Lewisham were highlighted. Consent to visit the GP practices was sought. The GP practices were visited to gain information from EMIS about follow-up CVD consultations as a result of the health checks.</td>
<td>From 351 health checks, 78 were referred to their GP. Only 33 of those could be followed-up (as 44 had to be excluded due to lack of patient consent and 1 had to be excluded as they could not be found on the EMIS computer system).</td>
<td>Document analysis, Descriptive statistical analysis</td>
</tr>
<tr>
<td>Increased community engagement to raise awareness of health and promote the uptake of services</td>
<td></td>
<td>The aims were to find out how useful the health checks had been in raising people’s awareness of their health and in prompting them to make changes in their lifestyle, including seeing their GP. It also looked into how many people used their health passports (little booklets given out at the health checks where measurements are recorded and contain contact details of GPs, and other services such as support groups) in helping them to attain a healthier lifestyle.</td>
<td>203 questionnaires were sent out in the post and 67 questionnaires were done over the telephone. 38 completed postal questionnaires were received back in the post and 65 telephone consultations were completed. The total number of questionnaires together is 103.</td>
<td>38 postal questionnaires and 65 telephone consultations of people who had had health checks from project ePACT prescribing database</td>
<td>Descriptive statistical analysis</td>
</tr>
<tr>
<td>Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards</td>
<td></td>
<td>Raise awareness of and promote the early Evidence of identification of people at risk of cardiovascular disease (CVD)</td>
<td>Document search Questionnaires Telephone interviews</td>
<td>ePACT prescribing database CVD ‘at risk’ registers GP referral data Attendance registers Activity records</td>
<td>Interrupted time series analysis, using number of items prescribed before and after the start of the NLP, comparing North Lewisham practices with the rest of the borough</td>
</tr>
<tr>
<td>Programme objective(s)</td>
<td>Project/Initiative</td>
<td>Specific project objective(s) to be evaluated</td>
<td>Data Collection Method</td>
<td>Data Source(s)</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Increased uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness</td>
<td>Cancer Healthy Community Collaborative</td>
<td>Evidence of promotion of early presentation of cancer symptoms in breast, lung and bowel to GPs and facilitate early detection and treatment of these cancers</td>
<td>Activity data</td>
<td>Activity data, Attendance data, Monthly GP data, Evidence of GP promotion of scheme, Demand for cancer awareness training, GP verbal feedback, Project partner feedback, Training logs, Training feedback (volunteers), Number of GPs appropriately using the “two week fast track referral system” with patients who expressed concerns or who had suspected cancer symptoms.</td>
<td>Document analysis, Thematic analysis, Descriptive statistical analysis</td>
</tr>
<tr>
<td>Increased community engagement to raise awareness of health and promote the uptake of services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme objective(s)</td>
<td>Project/Initiative</td>
<td>Specific project objective(s) to be evaluated</td>
<td>Data Collection Method</td>
<td>Data Source(s)</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------</td>
<td>----------------------------------------------</td>
<td>------------------------</td>
<td>----------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.</td>
<td>Deptford &amp; New Cross Community Health Forum</td>
<td>Evidence of promotion of community cohesion, partnership working and ownership</td>
<td>Document search</td>
<td>Activity data (individual and group participation in interventions, and attendances at stakeholder events and meeting)</td>
<td>Documentary analysis</td>
</tr>
<tr>
<td>Increased community engagement to raise awareness of health and promote the uptake of services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified mechanisms for partners working in a different way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme objective(s)</td>
<td>Project/Initiative</td>
<td>Specific project objective(s) to be evaluated</td>
<td>Data Collection Method</td>
<td>Data Source(s)</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Completed a health needs assessment of New Cross and Evelyn wards.                  | Stakeholder Involvement     | Knowledge about members' views & experience of stakeholder group & NLHIP Evidence of increase in partnership working | Interviews, Document search | Regular attendees of Stakeholder Group; Sample of other core members and time limited members Attendance registers Minutes of the Stakeholder Group meetings and records of attendance Minutes of ward assembly meetings | Thematic analysis
Descriptive statistical analysis
The calculation of mean response scores and percentages were used to analyse the results of the stakeholder questionnaire. Cumulative frequencies, percentages, rates and means were applied to the activity data, and where appropriate, the outcome data. |
<p>| Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham. |                              |                                                                                                               |                            |                                                                                                   |                                                                               |
| Established effective initiatives which promote health and reduce health inequalities in North Lewisham. |                              |                                                                                                               |                            |                                                                                                   |                                                                               |
| Increased community engagement to raise awareness of health and promote the uptake of services. |                              |                                                                                                               |                            |                                                                                                   |                                                                               |
| Increased uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness. |                              |                                                                                                               |                            |                                                                                                   |                                                                               |
| Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards. |                              |                                                                                                               |                            |                                                                                                   |                                                                               |</p>
<table>
<thead>
<tr>
<th>Programme objective(s)</th>
<th>Project/Initiative</th>
<th>Specific project objective(s) to be evaluated</th>
<th>Data Collection Method</th>
<th>Data Source(s)</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham. Establishment of effective initiatives which promote health and reduce health inequalities in North Lewisham. Increased community engagement to raise awareness of health and promote the uptake of services. Increased uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness.</td>
<td>Reducing Alcohol Harm</td>
<td>IBA training of community groups Seasonal awareness campaigns</td>
<td>Evaluation sheets</td>
<td>Lewisham Alcohol delivery plan</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>Programme objective(s)</td>
<td>Project/Initiative</td>
<td>Specific project objective(s) to be evaluated</td>
<td>Data Collection Method</td>
<td>Data Source(s)</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.</td>
<td>Small Grants programmes</td>
<td>Collect evidence of, and views about, delivery of interventions to support individuals in making lifestyle changes in relation to smoking, eating and physical activity</td>
<td>In-depth interviews (telephone and face-to-face)</td>
<td>N=47: 17 project leads, 5 steering group members, 25 participants in the activities delivered under the Fund</td>
<td>Framework analysis</td>
</tr>
<tr>
<td>Established effective initiatives which promote health and reduce health inequalities in North Lewisham.</td>
<td></td>
<td></td>
<td>Monitoring reports community groups receiving grants</td>
<td>More than 300 projects</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>Increased community engagement to raise awareness of health and promote the uptake of services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified mechanisms for partners working in a different way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified local targets and indicators, and evaluated the health impact of the plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme objective(s)</td>
<td>Project/Initiative</td>
<td>Specific project objective(s) to be evaluated</td>
<td>Data Collection Method</td>
<td>Data Source(s)</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.</td>
<td>Project 170 Community Nutrition Worker</td>
<td>Face to face interviews with worker &amp; project director Telephone interviews Questionnaire by e mail Participant observation of Community Health Forum</td>
<td>N=15 individuals and groups participating in project activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme objective(s)</td>
<td>Project/Initiative</td>
<td>Specific project objective(s) to be evaluated</td>
<td>Data Collection Method</td>
<td>Data Source(s)</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.</td>
<td>New Cross Gate Food Coop</td>
<td>Evidence of provision of support to volunteers and delivery of project activities</td>
<td>Stallholder questionnaire</td>
<td>Management Steering Group minutes</td>
<td>Descriptive statistical analysis</td>
</tr>
<tr>
<td>Established effective initiatives, which promote health and reduce health inequalities in North Lewisham.</td>
<td></td>
<td></td>
<td>Informal feedback procedures</td>
<td>Records of sales of fruit</td>
<td>Document analysis</td>
</tr>
<tr>
<td>Increased community engagement to raise awareness of health and promote the uptake of services.</td>
<td></td>
<td></td>
<td>Document search</td>
<td>Record of events</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Customer numbers</td>
<td></td>
</tr>
<tr>
<td>Programme objective(s)</td>
<td>Project/Initiative</td>
<td>Specific project objective(s) to be evaluated</td>
<td>Data Collection Method</td>
<td>Data Source(s)</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.</td>
<td>Spatial Planning for Health</td>
<td>Evidence of action to ensure that the environment and infrastructure provision in the area encourage and enable healthy lifestyles</td>
<td></td>
<td>Minutes of stakeholder meetings, Presentations to stakeholder meetings</td>
<td></td>
</tr>
<tr>
<td>Established effective initiatives, which promote health and reduce health inequalities in North Lewisham.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified mechanisms for partners working in a different way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Findings

This section summarises the evaluation findings of the projects/services or initiatives that were established under the programme, including the social return on investment for some of the projects. It also uses the framework developed by the National Health Inequalities Support Team (2007) and the Beattie (1991) model of health promotion, described in the previous section, to assess the approach used.

It is clear that more than 10,000 people benefited from the programme using monitoring information from several projects (Figure 4). This is likely to be an under estimate as many community groups and some projects have not had systems in place to capture all their users for the whole period of the programme.

**Figure 4: Number of people who have benefited from programme**
For each project, the findings are organised under the following headings:

- **Programme Objective(s) Met**: the objectives of the programme to which it contributed
- **Key Findings**: the main points arising from the embedded evaluation(s) undertaken
- **Discussion**: what the findings show in relation to its impact on the outcomes of the overall programme, such as knowledge, behaviour change, disease prevalence, and mortality.

1. **North Lewisham Health Needs Assessment**

**Programme Objective(s) Met:**
- Completed a health needs assessment of New Cross and Evelyn wards.

**Key findings:**

a. The health needs assessment confirmed the pattern and level of deprivation and poor health of north Lewisham that was estimated when the programme was established, in terms of lifestyle behaviour, disease and mortality. The high proportion of under 75 year olds reporting a long term illness, the comparatively low levels of life expectancy and the high rates of premature death together with lower than expected diagnosis of chronic diseases were identified as areas of concern.

b. The large projected increase in the population of North Lewisham which is very mobile, together with the high levels of deprivation, comparatively high numbers of residents whose first language is not English and poor health outcomes present enormous challenges to both service providers and commissioners.

c. The needs assessment report was added to the Lewisham Joint Strategic Needs Assessment website and presentations were made to key stakeholders, including the North Lewisham Health Improvement Stakeholder Group, the GP Neighbourhood 1 Clinical Commissioning Group and the Lewisham Adult Joint Commissioning Group.

d. The needs assessment has informed the North Lewisham programme and its priorities and most of its recommendations have been addressed.

**Discussion:**
The needs assessment provided valuable baseline information about knowledge, healthy lifestyles, behaviour, disease prevalence and mortality at the time of writing in 2010, including trends. It provided useful information to inform the programme by confirming the rationale for the programme, identifying gaps, documenting some changes that had taken place since the beginning of the
programme, including the increased recording of blood pressure by GPs amongst patients with hypertension and making recommendations.

5.2 Vietnamese Focus Groups

Programme Objective(s) Met:
- Completed a health needs assessment of New Cross and Evelyn wards
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham

Key findings:

a. Focus groups were undertaken in 2009, followed by a comprehensive report summarising the findings and giving key recommendations. The Vietnamese community has many features of a newly settled community although the majority of Vietnamese residents arrived in the late 1970s and in the 1980s. Many people from the Vietnamese community do not speak fluent English, are unemployed, have low levels of educational achievement and do not access mainstream services (Paton 2009).

b. Most of the issues raised in the focus groups related to the wider determinants of health, such as income, social status, education, physical environment, social support networks, housing, unemployment and gender. Other related issues that emerged were: difficulty in learning and communicating in English; family relationships; safety; addictions; mental health, health services; the influence of culture and background and access to services.

c. The key recommendations were: establish a working group to improve collaborative working and community action using a community development approach; disseminate the findings of the report to relevant organisations to explore ways of changing practice; increase understanding of the interplay of background, culture and community needs; develop skills by providing learning opportunities for the community.

d. A working group representing the Deptford Vietnamese Project, Federation of Vietnamese Refugees from Vietnam in Lewisham (FORVIL) North Lewisham Community Development for health team and the North Lewisham Health Improvement Programme, was formed in September 2010 and met three times, but has since not been convened.
e. The findings of the focus groups were shared with the North Lewisham Stakeholder Group and other partners, including the Young Adults Partnership Board and the ward assemblies.

f. The Directorate of Public Health revised the service specifications of the Lewisham Refugee Network (LRN), FORVIL and the Deptford Vietnamese Project to include performance measures for reporting on how these organisations co-ordinate their activities in supporting the Vietnamese community. As a result, the uptake of the NHS Health Checks and the Stop Smoking Services increased among the Vietnamese community.

Discussion:
The focus groups and subsequent report provided comprehensive information about the Vietnamese community, including key concerns and issues as well as providing insight into barriers to behaviour change, which informed the programme. A number of changes were made in terms of public health commissioning. The uptake of NHS Health Checks and the Stop Smoking Services increased among the Vietnamese community, which would lead to some reduction in smoking prevalence and more people at cardiovascular risk being identified.

A number of the recommendations from the report were not taken forward, as the working group ceased to meet after a couple of meetings.

5.3 The Mental Health and Well Being Impact Assessment (MWIA).

Programme Objective(s) Met:
- Completed a health needs assessment of New Cross and Evelyn wards
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham

Key findings:

a. The MWIA identified that the NLHIP had a number of potential positive impacts on wider determinants of mental well-being, such as access to high quality public services, access to affordable healthy food and leisure services.

b. A MWIA stakeholder workshop was held in October 2009 focusing on how local healthy living services (including healthy walks, health checks

---

2 Community Development Health Team and Stop Smoking Service Quarterly Performance Monitoring Reports 2012/13
3 Community Development Health Team and Stop Smoking Service Quarterly Performance Monitoring Reports 2012/13
and screening, stop smoking, weight management, Health Trainer services) can improve their impact on mental well-being. This workshop also identified actions to maximise positive impacts and minimise potential negative impacts on mental well-being.

c. The stakeholders involved in the MWIA identified 12 key determinants of mental well-being that were both of high importance and had the potential to have a high impact on the promotion of mental well-being of people living in New Cross and Evelyn (Table 5).

**Table 5: MWIA determinants**

<table>
<thead>
<tr>
<th>MWIA Area</th>
<th>Increasing Control</th>
<th>Resilience</th>
<th>Participation and inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Determinants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressing views and influencing decisions</td>
<td>Emotional well-being, self-esteem, confidence, hope, optimism and life satisfaction.</td>
<td>Accessible and acceptable goods and services.</td>
<td></td>
</tr>
<tr>
<td>Workplace</td>
<td>Steps towards a healthy lifestyle</td>
<td></td>
<td>Practical support</td>
</tr>
<tr>
<td>Belief in own capabilities</td>
<td>Trust and safety</td>
<td></td>
<td>Feeling involved feeling of belonging</td>
</tr>
<tr>
<td>Maintaining Independence</td>
<td>Sustainable local economy</td>
<td></td>
<td>Safe, confident, secure</td>
</tr>
</tbody>
</table>


**d.** The plan was identified as having the potential to positively affect 'enhancing control' by increasing a sense of control, belief in one own capability, opportunities to influence decisions and collective action. These impacts are largely on individuals who access services like health trainers, stop smoking services, exercise on referral, or who are volunteers involved in the collaborative or community projects involved in participatory budgeting.

**e.** The plan was identified as having a number of potential positive impacts on components of 'resilience and community assets' through improving emotional well-being, learning and development, social networks and relationships and emotional support. Many of these impacts were specific to volunteers or people engaged in specific projects.
f. The plan was identified as having a number of potential positive impacts on components of ‘participation and inclusion’ by increasing volunteers’ sense of belonging and having a valued role.

g. Stakeholders’ recommendations included:

- More outreach by healthy living services to the places where people are, like workplaces and markets. The stop smoking service was felt to have achieved this successfully
- Improved information and publicity of services and projects, including making messages clear and accessible to those who speak English as a second language and using Lewisham Life and local assemblies
- Review opening hours of key local services and organise workshops are held outside of 9am to 5pm, and ensure initiatives funded by participatory budgeting process schedule activities to cater for out-of-hours participation.
- Training on signposting, engagement, negotiation and motivation to enable front line, non-health staff (e.g. wardens) to successfully work with residents to encourage them to engage in healthy living services.

h. As a result of the recommendations from the MWIA:

- The NLHIP Stakeholder Group agreed to use MWIA as a way of integrating the promotion of mental well-being into the plan and also to provide possible measures for the impact of the programme on the mental well-being of the local community.
- It influenced the third round of participatory budgeting priorities through increasing community projects addressing mental well-being activities.
- The Improving Access to Psychological Therapy (IAPT) service has become part of the stakeholder group and has identified opportunities to link with the programme initiatives and therefore enhanced mental health and wellbeing support in North Lewisham.

Discussion:
The MWIA served three key purposes. It identified some indicators to use to measure mental wellbeing. It raised awareness of how the programme was contributing to mental well being, some gaps and how these were to be addressed. It strengthened the mental well being element of the programme through making promoting well being more explicit in the criteria for small grants funding and in promoting more effective referral pathways between

---

4 The impact on mental well being achieved through these initiatives is described under each initiative, later in this report
the Improving Access to Psychological Therapies service and community groups funded through the programme.

The methodology used was an inclusive way of enabling stakeholders to assess the actual and potential impact of the programme, leading to concrete ways to improve the mental well being focus of the programme.

4. Evelyn Stop Smoking Social Marketing Project

Programme Objective(s) Met:
- Completed a health needs assessment of New Cross and Evelyn wards.
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.
- Established effective initiatives which promote health and reduce health inequalities in North Lewisham.
- Increased community engagement to raise awareness of health and promote the uptake of services.
- Increased uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness.
- Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards.
- Identified mechanisms for partners working in a different way.
- Identified local targets and indicators, and evaluated the health impact of the plan.

Key findings:

a. A study undertaken with smokers in Evelyn ward to identify reasons for smoking and barriers to stopping found that the primary motivations to smoke were: as a means of dealing with stressful situations; to relax or to have time and space to find calm. Smoking was also perceived as an integral part of socialising. Smokers also acknowledged that they smoked because of physical and mental addiction to cigarettes, and felt that habit as much as addiction was important.

b. Smokers were motivated to stop when becoming pregnant, although all respondents who had quit while pregnant resumed smoking within a few weeks after the birth, although there was no longer a physical nicotine addiction. Smokers were also inspired to stop if they felt that smoking might affect their families’ health, or if it could be ‘proven’ that it led to their parents’ ill health and death, especially among the respondent group with young children. However, rather than stopping, smokers often made adjustments to their practice, such as smoking outside or in a different room.
c. Respondents overwhelmingly felt that stopping was impossible or undesirable during stressful times in life, whether ongoing or acute. Smokers perceived that ‘stress’ or adverse life events led to them resuming smoking even after they had stopped for months or years.

d. All smokers in this study were aware that help to stop smoking was available from their primary health care providers, but were not able to distinguish which would be the most appropriate advisor for their situation. Of those respondents who remembered seeing written information, most learned about the provision of stop smoking support through posters at their GP surgery and posters and leaflets at pharmacies.

e. Smokers’ experience of using the service previously was generally positive.

f. The fear of ‘being lectured’ was the main barrier to using the service, but this was not necessarily based on concrete experiences of using the service in Lewisham. Another perceived barrier was the delay between being referred to an advisor and actually getting an appointment. The health professional service providers all noted that failure to stay stopped was a huge barrier to smokers approaching the service again, at least through the same route.

g. The most common area for service improvement or innovation mentioned by smokers was the introduction of group support both to provide camaraderie during the early stages of quitting, and to make available ongoing, more casual support in the following months when smokers felt they might relapse, especially if experiencing an adverse life event. Having more ‘round the clock’ access to an advisor, was also raised. Smokers did not want stop smoking sessions in places of recreation or relaxation, such as the hairdressers, small shops or other local outlets.

h. Key stakeholders felt that social marketing concepts had changed the approach of the stop smoking service and its advisors, and that customer insight and listening to smokers had been central to the project.

i. However, most stakeholders felt that barriers to behaviour change (such as stress and weight management) had been considered, but not
adequately addressed. Some of the interviewees said that the factors that kept the target group smoking were so deeply entrenched in their socio-economic position, social values and networks that the problems were too difficult to address within the scope of the project. It was felt that the system of incentives and signposting to extended services, which the project aspired to provide could not be an adequate exchange for the costs of behaviour change (National Social Marketing Centre 2010).

j. There was an increased focus on Evelyn and New Cross wards by the Lewisham Stop Smoking Service, including the establishment of the Waldron Stop Smoking Drop-In in 2008, following the Evelyn Social Marketing Project.

k. There was a notable increase in the number of residents entering the Lewisham Stop Smoking Service from Evelyn and New Cross wards (53% and 103%, respectively) between January and December 2008 and January and December 2009, and this was far greater than the 23% increase across Lewisham as a whole. The number of successful quitters also increased during that time period (by 30% in Evelyn and by 62% in New Cross), compared with a 7% increase in the numbers quitting in the rest of Lewisham. The higher levels have also been sustained beyond the lifetime of the project (2010 & and 2011) in comparison with the rest of Lewisham.

Table 6: Numbers of smokers setting quit dates and successfully quitting in Lewisham

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Total</th>
<th>Change 08 to 09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evelyn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Quit Dates Set</td>
<td>134</td>
<td>205</td>
<td>209</td>
<td>194</td>
<td>742</td>
<td>+53%</td>
</tr>
<tr>
<td>4 Week quit?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>60</td>
<td>78</td>
<td>96</td>
<td>87</td>
<td></td>
<td>+30%</td>
</tr>
<tr>
<td>No</td>
<td>29</td>
<td>28</td>
<td>40</td>
<td>57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>45</td>
<td>99</td>
<td>73</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quit Rate</td>
<td>44.8%</td>
<td>38.0%</td>
<td>45.9%</td>
<td>44.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Cross</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Quit Dates Set</td>
<td>111</td>
<td>225</td>
<td>18</td>
<td>215</td>
<td>732</td>
<td>+103%</td>
</tr>
<tr>
<td>4 Week quit?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>58</td>
<td>94</td>
<td>82</td>
<td>91</td>
<td></td>
<td>+62%</td>
</tr>
</tbody>
</table>
### Table: All Wards (Lewisham)

<table>
<thead>
<tr>
<th>4 Week quit?</th>
<th>Yes</th>
<th>1429</th>
<th>1526</th>
<th>1466</th>
<th>1427</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>625</td>
<td>820</td>
<td>487</td>
<td>603</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>703</td>
<td>1038</td>
<td>1206</td>
<td>1374</td>
<td></td>
</tr>
</tbody>
</table>

Source: Lewisham Stop Smoking Service Quit Manager Database Oct 2012

**Discussion:**

In the years preceding the NLHIP, the number of smokers setting quit dates in Evelyn and New Cross wards had been lower than the average number setting quit dates in the rest of Lewisham, despite the estimated higher smoking prevalence in these wards (Health Equity Audit, 2006, Lewisham Public Health, Miller). This was still the case in 2008, when the social marketing project was established (Table 7).

There was a notable increase in the number of residents entering the Lewisham Stop Smoking Service from Evelyn and New Cross wards (53% and 103%, respectively) between January and December 2008 and January and December 2009, and this was far greater than the 23% increase across Lewisham as a whole. The number of successful quitters also increased during that time period (by 30% in Evelyn and by 62% in New Cross), compared with a 7% increase in the numbers quitting in the rest of Lewisham. The higher levels have also been sustained beyond the lifetime of the project (2010 & and 2011) in comparison with the rest of Lewisham.

The use of social marketing techniques to obtain an insight into smokers views enabled the Stop Smoking Service to improve the way the service was provided and led to an increase in the number of smokers accessing the service, setting quit dates and stopping smoking. The project had an impact on activity and quit rates both during its lifetime, and also beyond. **It should be noted, however, that the magnitude of the impact was much greater during and immediately after the project, than in the two years after the project.**
Despite the fact that many of the social determinants of smoking, identified as barriers to smokers quitting were not addressed, there was nevertheless an increase in the numbers of smokers quitting, as a result of the project.

5. **New Cross Gate New Deal for Communities (NDC) Programme 2001-2011**

**Programme Objective(s) Met:**
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.
- Established effective initiatives which promote health and reduce health inequalities in North Lewisham.
- Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards.
- Identified mechanisms for partners working in a different way.

**Key findings:**

a. The NDC Programme Manager and members of the Board regularly attended the stakeholder meetings and contributed to the alignment of NDC programme health objectives to the North Lewisham programme.

b. An external evaluation of the NDC programme (Centre for Regional Economic and Social Research, Sheffield Hallam University 2010) found that people felt that access to, and trust in, local health services had improved, but were less satisfied with GP services. There were modest improvements in healthy lifestyle indicators and self-reported health. The New Cross Gate NDC area health indicators improved more than similarly deprived benchmark areas, with NDC programmes.

c. The New Cross Gate Trust, which was established by the NDC programme, drew on the North Lewisham Needs Assessment to inform its priorities and also used its funds to supplement the North Lewisham Participatory Budget Fund, ‘DeptfordNewCross ChoosesHealth’.

'To ensure that the health provision in New Cross Gate continues to improve the Trust should ensure that it is represented on the North Lewisham Health Stakeholders Group and the North Lewisham Health Improvement Plan. Trust members involved in the health theme should keep themselves up to date with health policy initiatives and strategic objectives so that opportunities can be seized when they arise’

'Trust members should agree on the health priorities they wish to support that will best support the health needs that have recently been assessed in North Lewisham’

---

5 New Cross Gate NDC/Trust Health Strategy, 2010-15, April 2010
6 New Cross Gate NDC/Trust Health Strategy, 2010-15, April 2010

- 57 -
A number of the projects continued beyond the life of the NDC programme and were supported through the North Lewisham health improvement programme, including the Food Co-op (see 5.13) and JOY (Just Older Youth). JOY encourages older people to become physically active and, since the NDC funding ceased in 2008, JOY accessed funding through the Participatory Budgeting Scheme, has gained new members and provides activities for older people such as line dancing and tai chi.

Discussion:
The alignment of the NDC programme with the North Lewisham Health Improvement Programme strengthened each programme and enabled health promotion interventions to be sustained, which had been started by the NDC. The modest changes in health behaviour identified in the NDC Mori Poll (Miller 2010) are likely to have been sustained through these interventions.

5.6 Cardiovascular Disease Healthy Communities Collaborative (CVD HCC)

Programme Objective(s) Met:

- Increased uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness
- Increased community engagement to raise awareness of health and promote the uptake of services
  - Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards

Key findings:
a. The final report of the project found that community teams, whose members came from a diverse range of communities, were effective in reaching and engaging target groups due to their local knowledge of events, venues, networks and target groups. For example, the HCC was invited to a Saturday club of Somali women, and to the Chinese New Year, organised by the Vietnamese community.

b. The PDSA (Plan-Do-Study-Act) methodology was useful in evaluating outreach activities and venues to see if they were effective in reaching the target population.
c. Thirty volunteers or members of community organisations were recruited and trained. Most volunteers evaluated the training provided as ‘useful’ or ‘very useful’.

d. As the project developed, the HCC identified the need for a volunteer information pack, with information about the role of the HCC volunteer, expenses and claims, and useful contacts. They also identified the need for an overarching NHS Lewisham policy on volunteering. Using volunteers requires policy decisions about roles and remuneration.

e. The collaborative model can reach its potential when it is well supported. It was useful to work with different community groups, local authority and health organisations, such as the stop smoking team, to establish potential referral routes or lifestyle support opportunities.

f. The standardisation of information collection was identified as important. Obtaining patients’ consent to send information to GPs, broadening the criteria for referral to GPs and clarifying responsibility for follow-up. Additionally, the definition of what constitutes a ‘CVD at risk register’ must be agreed beforehand.

g. GP practices require a lead person, appropriate IT support and templates for risk assessment. An incentive scheme such as a Local Enhanced Service is necessary. All practice staff need to be informed and involved in some part of the work for it to be successful.

h. Invitation letters must be well thought through. Long pre-consultation questionnaires may be discouraging for people. The letter together with a request for a blood test seems to work better than sending a pre-consultation questionnaire.

i. Overall, 2,247 health checks were undertaken by the project, with 1,389 people aged 40 to 75 years old, exceeding the target of 1,300. The project was successful in reaching women (70%), people from black and minority communities (70%) and those not registered with GPs (4%), but less successful in reaching residents living in the catchment area (40%) and men (30%).

j. Regarding blood pressure, 27% of people had a high reading (>140/90). 52% of people with a high blood pressure reading reported

---

7 CVD, Healthy Communities Collaborative, End of Project Report, September 2009
8 Jessica Gullard, (VTS GP Trainee) Lewisham Public Health 2008
having been diagnosed with high blood pressure. The remaining 48% (169 people) were referred to their GP.

k. Overall, 66% of the people checked were either overweight or obese, with 37% overweight (BMI= 25 - 29.9) and 29% obese (BMI>30).

l. A follow up evaluation of a sample of people who had had health checks, by Lewisham Refugee Network (a community organisation based in Evelyn ward) showed that:

- 36% of people said they kept the health passport
- 25% of people said they had visited their GP or practice nurse as a result of the health check
- 33% reported having taken up exercise
- 10% reported trying to lose weight
- 53% reported making healthy lifestyle changes

m. In another local study of 33 people referred to their GP as a result of a health check, only four went to see their GP for a CVD consultation. When these patients went in to see their GP, two were started on antihypertensive drugs and two had already been prescribed medication.

n. Five of the six GP practices in the pilot established CVD risk registers following the HCC guidance. Numbers on the CVD risk registers were small, but were still increasing at the end of the project.

o. Volunteers reported that the project raised their own awareness or CVD, its prevention and risk factors, and influenced their willingness to change their behaviour.

p. The potential for intervention by community pharmacists is clear and apparent given the demographic data collected from people within the borough. People will access a community pharmacy for their CVD risk assessment and are likely to come from an area in close proximity to the community pharmacy (NHS Lewisham 2009).

q. A relatively high percentage (22%) of health checks undertaken by pharmacies were on people who were not registered with a GP in NHS Lewisham (NHS Lewisham 2009).

---

9 Health passport and Heath Check follow up by Margot Lawrence (Lewisham Refugee Network), 2008
10 Jessica Gullard, (VTS GP Trainee) Lewisham Public Health 2008
11 End of Year Report, CVD HCC September 2009, Lewisham Public Health
r. Recording of blood pressure among GP Practices in Cluster 1 (where the HCC from 2008-2010 was based) was compared the rest of Lewisham (regarded as the control group). There was a step change improvement in the recording of blood pressure for patients with hypertension in 2008, (the HCC was from Sep 2007 to Sep 2009), and this has been maintained (Figure 5).

![Graph showing achievement of blood pressure recording in North Lewisham compared to the rest of Lewisham and England]

**Figure 5: Recording of blood pressure among GP Practices**

s. An analysis of the monthly prescribing of medicines used to treat hypertension and high levels of cholesterol (renin-angiotensin system drugs) from October 2006 to September 2011, and November 2006 to October 2011, showed a 29% higher rate of increase in prescribing in the intervention group, and a 24% lower rate of increase in the control group in the period following the start of the programme. When analysed by cost, the period following the start of the programme showed an 11% higher rate of increase in prescribing rates in the intervention group, and a 8% lower rate of increase in the control group. The change in rate of increase is not statistically significant at the 5% level (Figure 5).
Figure 6: An analysis of the monthly prescribing of medicines used to treat hypertension and high levels of cholesterol

The period following the start of the programme showed a 41% higher rate of increase in prescribing of all anti-hypertensive and heart failure drugs in the intervention group, and a 19% lower rate of increase in the control group. For lipid-regulation drugs (statins) and heart failure drugs, the period following the start of the programme showed a 62% higher rate of increase in prescribing in the intervention group, and a 22% lower rate of increase in the control group.

Per cost of lipid-regulating drug, the period following the start of the programme showed a 44% higher rate of increase in prescribing rates in the intervention group, and a 6% lower rate of increase in the control group. The change in the rate of increase in not statistically significant at the 5% level, however, it seems plausible that the greater rate of increase in the intervention group is real, but there are too few data points before the NLP to narrow the confidence intervals sufficiently to confirm this.

Regarding thiazide and related diuretics, it is not clear that there was any definite change in prescribing patterns for these drugs over the period. It is not clear that there was any definite change in prescribing patterns for these drugs over the period. However, for most months in the period,
prescribing rates of thiazide diuretics were higher in the intervention
group than in the control group.

Discussion:
There were many outcomes from this collaborative. Social capital was built
through the recruitment and training of local volunteers. A large number of
residents were reached and a high proportion of residents reached were from
black and minority communities. The project was more successful at reaching
men than women, which may be because the majority of volunteers were
women. Awareness of CVD was raised in the community, leading to some
lifestyle behaviour change. There are many lessons from this project about how
to successfully reach and engage communities with poor health outcomes.

In addition, in most medicines for hypertension, prescribing increased more
rapidly in North Lewisham than in the rest of Lewisham, and rates of increase
were lower in the rest of Lewisham after the programme began, but higher in
North Lewisham. The prescribing data are consistent with improved diagnosis
and management of CVD, but the changes are not statistically significant at the
usually accepted level. This is probably because of the small number of data
points available for the period before the programme began.

It is reasonable to conclude that the step change improvement in recording the
blood pressure of those with hypertension and increased prescribing in the
management of hypertension, compared with the rest of Lewisham, were linked
to the establishment of the CVD Healthy Communities Collaborative and the
increased focus on CVD and the engagement of GPs in the North Lewisham
Health Improvement Programme, its stakeholder group and events.

5.7 Cancer Healthy Communities Collaborative (Cancer HCC)

Programme Objective(s) Met:

- Increased uptake of primary care services and screening, including the
  identification of risk factors in patient populations, and the diagnosis of illness
- Increased community engagement to raise awareness of health and
  promote the uptake of services
- Increased resource allocation and opportunities to target additional
  investment towards Evelyn and New Cross wards

Key findings:

a. During the course of the project, effective partnerships were made with the
   South East London Cancer Network, Macmillan Cancer Support, Breast
   Cancer Care, the Bowel Screening Programme, University Hospital
Lewisham, Local Authority, the Metropolitan Police and over 70 local voluntary and black and minority ethnic (BME) groups.

b. The HCC was involved in more than 80 local events and festivals. These public health interventions and community activities were carefully planned and successfully implemented, using a community-based approach and a collaborative work methodology. Recording the number of people engaged in the work was identified as useful as this is valuable to show the success of the project, as well as informing which events are the most useful to attend.

c. Messages to increase awareness of cancer symptoms that were tailored to the needs of different sectors of the community, using culturally appropriate materials and delivered by volunteer team members who were from a variety of backgrounds, were found to be particularly successful. People were more likely to engage if they saw someone who they could relate to either in terms of gender, age, ethnicity or lay status.

d. The importance of focused efforts on the retention of the volunteers through training and support and ensuring they remain motivated, was identified. The Cancer HCC offered volunteers an opportunity to gain relevant skills and abilities valued by employers. The volunteers were encouraged and supported to seek paid work, and five are currently employed full time and another six in part time jobs. Additionally, more than twelve of them were shortlisted for jobs or enrolled in further education colleges during the course of the project.

e. The importance of identifying a single point of contact within the practice, when trying to engage with GP practices was identified.

f. Future work should take into account the need to continuously encourage GPs to look proactively for early cancer symptoms.

g. Regular monitoring and evaluation of progress and the identification of challenges is essential to enhance the learning from the planning and delivery of the activities and to improve outcomes.

h. The Cancer HCC reached 7525 people (approximately 50-70% of whom were north Lewisham residents), exceeding the target of 6320.

i. Twenty-one volunteers were recruited and formed a team covering the north of the borough (New Cross & Evelyn Team).
k. Volunteers with the project reported increased awareness of cancer symptoms and adopting healthier lifestyles.\(^\text{12}\)

l. The main reasons found for why people do not see their GP when they notice the early signs and symptoms of cancer include:
   - Fear of what they might find out;
   - Lack of cancer awareness;
   - Embarrassed about wasting GP’s time;
   - Have no knowledge of the early signs and symptoms;
   - Unable to describe his/her symptoms to the GP due to language barriers, shame or anxiety;
   - Fear that the GP would not break bad news to them in a culturally acceptable manner;
   - Being unable to get an appointment;
   - Gender of the GPs

m. Among the 12 target GP practices, there was a fourfold increase in the average monthly number of patients expressing concerns or who had suspected cancer symptoms being appropriately referred using the “two week fast track referral system” from May 2009 to August 2010, compared with September 2008 to April 2009 (Table 7).

Table 7: Summary of 2 week referral figures for patients with suspected cancer

<table>
<thead>
<tr>
<th></th>
<th>Number of practices</th>
<th>Total number of referrals</th>
<th>Average number of referrals per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep 08 - Apr 2009</td>
<td>12</td>
<td>32</td>
<td>4</td>
</tr>
<tr>
<td>May 09 - Aug 2010</td>
<td>12</td>
<td>256</td>
<td>16</td>
</tr>
</tbody>
</table>

n. The analysis of the monthly data provided by the GP practices for the same periods showed an increase in the number of people with bowel, breast and cervical cancers referred from primary care (Table 8).

\(^\text{12}\) Lewisham Healthy Communities Collaborative Project – Cancer Promoting Early Presentation of Breast, Lung and Bowel Cancer Signs & Symptoms, End of Project Report, Lewisham Public Health, September 2010
Table 8: Number or cases of bowel, breast and cervical cancers referred from primary care

<table>
<thead>
<tr>
<th></th>
<th>Total cases referred [per month]</th>
<th>Referred within 2 weeks</th>
<th>Type of cancer</th>
<th>Number of cancer cases</th>
<th>Diagnosed with 2 weeks</th>
<th>Diagnosed in more than 2 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep 08 - Apr 09</td>
<td>47 [6]</td>
<td>32</td>
<td>Breast</td>
<td>24</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bowel</td>
<td>17</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lung</td>
<td>6</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>May 09 - Aug 10</td>
<td>298 [19]</td>
<td>256</td>
<td>Breast</td>
<td>124</td>
<td>54</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bowel</td>
<td>108</td>
<td>52</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lung</td>
<td>43</td>
<td>18</td>
<td>5</td>
</tr>
</tbody>
</table>

Discussion:
The outcomes of this collaborative were very similar to the CVD collaborative in that it built social capital through recruiting and training more than 20 volunteers from local communities and it raised awareness of the importance of cancer prevention and the early diagnosis of cancer, with a fourfold increase in those presenting with symptoms. It also led to a change in practice within primary care leading to a trebling of the number of cancer referrals per month and a dramatic improvement in the numbers referred within two weeks for breast, bowel and lung cancer.

5.8 Deptford and New Cross Community Health Forum

Programme Objective(s) Met:
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.
- Increased community engagement to raise awareness of health and promote the uptake of services.
- Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards.
- Identified mechanisms for partners working in a different way.

Key findings:
a. The forum offered 92 community groups the opportunity to look at best practice. The average attendance was six, with a core group of 11 groups who came regularly.

b. In its first year, six health forum meetings were held and four groups were helped to set up, demonstrating partnership working.
c. The forum addressed groups’ training needs, funding information, capacity building, current local issues and locality meetings. It has also provided a forum for members to receive information from Public Health Lewisham and other health organisations.

d. A training course on fund raising and setting up social enterprises, “Treble your chances”, was delivered to members by an experienced facilitator to increase the number of successful funding applications.

e. The forum publicised its work through Cluster 1 GP surgeries so that patients could be signposted to services in their area.

f. The forum became a constituted group so that it can continue to support newly-formed community groups.

Discussion:
The establishment of the Community Health Forum enabled community groups to network and to deliver effective health improvement interventions. The Community Health Forum, established by the 170 Community Development worker has supported 92 groups in a range of ways, including fund raising, capacity building, sharing good practice and networking with other groups and learning how to address key public health concerns such as alcohol, obesity, and smoking. Community Groups and organisations at times are in the best position to network with existing services in the community and link them with the needs of their clients.

The community development approach used means that the forum will be able to sustain itself and support newly formed groups beyond the life of the programme.

5.9 Stakeholder Involvement

Programme Objective(s) Met:
- Completed a health needs assessment of New Cross and Evelyn wards.
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.
- Established effective initiatives which promote health and reduce health inequalities in North Lewisham.
- Increased community engagement to raise awareness of health and promote the uptake of services.
- Increased uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness.
- Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards.
- Identified mechanisms for partners working in a different way.
- Identified local targets and indicators, and evaluated the health impact of the plan

5.9.1 Bi-Monthly Stakeholder Group

Key findings:

a. Since July 2008 there were 27 stakeholder meetings with an average attendance of 15-20 people, representing over 12 organisations. As the programme of work has developed; a number of organisations or departments who were not named in the original terms of reference have joined the stakeholder group, a sign of increased partnership working.

b. This group has brought together, on a regular basis, GP representatives, people from the voluntary and community sector, and local authority and NHS officers, successfully engaging stakeholders who may not normally associate health impact with their work, as well as those who often focus on biological, rather than social health determinants.

c. It was generally acknowledged during stakeholder interviews that it was unusual to have such a good representation from the voluntary sector actively involved in influencing the planning and allocation of health resources. The Chair of the Stakeholder Group is from the Voluntary Sector. The Stakeholder Group was seen by most of those interviewed as a very important part of successfully delivering the NLHIP. Especially important is the role of the Group in identifying local needs and assisting in the focusing of resources. It was felt by more than one stakeholder to be unique in this respect (PPCR Associates 2011).

d. The NLHIP was seen as having provided an opportunity for open and broad-ranging debates, and for identifying gaps in provision of health and well-being services.

e. It was generally felt that the Stakeholder Group is representative of the community, examples were given of the high attendances at stakeholder events (100+) and the wide range of people and organisations that are or have been involved in the Stakeholder Group (86).

f. There were positive views about the links that had been made through the NLHIP stakeholder group, especially with regard to involving the group in consultations on local regeneration initiatives. There was, nevertheless, a view that the Group needed to develop better links with all directorates of the local authority.
g. The stakeholders involved in the North Lewisham Health Improvement Programme recognized and acknowledged the importance of owning the partnership processes.

h. A powerful example of partnership working was raised by a number of those interviewed, that of the introduction of mental wellbeing into the Plan. It was felt that this happened as a direct result of partnership working and collective community intelligence.

i. The existence of the Group was thought to help smaller voluntary sector groups work together a lot more and benefit from fruitful cross fertilisation.

j. It was said that attending Stakeholder Group meetings gives participants an overview of what's happening in the area and the nature of the work being done. Awareness, knowledge and referral were described as assisting a collaborative approach, especially useful in raising the bar in terms of general awareness of specific health issues, outcomes and impact and the differences between these.

k. It was generally thought by stakeholders that the existence and implementation of the Plan has had some influence on access to healthy lifestyle activities and that some GPs have a better understanding of what community organisations are saying and that the stakeholder group dialogue to happen.

l. The Stakeholder Group was seen as being good at identifying local needs in an organic and dynamic interpretation of the early comprehensive needs assessment that was carried out.

m. A number of stakeholders thought that people had made significant behavioural changes due to the existence of the Plan.

n. Stakeholders thought that the idea was very ambitious from the start, but thought to be generally very positive outcomes with a relatively small amount of money.

o. Some stakeholders suggested the agenda was slanted too much towards health and there could have been greater local authority inputs from the start and thought the profile and publicity could have been better.

g. Overall, the general feedback was that the NLHIP provided as much benefit from the informal networking as from formal meetings. It was also good for making connections, but as meetings were bi-monthly and different people attended, there was a recognition that it ‘takes years to build up any momentum’ and that it was important this did not stop.

5.9.2 Stakeholder events
Key findings:

a. Three stakeholder events took place. The first was in June 2008 and led to the establishment of the stakeholder group. It was attended by 37 people from the local community. The purpose was to establish the best way to allocate the small grants funding and the participatory budgeting approach was agreed upon.

b. The second took place in October 2009 and was attended by 32 representatives. The agenda included presentations on the health needs assessment, progress report on one of the projects within the Plan (the Healthy Communities Collaborative for Cardiovascular Disease), other key achievements and next steps.

c. The third one was held in November 2011 and was attended by over 45 representatives. It focused on sharing good practise including showcasing funded projects, as well consulting stakeholders on priorities for 2012-2014.

5.9.3 New Cross & Evelyn Ward Assemblies

Key findings:

a. The assemblies were regularly attended by the programme support officer to share information on work streams delivered by the programme. The programme manager periodically attended to provide progress reports and consult on work being delivered in the local area.

b. Two-way joint working arrangements were demonstrated by the assembly coordinators attendance at stakeholder meetings to update on priorities for the area, and a Lewisham PCT representative on the local funding panel.

Discussion:

Chaired by the voluntary sector and supported by Lewisham Public Health and the North Lewisham Health Improvement officer (based within the Community Development for Health Team), the stakeholder group has worked in a unique way and introduced a different way of working on health inequalities, through bringing together a wide range of partners to take responsibility for the programme, sitting under a strategic framework to address health inequalities, but informed at a local level.

The inclusive nature of the stakeholder group and the community development approach used to both develop and implement the programme allowed many projects to develop and flourish and there are many examples provided in this
report where social capital has increased, whether it was through volunteering, training opportunities or community group activities.

Grassroots involvement, both through the stakeholder events, meetings and ward assemblies has ensured that the priorities and direction of the programme have been informed by local communities and are therefore delivered in a way that is effective and relevant to people’s lives.

5.10 Reducing Alcohol harm

Programme Objective(s) Met:
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.
- Established effective initiatives which promote health and reduce health inequalities in North Lewisham.
- Increased community engagement to raise awareness of health and promote the uptake of services.
- Increased uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness.

Key findings:
- As part of the alignment of the work within north Lewisham with the borough wide programme to tackle alcohol harm, updates on relevant sections of the Lewisham-wide Alcohol Delivery Plan have been reported monthly to the North Lewisham Health Improvement Steering Group via milestone reports.
- Targeted interventions, such as the seasonal alcohol awareness campaigns and a Valentine’s campaign, have been delivered in the local area.
- Links have been established between the Alcohol Brief Intervention worker, employed by CRI (New Directions), and local community groups, and referral pathways developed.
- Brief intervention training on alcohol has been delivered to community groups in New Cross and Deptford. The feedback from participants on the training was that they had increased their knowledge about alcohol, were more confident in talking to their users about alcohol harm and were in a better position to encourage them to access services where necessary.

Discussion:
The alignment of the programme with the Lewisham Alcohol Delivery Plan has been valuable in ensuring effective use of resources, and increased knowledge among community groups about alcohol and services available. There has been no specific data collated to date about the impact on alcohol use among the local population, nor about the numbers accessing services as a result of these actions.

5.11 Small Grants programmes

Programme Objective(s) Met:
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.
- Established effective initiatives which promote health and reduce health inequalities in North Lewisham.
- Increased community engagement to raise awareness of health and promote the uptake of services.
- Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards.
- Identified mechanisms for partners working in a different way.
- Identified local targets and indicators, and evaluated the health impact of the plan

5.11.1 Evelyn Chooses Health Fund (ECHF)

Key findings:

These findings were from the external evaluation report.13

a. Participants in ECHF projects reported increased awareness and understanding of, and motivation to improve, health and well being, for example through changes in physical activity and healthier eating habits. Project workers also felt that project participants were likely to have better cognitive function.

b. Improved physical health, including maintained or increased fitness and energy, weight loss, a sense of physical well-being and more effective management of chronic health problems like back pain and diabetes, were identified as outcomes of ECHF projects. Participants with severe pain and mobility difficulties reported how becoming more physically active had helped them to manage their conditions, with what they described as life-changing effects. In exceptional cases, participation in ECHF projects was felt to help in reducing harmful behaviour amongst people with drug and alcohol dependency by providing a diversionary activity.

---

13 Evaluation of the Evelyn Chooses Health Fund, November 2008
c. Participants reported increased confidence and self-esteem; and a sense of achievement, which were particularly important for those who had lost confidence and self-esteem as a result of having been out of work due to caring responsibilities or health, as well as for participants who had been socially isolated prior to involvement in ECHF activity. It was hoped that participants who were better able to manage their health problems, or who had gained employment-related skills and experience, as part of ECHF, acquired a sense of empowerment.

d. Participants with mental health problems reported improvements in depression and anxiety, although those with severe mental and physical health problems had in some instances limited in their participation in ECHF activities, and significantly, these participants do not appear to have been enthused by the activities and support on offer.

e. Projects also had an impact on participants’ families through a new emphasis on health and well-being, by, for example, cooking healthier meals, and managing what children ate more actively. Participants also influenced family members to become more involved in physical exercise. Family relationships were improved for participants who felt calmer and had more energy as a result of improved physical health, and who felt were more able to play with their children as a result.

f. Although presenting applications for funding from the project was felt to work well, some considered that it had the potential to discriminate unintentionally against presenters for whom English was not their first language. Consideration was therefore given to whether, in addition to offering support with presentation skills, there may be value in offering further one-to-one capacity building support to project workers who need it.

g. The evaluation also suggested that the criteria used to assess applications required closer examination and more transparency. Participants in the participatory budgeting process were found to have voted not just on the proposals outlined in project applications, but also based on personal sympathies, emotional responses to presentations or, in exceptional examples, self-interest. Future participatory budgeting projects need to address this.

h. The policy of encouraging projects that had been awarded funding to give some of this funding back so that it could be re-allocated to unsuccessful projects, led some project workers to feel that they had given too much money back, and had needed to revise their project plans as a result. Whilst participants in the participatory budgeting process were
enthusiastic about the generosity and sense of community solidarity exhibited by projects returning funding, there were also concerns that if this system continued, projects would inflate their budgets to accommodate this. In future processes, the rationale for and the circumstances under which projects might consider retuning funding needs to make more transparent.

i. Participants in the evaluation still felt that spending more time and resources in the early stages of any participatory budgeting process to undertake community development work with local residents would help increase the reach of the fund to a wider and more diverse range of groups. A second way of increasing the involvement of the local community would be to consider the inclusion of local residents in the participatory budgeting process, in an 'open pool' process.

j. Recipients of ECHF funding, though fairly diverse, did not always reflect the most disadvantaged people in the area. Where projects were based outside the Evelyn Ward and worked across the borough, some participants exhibited relatively few indicators of disadvantage. The ECHF needs to define its expectations of projects more clearly, in terms of who the funding should be delivered to, to reach residents in most need.

k. ECHF projects were most effective when they were grounded in an understanding of types of activities and support local communities were likely to want. Projects appeared to have been less successful in engaging and retaining participants where they had designed interventions that had not explored how attractive what they were offering would be for the local community.

l. Collaboration with ECHF projects had positive outcomes for projects not previously involved in the delivery of health and well-being activities. Partner projects were prompted to consider new approaches where ECHF projects used methods of delivery with which they had been unfamiliar.

n. The sustainability of projects beyond the ECHF varied considerably. More newly established projects in particular, felt that they required more support to identify new sources of project funding. Voluntary Action Lewisham (VAL) may wish to consider how it might help to retain learning and experience from ECHF activities by supporting the training and development of individual project workers, particularly those working on a voluntary basis, as well as offering capacity building.

o. It was not clear how far outcomes from participation would be sustained by participants who were not confident that they would be able to find equally accessible, affordable and non-threatening alternative activities or
support. Outcomes from ECHF projects appeared to be sustainable for three sets of participants:

- those who had completed skills-focused courses and who felt that not only would they retain the knowledge and skills gained on the course, but they would be able to build on them in the future;
- those who had undertaken activity based courses, which had resulted in outcomes including increased confidence, self esteem, and new friendships, which they felt able to sustain for themselves; and
- those who had been involved in projects delivering nutrition and exercise classes, and who felt that they had sufficient motivation to, and strategies for, implementing lessons learned.

This raises questions about how sustainable any outcomes from ECHF are likely to be for others. Steering Group members had concerns about participants becoming dependant on ECHF projects. Those administering the second round may wish to consider how they can orient their activity towards equipping participants with health and well-being strategies and techniques that they can use themselves once the project is over; what referrals to mainstream activity and support they might offer; and the whether they might encourage participants to consider whether they can replicate project activity themselves, through friendship based support groups, for example.

5.11.2 Supporting Communities Fund

Key Findings:

a. Of the 464 people participating in this programme, 60% were the target age of 40-75yrs, 78% of clients were women, 34% of clients were unemployed, 30% students, 24% were retired and 12% employed. There was an under representation of White ethnic groups (24%) and Black ethnic groups (17%) compared to the actual representation in North Lewisham. The Chinese and Vietnamese groups were over-represented indicating more engagement with this least-engaged community. Analysis of full and partial post code data showed that 55% of clients were residents of Evelyn or New Cross wards.

b. Collected data showed that 22% of people said they increased their consumption of fruit and vegetables, and 62.5% of people said they increased their physical activity levels. 26.3%. There were no health improvements measured around supporting people to stop smoking.

c. There were a number of recommendations about how the programme delivery could be improved. These were:

---

14 Final Report, Supporting Communities Fund, Keji Kazzim, NHS Lewisham
• Encourage community groups to provide services that are accessible to
groups in the community who have learning difficulties or disabilities.
• Encourage community groups to apply for funding to deliver
programmes solely to support stop smoking in individuals, or to
prioritise it in their activities
• Set a target amount of North Lewisham clients to be recruited and
outline in the initial application guidelines for the fund. At least 50% of
clients should represent the North Lewisham population
• Encourage groups funded to target proportionally to have a good
representation of all groups in the community
• Provide workshops and training opportunities on social marketing
methods, evaluations, budgeting, ITC skills, publicity and marketing so
the most hard-to-reach communities can be accessed
• Ensure that at the onset of project proposal project leads are made
aware of the requirements of the evaluation and the importance of
accurate information they need to provide in the final report
• Ensure that the monitoring forms are standardized, are very specific to
the desired outcomes of the project, and are issued before the project
starts to deliver activities

d. The learning from this programme informed the development of the
participatory budgeting programmes and the commissioning of the Food
Co op and the 170 Community Development for Health Nutrition project.

5.11.3 Deptford and New Cross Choose Health

Key Findings:

a. In the 2011 round, from the 13 community groups that submitted a final
report, a total of 604 people had taken part in the delivered activities (53%
women and 47% men). Most were aged between 26 to 39 years (209)
and 40 to 74 years old (280). Half of all recruited clients were either from
the Black or Black British African, Caribbean or black other groups. White
British, Irish or other white groups represented 25% of attendees.

b. The community groups reported that 229 people considered themselves
to have a disability. There were two funded groups whose activities were
targeted specifically towards people who had physical, learning and
cognitive disabilities. One group targeted individuals with long-term
conditions.

c. The majority of clients were unemployed (169), followed by those who
were retired (130) and students (100). These groups were most likely to be

---

15 DeptfordNewCross Choose Health 2011, Summary of the End of Project Reports, Keji Kazzim, NHS
Lewisham
able to take part in daytime activities. More projects delivering activities on weekends would increase accessibility of employed clients (61) to take part. About 50% of users of the projects were from Evelyn and New Cross.

d. Community groups funded in the 2011 round were very successful in linking in with other funded groups, and other community groups and voluntary organisations operating in North Lewisham and across the borough. The activities included delivering workshops on health or other activities for clients, donating resources, referring clients to activities or signposting.

e. At the beginning of the activities, 173 clients reported eating fewer than three portions of fruit and vegetables a day. When the grant programme ended, 129 reported having increased their consumption to more than three portions a day, showing a 42% increase. Similarly, 172 clients were recorded a doing less than the recommended level of physical activity; by the end on the activities, 219 clients had increased their levels of physical activity to the recommended levels. This is an increase of 56% of clients.

f. The groups reported that a total of 330 (54%) people had improved their mental wellbeing.

g. There were eight groups that had identified 71 smokers, with 24 referred to the Lewisham Stop Smoking Service.

h. Community groups were asked which methods they used to raise awareness of alcohol consumption. The most popular method of the nine that did was by delivering workshops or giving out leaflets. Three projects did not raise awareness.

i. The management of participatory budgeting is seen as a big strength of the Stakeholder Group. Many stakeholders were positive about participatory budgeting and there was a recognition that there has been a ‘questioning what we’re doing’ and a willingness to evolve and change the system to make access to funding as open and fair as possible. There have been measures to try and ensure that ‘new’ projects/groups don’t suffer through evolutionary changes to the process in having different levels of assessing applications.

Discussion:
Allocating funding to community organisations has been demonstrated as an ideal way to reach and respond to the needs of different communities. Small grants programmes have been effective at raising awareness about health, and in changing the lifestyle behaviour of not only their participants, but also their friends and families.
Community groups are more effective at delivering health promotion interventions when they receive advice and training and development from public health specialists and when they have opportunities to network with each other.

The various small grants schemes have been amended and improved by incorporating the learning from the previous schemes.

5.12 Community Development for Health – Nutrition Worker (170 Community Project)

Programme Objective(s) Met:
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.
- Increased community engagement to raise awareness of health and promote the uptake of services.
- Increased resource allocation and opportunities to target additional investment towards Evelyn and New Cross wards.

Key Findings:
a. The project worker has provided community development support to 92 community groups and organisations in New Cross and Deptford.

b. Evidence, from the project reports and surveys, shows that there was an increase in available nutritional advice and expertise. A total of 21 workshops were completed and nine health events held between 2009 and 2010.

c. Individuals who completed the external evaluation questionnaires stated that the greatest influence of the project was a positive change in their attitudes to nutrition and healthy eating (Monrose 2012). This change in awareness was also confirmed from data collected before and after nutrition workshops, organised by the project (Table 9).

Table 9: Workshop participant questionnaire

<table>
<thead>
<tr>
<th>Evaluation Indicator</th>
<th>Question</th>
<th>Before evaluation outcome</th>
<th>After evaluation outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Know</td>
<td>Don’t know</td>
<td>Know</td>
</tr>
<tr>
<td>Know what a calorie is</td>
<td>40%</td>
<td>59%</td>
<td>95%</td>
</tr>
<tr>
<td>Name two types of fat</td>
<td>57%</td>
<td>42%</td>
<td>100%</td>
</tr>
</tbody>
</table>
d. The community development worker supported small community groups to develop themselves into social enterprises and obtain funding for growth.

e. Respondents to the evaluation said they benefited from the project through: mapping information on the range of services; addressing health related issues; information on funding opportunities; networking and support; capacity building and health related training; and networking to enable better collaboration. Most groups rated the information, support, accessibility and effectiveness that they received from the project as either good or very good.

**Discussion:**

The worker was successful in reaching and supporting a large number of community groups in the Deptford and New Cross area, through a range of events and workshops. There was evidence of awareness raised and changing attitudes regarding healthy eating among most of the participants.

### 5.13 New Cross Gate Food Co-op

**Programme Objective(s) Met:**
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.
- Established effective initiatives, which promote health and reduce health inequalities in North Lewisham.
- Increased community engagement to raise awareness of health and promote the uptake of services.

**Key Findings:**
- A survey conducted in March 2011 to which 230 people responded found that 25% reported increasing the number of portions of fruit and vegetables consumed from one to three per day, and 12% from two to four.
b. This self-reported behaviour change is supported by evidence from the Food Co-operative monitoring reports showing increased sales of fruit from stalls; increased membership numbers, and positive feedback from customer surveys.

Discussion:
In addition to building social capital through the recruitment and training of volunteers, the Food Co-op appears to be a very effective way to increase access to healthy fruit and vegetables and increase the consumption of fruit and vegetables at a relatively low cost. It is interesting to note that the Food Co-op was set up in response to the local health impact assessment of the New Deal for Communities programme, which used a community development approach.

5.14 Spatial Planning for health

Programme Objective(s) Met:
- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham.
- Established effective initiatives, which promote health and reduce health inequalities in North Lewisham.
- Identified mechanisms for partners working in a different way.

Key Findings:
a. Since 2008, the North Lewisham Stakeholder group and sub-groups have met with and received presentations from the London Borough of Lewisham Planning department.

b. The areas of focus have included: implementation of the Links project to help create safe and more attractive walking and cycling routes; implementation of open space enhancements and includes adult trim trails as well as children’s play space; consultation on local regeneration projects such as Convoys Wharf and Surrey Canal developments; ensuring new developments provides good cycle parking and (where necessary) changing and equipment storage facilities; development and implementation of School Travel Plans for all existing and new schools in the area and progressing the PCT’s ‘GP Capacity Assessment’ to ensure sufficient planning to cope with the expected increase in population.

c. Collaboration between the LBL Planning Department and the stakeholder group led to the production of Health Development in Deptford & New Cross Dec 2011, by the Planning Department which provided a local framework to inform future development.

Discussion:
The engagement between Lewisham Planning Department and the stakeholder group has been ongoing on a number of schemes through the lifetime of the programme. There has been no structured evaluation of the impact that the stakeholder group has had on planning developments in the local area.

5.15 Waldron Health Centre

Programme Objective(s) Met:

- Increased partnership working with key stakeholders to identify ways to reduce health inequalities in North Lewisham
- Increased uptake of primary care services and screening, including the identification of risk factors in patient populations, and the diagnosis of illness

Key Findings:

a. The Waldron Health Centre has provided a new and central location for the delivery of a wide range of services, (including several GPs, a Walk In Centre, sexual health services, child and maternity clinics) to meet the health needs of the north Lewisham population. It has also provided a valuable resource for community health events, health promotion and training.

b. From the minutes of the stakeholder meetings it was clear that the following issues were discussed: Patient participation (involvement in Patient Groups, user surveys and feedback); opening and closing times (offering extended opening hours and access for early and late appointments for people in 9-5 job routines); car parking (misuse of the disabled parking bays and difficulty in entry to the building by disabled clients); Waiting areas (recommendations to use the space for information on services and cleanliness of the space).

Discussion:
Despite some influence on some issues, as described above, it is clear that the stakeholder group did not play a major role in determining what and how services were delivered from the Waldron. The potential for synergy between the programme and the Waldron Health Centre, as a key location to contribute to the objectives of the programme was not fully realised.

5.16 Cost effectiveness

The average cost of £78 per contact with the programme illustrates value for money.
A social return on investment of a ratio of 1.8:1 to 3.0:1 suggests good value for money. This is particularly true as the only value included is value to the client/patient. Potential ‘longer term cost’ savings to the NHS are not included. A lack of longitudinal data also means that benefits are often only counted for the short term, and in some cases there may be longer term value that is not incorporated into this evaluation.

Nonetheless, the calculations used within this evaluation do rely on a set of assumptions with varying degrees of evidence to support them. The results, while more robust than most localised cost-benefit analyses of public health interventions, should not be equated with the results of national clinical trials and medical studies.

5.17 Assessment against the National Support Team for Health Inequalities framework for systematically addressing health inequalities and the Beattie model for health promotion.

Systematically addressing health inequalities

When the programme is benchmarked against the dimensions of the framework for achieving a change in health inequalities at a population level, it measures up well, in terms of the approach it has taken, as described below.

Figure 7: Bentley C (2007), Systematically Addressing Health Inequalities, Health Inequalities National Support Team
Systematic community development (C), rather than ad hoc, targeting engagement and support to the weakest and least capable of responding:

The inclusive nature of the stakeholder group and the community development approach used to both develop and implement the programme allowed many projects to develop and flourish and there are many examples provided in this report where social capital has increased, whether it was through volunteering, training opportunities or community group activities.

Some of the evidence suggested that approaches such as participatory budgeting and stakeholder engagement contributed to what could be described as 'social capital' through providing a focus on and relationships around community-based health improvement programmes and projects.

A range of processes to connect frontline services into the heart of communities, reaching out to seldom seen, seldom heard groups and individuals (D):

As demonstrated in this report, a range of processes were used by the programme to connect frontline services into the heart of communities. For example, it has been demonstrated that allocating funding to community
organisations is an ideal way to reach and respond to the needs of different communities.

The recruitment and training of volunteers from local communities enabled the ‘Healthy Communities Collaboratives’ to reach seldom seen or heard communities in north Lewisham. The two pronged approach, working with both General Practice and local communities led to improved health outcomes in both early diagnosis of cancer and cardiovascular risk.

The 170 Community Project, funded to deliver a number of interventions on healthy eating and physical activity using a community development approach, worked with many seldom seen or heard groups and individuals.

The use of social marketing techniques to obtain an insight into smokers views enabled the Stop Smoking Service to improve the way the service was provided and led to an increase in the number of smokers accessing the service, setting quit dates and stopping smoking.

Driven by committed leadership fostering engagement, effective local strategic partnership and a locally owned coherent vision and strategy (A):

The stakeholder group provided the ‘Partnership, vision, strategy, leadership and engagement’ central to the framework, in the middle of the triangle above. This was central to the success of the programme. The group, with joint leadership from Public Health and the voluntary and community sector and a dedicated resource to sustain its delivery plan and meetings not only provided the vision at the beginning of the programme but continually monitored and amended the programme to ensure it was focused on the right priorities and it was using the right approach. The stakeholder group proved a space for different stakeholders, not only to come together, but also to openly debate how to move forward with the programme.

Beattie Health promotion model

It is clear that a negotiated and collective approach to health promotion has predominated within the programme using Beattie’s model (Figure 8), from examples of projects provided in the green and pink boxes below.
5.17 Overall Assessment of the Impact of the North Lewisham Plan

The consensus of the expert panel was that overall, large health impacts were observed for all outcomes except reducing premature deaths in at least one individual project within the North Lewisham Plan. Large improvements were observed in: knowledge in 3 projects; behaviour in 5 projects; disease prevalence in 1 project; health needs assessment in 4 projects; increased partnership...
working in 7 projects; increased health promotion initiatives in 5 projects; increased community engagement in 10 projects; increased primary care uptake in 3 projects; increased resource allocation in 8 projects; improved working in a different way in 10 projects; and increased identification of targets in 3 projects.

A moderate overall health impact was observed for seven outcomes: improved knowledge, improved behaviour, increased partnership working, increased health promotion initiatives, increased community engagement, increased resource allocation, and improved working in a different way. A small positive health impact was observed for four outcomes: reduced disease prevalence, health needs assessment, improved primary care uptake, and identifying local targets. Minimal or no overall health impact was observed for reducing premature deaths.
6. Conclusions

Overall this large, ambitious and challenging programme has made good progress in achieving its objectives.

All the projects within the programme contributed to the objectives of the programme. Some projects contributed to several or most of the objectives, whilst other projects contributed to one or two of the objectives.

The reach of the programme was impressive. At least 10,000 people benefitted directly from the programme and many more benefitted from the programme indirectly through families and friends.

The programme successfully targeted people from black and minority ethnic populations living in north Lewisham. The numbers of people accessing services on the whole represented the ethnic composition of the population, although the Vietnamese community were sometimes over represented.

All the projects were successful at reaching women. Some projects were more successful than others at reaching men and disadvantaged communities with poorer health.

Most of the people who benefited from the programme lived in Evelyn and New Cross wards, although a number of people from other parts of Lewisham and a very small number from other boroughs also benefited. It is important to recognise, when planning geographically targeted interventions, that social networks do not stop at ward boundaries.

A broad spectrum of ages benefited from the programme although the predominant age of people participating in projects were adults aged between 30 and 75. Given the identified outcomes of this five-year programme, the focus on this age group is appropriate.

The numbers of people with disabilities accessing projects were low initially, but action was taken to address this, particularly in the Participatory Budgeting programme, whereby higher numbers of people with disabilities accessed funded projects in later years.

The programme has impacted on health knowledge, behaviours and health outcomes. The evaluation findings indicate evidence of lifestyle behaviour change and improved health outcomes resulting from the implementation of the
North Lewisham Health Improvement Plan, evidenced by the Mori Poll of the NDC programme (Miller 2010), the external evaluation of Evelyn Chooses Health Fund; monitoring reports from the small grants programmes, follow up surveys by community groups for different projects and programmes and monitoring activity such as smoking quits.

Many projects were effective at raising awareness and changing behaviour, through using a community development approach. Some projects were more effective than others. Small grants programmes have been effective at raising awareness about health, and in changing the lifestyle behaviour of not only their participants but also their friends and families.

Many of the behaviour changes were in healthier eating and increased levels of physical activity. A range of behavioural changes resulted from participants’ increased awareness and understanding of, and motivation to improve health and well-being. These were changes in level of physical activity and healthier eating habits as part of project activity and outside it.

Sixty six percent of the people receiving health checks, through the CVD Healthy Communities Collaborative were either overweight or obese, with 37% overweight and 29% obese. Thirty six percent of people said they kept the health passport; 25% of people said they had visited their GP or practice nurse as a result of the health check; 33% reported having taken up exercise; 10% reported trying to lose weight; 53% reported making healthy lifestyle changes.

Several projects demonstrated improved health outcomes, notably the Evelyn Chooses Health Fund, whereby the external evaluation identified both improved physical and mental health outcomes; the two Healthy Communities Collaboratives, which demonstrated earlier and increased referrals for cancer and improved management of patients with hypertension; and the Social Marketing Project which led to a notable increase in the number of residents entering the Lewisham Stop Smoking Service.

Health-related benefits were identified from self-reported feedback given by individuals who took part in community-based health improvement activities.

There was evidence of the impact on the health and well being of participants in the projects and their families. Participants in projects reported a range of positive outcomes arising from their involvement, relating to improvements in the mental and physical well being of themselves and their families, as well as a raft of other social, work and financial outcomes.

Specific to mental well being outcomes; participants reported a number of outcomes which improved their sense of well being including increased confidence and self-esteem; and a sense of achievement. These types of
outcomes were particularly important for those who had lost confidence and self-esteem as a result of having been out of work due to caring responsibilities or health, as well as participants who had been socially isolated prior to involvement in activity. In addition to these outcomes, participants with mental health problems reported improvements in conditions including depression and anxiety resulting from participant in the projects.

Participants sometimes reported additional and unexpected outcomes including increased self-esteem, more energy, new friendships or social networks. The combination of the different outcomes experienced had a marked impact on the sense of health and well being experienced by some, with particularly dramatic impacts on participants who had suffered from depression and social isolation.

A number of physical health outcomes were identified as having arisen out of projects, including increased fitness; a feeling of maintaining previous levels of fitness and energy; weight loss; and more effective management of chronic health problems like back pain and diabetes.

There was a higher rate of smoking quitters in comparison with the average for Lewisham following the Evelyn Social Marketing project. The higher levels have also been sustained beyond the lifetime of the project (2010 & and 2011) in comparison with the rest of Lewisham.

There was a step change improvement in the recording of blood pressure for patients with hypertension in 2008, at the same time as the CVD Healthy Community Collaborative, and this has been maintained. It is reasonable to conclude that the health outcomes improved for those patients having their blood pressure monitored more regularly.

It was too early to identify any evidence relating to early deaths and life expectancy.

During the lifetime of the programme there were improvements in access to, and trust in, local health services, but there was a small decrease in satisfaction with GP services; there were also modest improvements in healthy lifestyle indicators and self-reported health. New Cross Gate NDC area improved more than similarly deprived benchmarks in the theme areas of health.16

There was evidence of commitment and vision to empower community partners in helping promote health by using community development approaches. While

16 Centre for Regional Economic and Social Research, Sheffield Hallam University, New Cross Gate New Deal for Communities Partnership, End of Programme Review Final Report, September 2010
there was commitment to align programme initiatives to tackling the broader determinants of health and health inequalities, addressing lifestyle risk factors was the main focus of many of the projects.

Most projects explicitly used a community development approach to health improvement. The programme was effective at building social networks and social capital. Approaches such as participatory budgeting and stakeholder engagement contributed to what could be described as 'social capital' through providing a focus on and relationships around community-based health improvement programmes and projects.

In terms of organisational development, the programme provided support to both primary care and the community and voluntary sector. The Healthy Communities Collaboratives supported general practices and pharmacies to improve systems, resulting for example in increased recording of blood pressure among those diagnosed with hypertension and the establishment of CVD risk registers and the community and voluntary sector were supported through the Community Health Forum.

The programme has developed a rich knowledge base about how to reach communities, raise awareness, change behaviour and improve health outcomes. The innovative nature of the programme allowed projects to try new and different ways of working and there are many practical examples of what works and what does not work that can inform similar health improvement programmes and projects.

For example: community groups are more effective at delivering health promotion interventions when they receive advice, training and development from public health specialists and when they have opportunities to network with each other; projects were most effective when they were grounded in an understanding of the types of activities and support local communities were likely to want; allocating funding to community organisations has been demonstrated as an ideal way to reach and respond to the needs of different communities; small grants programmes have been effective at raising awareness about health, and in changing the lifestyle behaviour of not only their participants, but also their friends and families; the two-pronged approach used by the Healthy Communities Collaboratives, working with providers of services at the same time as raising awareness among communities was particularly effective.

Using a community development approach within a strategic framework to reduce health inequalities was an important feature of the programme. Knowledge about the evidence base about the health of the population and the effectiveness of interventions and the key strategic priorities were shared with local communities, front line staff and statutory and voluntary organisations so
that they could use that knowledge to inform their practice. Likewise the knowledge about local communities was harnessed and has informed how the programme was delivered.

A return on investment of a ratio of 1.8:1 to 3.0:1 suggests good value for money. This is particularly true as the only value included is value to the client/patient. Potential 'longer term cost' savings to the NHS are not included. A lack of longitudinal data also means that benefits are often only counted for the short term, and in some cases there may be longer term value that is not incorporated into this evaluation.

The impact from this programme is perhaps not surprising as it has been implemented in line with recent NICE Guidance (NICE 2008), which acknowledges the impact resulting from devolved power and its contribution to building social capital or community bonding.

This evaluation demonstrates that the national recognition this programme has received is warranted. The DH National Support Team on Health Inequalities described the programme as unique and innovative. Lewisham has been recognized nationally by the Department of Health (DH) for the ground-breaking approach of its CVD Healthy Communities Collaborative, involving local communities and for it participatory budgeting grant scheme, 'Evelyn Chooses Health'. North Lewisham Health Improvement Programme was the first example in this country where a participatory budgeting approach was taken to allocating funds to community groups to promote healthy lifestyles.

In summary this programme has been successful in raising awareness, changing behaviour and improving health outcomes for a proportion of the target population living in Evelyn and New Cross wards in a cost effective way. It has also provided valuable learning about how this can be achieved.
7. References

Cooke A & Beckingham A with input from Ruth Barnes & Kate Benson New Cross Gate First Health Impact Assessment Jan-Oct 2002


Bentley C., Health Inequalities National Support Team (2010), Redoubling Efforts to achieve 2010 National health inequalities Life Expectancy Target, Department of Health


Centre for Regional Economic and Social Research, Sheffield Hallam University, (2010), New Cross Gate New Deal for Communities Partnership, End of Programme Review Final Report


NHS Lewisham (2009), Vascular Health Check Community Pharmacy Pilot Evaluation

Evaluation of the Evelyn Chooses Health Fund, November 2008


Lewisham Public Health, End of Year Report, CVD Healthy Communities Collaborative, September 2009


Medical Research Council (2008), Developing and evaluating complex interventions: new guidance


Monrose Consultants (2012), Evaluation of Community Development for Health 170 Project

National Social Marketing Centre, Reducing Smoking in the London Borough of Lewisham, National Social Marketing Centre Demonstration Site Scheme, 2010
National Social Marketing Centre (2010), Reducing smoking in the borough of Lewisham, National Social Marketing Centre Demonstration Site


Parry C, Berdie J (April 2004), Moving from Teaching to Evaluation: Using Embedded Evaluation to Promote Learning and Provide Feedback

Paton W., Interim North Lewisham Health Improvement Officer, NHS Lewisham, Health Discussion Groups held with People from Vietnam Living in New Cross and Evelyn in the London Borough of Lewisham: A report produced as part of the implementation of the North Lewisham Health Improvement Plan, Nov 2009


PPCR Associates (2011), North Lewisham Health Improvement Plan Stakeholder Interviews, Final Report


8. Appendices

Guidance on SROI Evaluation of
North Lewisham Health Improvement Plan

This document examines the SROI evaluation process for the North Lewisham Health Improvement Plan. It is in six stages:

1. How the NHS Lewisham approach fits with the SROI methodology
2. Recommendations on indicators and proxies
3. Steps to creating a full SROI calculation
4. Steps to completing a full SROI evaluation to SROI Network assurance standards
5. SROI Network Assurance & Accreditation System
6. The Seven Principles of SROI

1. How the NHS Lewisham approach fits with the SROI methodology

Social Return on Investment (SROI) is a form of cost-benefit-analysis, developed primarily by the new economics foundation and the SROI Network. It is designed to help organisations better understand the impact and value-for-money of projects or activities, and to provide tools to help decision making.

The stages of an SROI analysis, as outlined in the Cabinet Office / SROI Network / new economics foundation model, are outlined in Box 1 below. The process outlined for the North Lewisham Health Improvement Plan covers

Box 1: The stages of SROI

Carrying out an SROI analysis involves six stages:

1. Establishing scope and identifying key stakeholders. It is important to have clear boundaries about what your SROI analysis will cover, who will be involved in the process and how.
2. Mapping outcomes. Through engaging with your stakeholders you will develop an impact map, or theory of change, which shows the relationship between inputs, outputs and outcomes.
3. Evidencing outcomes and giving them a value. This stage involves finding data to show whether outcomes have happened and then valuing them.
4. Establishing impact. Having collected evidence on outcomes and monetised them, those aspects of change that would have happened anyway or are a result of other factors are eliminated from consideration.
5. Calculating the SROI. This stage involves adding up all the benefits, subtracting any negatives and comparing the result to the investment. This is also where the sensitivity of the results can be tested.
6. Reporting, using and embedding. Easily forgotten, this vital last step involves sharing findings with stakeholders and responding to them, embedding good outcomes processes and
steps 3, 5 and 6. It partly covers steps 1 and 2, and doesn’t at this stage consider step 4.

The model as it stands allows for a calculation of social value created by the North Lewisham Health Improvement Plan. This would work by measuring the change for the identified outcomes and placing a monetary value on each of these outcomes. This would also allow a comparison against the original investment.

Further information is outlined below on:
- Initial recommendations on current indicators and proxies
- Steps required to create a full SROI calculation
- Steps required to complete a full SROI evaluation to SROI Network assurance standards

2. Recommendations on indicators and proxies

**Participatory budgeting: Involvement in decision making and budgeting**
The proxy description mentions empowerment. We’ll need to find a way of valuing this empowerment, maybe by linking it to well-being benefits. i.e. how does someone actually benefit by being more empowered – it might be that empowerment leads to an increase in self-esteem, or in mental well-being generally.

**Supporting communities fund:**
Proxies: The proxies here are all costs saved to the NHS, which demonstrate the value to the NHS (or to the government or the ‘tax-payer’). However there is also a benefit to the individuals who experience an improvement in well-being, and we would want to include and value this too. It is possible that we could use QALYs to do this.

**Improved physical activity levels:**
The proxy here is actually a cost-benefit ratio. This is fine as a forecastive tool, but we don’t know whether our activity costs the same as the activity in the report cited. We may need to adjust the ratio on that basis.

**Improving health through health eating and understanding about healthy food options:**
Looking at a reduction in future risk of cancer and other diseases is sensible. However we need to put a value on this – probably both to the NHS in cost savings and also to the individual in improved quality of life. Again, we can possibly use QALYs to do this.

**Improved engagement and skills**
This outcome would benefit from more clarity – as it is it may overlap with the Improved knowledge and skills for developing social enterprise outcome. If the outcome is about the personal benefits of involvement with volunteering, then we would need to adjust the proxy accordingly. Currently the proxy values the investment of volunteering, rather than the benefits of volunteering.

Health Persuasion outcomes:
Both of these proxies work, but again we may want to value the avoidance of disease to the individual as well as to the NHS, as has already been done for the Stop Smoking project.

A note on units: the indicator used will dictate the unit in which the outcome is measured. Often this is people, for example, ‘no. people reporting increased fruit & vegetable consumption’ or ‘number reporting reduced visits to GP practices’. However, sometimes the unit is something else, for example, ‘number of support sessions run in the designated area’. When the proxy that we find isn’t in the same unit as the indicator, e.g. the indicator counts the number of support sessions, but the proxy gives a value per person, then we will need to find a way to convert these into the same unit. This can be done at the calculation stage, but it is worth considering from an early stage.

3. Steps to creating a full SROI calculation

Below are the key steps that would need to be undertaken in order to create a full SROI calculation

• Fully consider the impact of the North Lewisham Health Improvement Plan. This would involve the consideration of:
  o The counterfactual, i.e. what would have happened anyway in the absence of the activities. For example, there may have been some increase in consumption of fruit and vegetables among the local population anyway.
  o Attribution levels, i.e. for any change that has been observed and measured, how much credit is due to the activities outlined in the Plan, and how much is due to other factors, such as the contribution of the local community
  o Any displacement of outcomes – particularly employment outcomes
  o Any unintended consequences, positive or negative, that might take place
• A stakeholder engagement process to understand the specific outcomes of each of the NLHIP programmes for all stakeholder groups. This may lead to adjustment of the outcomes list.
• A full evaluation of the investment in the programme (e.g. direct investment, time contribution of volunteers, full-cost recovery of NHS Lewisham staff time).

4. **Steps to completing a full SROI evaluation to SROI Network assurance standards**

For an SROI evaluation to be conducted to SROI Network assurance standards, it needs to quite closely follow the SROI process as set out in the Cabinet Office guide.\(^\text{17}\) Below are the key areas that would need to be addressed in order to meet this:

- Fully justified and audited decisions would need to be taken about the nature (forecastive or evaluative) and scope of the report.
- Stakeholder engagement and decisions over materiality of stakeholder groups and outcomes would need to be fully analysed, and a full impact map (including inputs, activities, outputs and outcomes for each stakeholder group) would need to be created on the back of the stakeholder engagement
- The total benefit period of outcomes would need to be estimate and any change (or ‘drop off’) over time calculated
- All decisions and judgements would need to be documented and justified
- A sensitivity analysis would need to be conducted on the results.

Below are the key points from the SROI Network’s assurance guide to assessors. These are the points that assessors will be looking for when evaluating an SROI report, and are based on the seven principles of SROI (section 6).

5. **SROI Network Assurance & Accreditation System\(^\text{18}\)**

1. **Involving stakeholders**

The important thing here is to test for a comprehensive identification of stakeholders and a convincing rationale for those that have been included and excluded from the engagement, feedback and reporting processes. Stakeholders are those people or organisations that experience change as a result of the activity and they will be best placed to describe the change. This principle means that stakeholders need to be identified and then involved in consultation throughout the analysis.


\(^{18}\) For more details see [http://www.thesroinetwork.org/publications-uk/cat_view/46-assurance](http://www.thesroinetwork.org/publications-uk/cat_view/46-assurance)
Important guidance points:
1. Have all stakeholders been identified who are relevant to the scope of the analysis
2. Have all significant stakeholders considered to experience material changes - positive & negative/intended or unintended - been consulted about what changes for them.
3. Is there an explanation of rationale for stakeholders included and excluded in determining outcomes
4. Has the method of stakeholder engagement been clearly outlined in the report and analysed in a way that is distinct from data collection?
5. Is there any reason to think that an insufficient number of stakeholders have been consulted?
6. Is there evidence that stakeholders have been involved as appropriate at some stages throughout the SROI analysis and reflected in the reporting

Additional guidance points (reflecting a higher standard of good practise):
1. Have significant stakeholders been fully involved in determining indicators
2. Have significant stakeholders been fully involved in determining financial proxies
3. Is there evidence of significant stakeholders being consulted at all stages where appropriate and useful to the analysis
4. Have significant stakeholders been involved in reviewing the account

2. Understand what changes

The report should be tested for a clear explanation of the theory of change for included stakeholders. First of all this will require a test that the scope of the analysis has a clear purpose and timescale. After this the assessor should check that report demonstrates understanding of the chain of events as well as reporting on consideration of changes that the stakeholders intend and do not intend, and changes that are positive and negative. This principle requires the theory of how these changes are created to be stated and supported by evidence. Assessors should come to a judgement about the quality/reasonableness of any data presented.

Important guidance points:
1. Has a clear scope and timescale been stated for the SROI analysis, AND is the rationale for choices made around activities included and excluded clear and convincing.
2. Is the theory of change presented in a way that is clear and easily understood by the reader (i.e. impact map that is discussed in the narrative) including any appropriate unintended positive and negative change as well as intended change.

3. Is the theory of change evidenced by information on the activity

4. For stakeholders considered significant to the change analysis, are the relationships between input, output and outcome adjudged to be reasonable

5. Do all outcomes relate properly to the stakeholder for which they are claimed

6. Are the claimed outcomes clearly explained in the report and have outcomes alone been taken forward to valuation.

7. Do all outcomes relate properly to the stakeholder for which they are claimed

8. Are the indicators reasonable and do they provide adequate information to show that the change is measurable.

9. Where appropriate have objective as well as subjective indicators been used without double counting

10. Have unintended, positive & negative outcomes where applicable been valued

11. Has double counting been avoided, for example when choosing more than one indicator per outcome

12. Does the model include figures for the duration of outcomes with explanations

13. Are the findings based on a reasonable sample. Is there a discussion about the reliability and validity of the sample.

14. Does the reporting follow clearly from the impact map and is the map clear and transparent.

**Additional guidance points (reflecting a higher standard of good practise):**

15. Has the analysis dealt with distance travelled? Is there an analysis of the chain of cause and effect between short, medium and longer term outcomes

**3. Value things that matter**

This principle is concerned with how outcomes are valued in the SROI process. The important thing here is that financial proxies are used in order that the value of the outcomes can be recognised. Assessors will look to ensure that financial proxies are clear, appropriate to the outcome and also that indicators are clear.
and appropriate. Any data for indicators and financial proxies will require source of information. Assessors should come to a judgement about the quality/ reasonableness of any data presented.

**Important guidance points:**

1. Is there a clear and reasonable explanation for any outcomes included in the impact map that have not been given financial proxies
2. Is the financial proxy adjudged to be reasonable and appropriate to the outcome and for the stakeholder to which it is attached
3. Is there information on the source of financial proxies, detailed enough that would enable the reader to refer.
4. Where an identified outcome is not recorded with at least one indicator and financial proxy, has the exclusion been explained and is the explanation reasonable
5. In a forecast study, in cases where outcomes have not been valued, does the sensitivity analysis cover a scenario in which they are valued

**Additional guidance points (reflecting a higher standard of good practise):**

6. Has a range of financial proxies been varied in sensitivity analysis
7. Is there a statement on issues arising from the use of financial proxies in this analysis

**4. Only include what is material**

This principle requires an assessment of whether a person would make a different decision about the activity if a particular piece of information were excluded. This covers decisions about which stakeholders experience significant change, as well as the information about the outcomes. Deciding what is material requires reference to a number of aspects, for example the organisation’s own policies, its peers, societal norms, and short-term financial impacts

**Important guidance points:**

1. Is there an explanation in the analysis to justify the consideration of what is considered material change for stakeholders
2. Is it clear that no material changes were expected to occur to excluded stakeholders in the context of the scope
3. Have all relevant inputs by significant stakeholders been included
4. Have inputs that would lead to the included outcomes been given a value
5. Is the sensitivity analysis adjudged to include appropriate elements relevant to the study with clear information on which aspects and which assumptions have been assessed for sensitivity

Additional guidance points (reflecting a higher standard of good practise):
6. Have the scope of the study, the analysis of change, the included outcomes and the claimed impact been based on a comprehensive analysis of materiality issues that have been explained in the report

5. Do not over claim

This principle requires reference to trends and benchmarks to help assess the change caused by the activity, as opposed to other factors, and to take account of what would have happened anyway. It also requires consideration of the contribution of other people or organisations to the reported outcomes in order to match the contributions to the outcomes.

Important guidance points:
1. Does the analysis include a rationale for the figures used for deadweight and attribution and are these reasonable
2. Does the analysis consider displacement and include a figure if appropriate with explanation
3. Are the decisions in relation to displacement reasonable
4. Does the analysis consider how outcomes drop-off over time
5. Have sources for information for drop-off been included
6. For instances where durations used have not been based on research evidence – is there a reasonable explanation and is it clear that any assumptions made have been subjected to sensitivity analysis and are to be monitored in the future

Additional guidance points (reflecting a higher standard of good practise):
7. Has a full counterfactual been included for deadweight
8. Has primary research been conducted in assessing attribution
9. Has drop off varied over time, or to different stakeholder groups

6. Be transparent

Assessors will look for evidence that reports demonstrate the basis on which the analysis may be considered accurate and honest, and show that it will be reported to and discussed with stakeholders. This principle requires that each decision relating to stakeholders, outcomes, indicators and benchmarks; the
sources and methods of information collection; the difference scenarios considered and the communication of the results to stakeholders should be explained and documented.

**Important guidance points:**
1. Is there an audit trail both of what is and what is not included relating to stakeholders, outcomes and financial proxies
2. Are all supporting calculations available in the report and the calculation method set out in a way that would allow for a repeat of the calculation of social return
3. Are all sources referenced
4. Is there enough information on the data set that makes it possible for the calculation to be replicated and to arrive at the same result

**Additional guidance points (reflecting a higher standard of good practise):**
5. Is there a systematic plan for reporting results to a range of significant stakeholders
6. Is there enough information on data and sources included that would allow a full audit of the report

7. **Verify the result**

Although an SROI analysis provides the opportunity for a more complete understanding of the value being created by an activity, it inevitably involves subjectivity. Appropriate independent assurance is required to help stakeholders assess whether or not the decisions made by those responsible for the analysis were reasonable.

**Important guidance points:**
1. Has the report been reviewed by at least one stakeholder
2. If there has not been a formal process for review by stakeholders – is there an explanation that is reasonable and does the report contain recommendations that would address such a process in the near future.

**Additional guidance points (reflecting a higher standard of good practise):**
3. Has the report been subject to independent peer review
4. Has there been a formal documented process for review by stakeholders

6. **The Seven Principles of SROI**

1 **Involve Stakeholders**
Stakeholders should inform what gets measured and how this is measured and valued.
The purpose of SROI analysis is to understand and manage the value created by an activity through the eyes of its stakeholders. Stakeholders are those people or organisations that experience change as a result of the activity and they will be best placed to describe the change. This principle means that stakeholders need to be identified and then involved in consultation throughout the analysis, inorder that the value, and the way that it is measured, is informed by those affected by or who affect the activity.

2 Understand what changes
Articulate how change is created and evaluate this through evidence gathered, recognising positive and negative changes as well as those that are intended and unintended.
Value is created for or by different stakeholders as a result of different types of change; changes that the stakeholders intend and do not intend, as well as changes that are positive and negative. This principle requires the theory of how these changes are created to be stated and supported by evidence. These changes are the outcomes of the activity, made possible by the contributions of stakeholders, and often thought of as social economic or environmental outcomes. It is these outcomes that should be measured in order to provide evidence that the change has taken place.

3 Value the things that matter
Use financial proxies in order that the value of the outcomes can be recognised
Many outcomes are not traded in markets and as a result their value is not recognised. Financial proxies should be used in order to recognise the value of these outcomes and to give a voice to those excluded from markets but who are affected by activities. This will influence the existing balance of power between different stakeholders.

4 Only include what is material
Determine what information and evidence must be included in the accounts to give a true and fair picture, such that stakeholders can draw reasonable conclusions about impact
This principle requires an assessment of whether a person would make a different decision about the activity if a particular piece of information were excluded. This covers decisions about which stakeholders experience significant change, as well as the information about the outcomes. Deciding what is material requires reference to the organisation’s own policies; its peers; societal norms; and short term financial impacts. External verification becomes important in order to give those using the account comfort that material issues have been included.
5 Do not over claim
Organisations should only claim the value which they are responsible for creating.
This principle requires reference to trends and benchmarks to help assess the change caused by the activity as opposed to other wider factors and to take account of what would have happened anyway. It also requires consideration of the contribution of other people or organisations to the reported outcomes in order to match the contributions to the outcomes.

6 Be transparent
Demonstrate the basis on which the analysis may be considered accurate and honest and show that they will be reported to and discussed with stakeholders
This principle requires that each decision, relating to stakeholders, outcomes, indicators and benchmarks; the sources and methods of information collection; the difference scenarios considered and the communication of the results to stakeholders, should be explained and documented. This would include an account of how those responsible for the activity will change the activity as a result of the analysis. The analysis will be more credible when the reasons for the decisions are transparent.

7 Verify the result
Ensure appropriate independent verification of the account.
Although an SROI analysis provides the opportunity for a more complete understanding of the value being created by an activity, it inevitably involves subjectivity. Appropriate independent verification is required to help stakeholders assess whether or not the decisions, made by those responsible for the analysis, were reasonable.
Appendix 2:

Analysis of prescribing data

Methods
It used a method known as “interrupted time series analysis”, which compares data series before and after an "interruption", here the start of the project. Each group was divided into before the intervention and after, trends were identified using linear regression. The regression calculation used Pearson’s method, and 95% confidence intervals were calculated from Student’s t-distribution. Three components were considered:

- Slope of the regression line before intervention
- Step change at the time of intervention
- Slope of the regression line after the intervention.

Three different groups of prescribed items were examined using the E Pact prescribing tools.

For analytical purposes GP practices affected by the NLP were defined as those making up Cluster 1 (now Neighbourhood 1). This includes all GP practices in Evelyn, New Cross, Brockley and Telegraph Hill wards except for one practice in the Waldron Health Centre which only opened after the NLP had been completed. The aggregate for the rest of Lewisham was used as the control group.

Single observations made at regular intervals, during which an intervention is made that may affect the variable constitute and interrupted time series. The standard technique for analysing these is due to Box and Jenkins\(^\text{19}\). It is known as ARIMA (Auto Regressive Integrated Moving Average). However, the focus of this techniques is on predictive modelling of a single time series, and much of the substantial mathematical complexity is unnecessary to the present question. I have followed the methodology described by Perrin\(^\text{20}\), with the addition of comparison of the intervention group with the control group. In this approach the process for each group is decomposed into before the intervention and after, trends are identified using linear regression, and the three components considered are

- Slope of the regression line before intervention
- Step change at the time of intervention
- Slope of the regression line after the intervention.

\(^{19}\) Box, G.E.P, Jenkins, G. M, Time-series analysis: Forecasting and control, Holden-Day, 1970

Regression was carried out using the LINEST function in Microsoft Excel, which returns among other items the Pearson regression slope, the degrees of freedom, and the standard error of the slope. Confidence interval for the slope were calculated from Student’s t-distribution, using the formula
\[ CI = t(\alpha, df) \times SE_{slope} \]
where \(\alpha\) = significance level = (1-% width of the confidence interval), so 0.05 for a 95% CI, \(df\) is the degree of freedom (2 fewer than the number of points analysed), and \(SE_{slope}\) is the Standard Error of the slope of the regression line.

Data used
The source of the data was ePACT, the NHS’s prescribing database. After consideration of possible alternatives, the unit of prescription for analysis was chosen to be the number of items dispensed, as this was regarded as less likely to vary systematically than number of prescriptions or aggregate dosage, and therefore the least likely to bias the outcomes.

In general, medicines prescribed for hypertension and lipid reduction may also be prescribed for other conditions, especially other cardiovascular conditions, and no data is available on which condition they are being used to treat. I have therefore considered these categories of drug:
Renin-Angiotensin System drugs, (which are also used for heart failure);
Thiazide diuretics, often regarded as first line therapy in treating hypertension;
All anti-hypertensives, whatever the reason for the prescription;
Lipid lowering drugs (statins).

Data is only held on the ePACT system for five years. As each month’s data is added, so the earliest month’s data is deleted. Data was extracted on two days, between which the system was updated, hence there are two time ranges used in the analyses. Since the North Lewisham Project began in January 2008, there are 14 or 15 monthly points before the start of the intervention, and 46 or 45 points after the intervention. One effect of this is that the smaller pre-intervention sample size leads to greater uncertainty in the statistics. We can have stronger belief in conclusions relating to post-intervention than in those relating to pre-intervention. This is reflected in the width of confidence intervals, and affects statistical significance of the results.

Over the period covered, Lewisham’s total register of GPs’ patients has risen by about 1% per annum. While most of this growth has been in younger age groups, there has also been a progressive reduction in premature mortality (deaths under age 75). Some increase in medicines prescribed would be expected purely from this change in population.

To express data as rates we need appropriate denominators. As well as plain GP registered patients, ePACT calculates “Star PUs”, which are weighted population estimates for particular prescribing categories. I have used the Cost based Drugs affecting renin-angiotensin system STAR Pus for analysis of Renin-Angiotensin System
drugs and Thiazide diuretics. These are often prescribed to the same population, and separate Star Pus have not been derived for thiazides specifically. I have used Cost based Lipid Regulating Drugs Star Pus for lipid lowering drugs.