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Evaluation of Equity Training and Advocacy Grant Pilot Programme

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Mae CISHE yn gwneud ymchwil rhyngddisgyblaethol sy'n arloesol o ran ei methodoleg. Mae hefyd yn cydlynu'r ymchwil honno, gyda chyfraniad cryf o'r gwyddorau cymdeithasol ac ym meysydd perthynol biofeddygaeth, gwasanaethau iechyd, iechyd cyhoeddus a biofoeseg. Rydym yn gwneud ymchwil o'r radd flaenaf yn rhyngwladol ac yn ei hyrwyddo, gan roi pwyslais ar fynd i'r afael ag anghydraddoldebau iechyd a sicrhau bod ein hymchwil yn cael effaith ar bolisi ac ymarfer yng Nghymru a thu hwnt.

Abstract:

The Townsend review of the arrangements for allocating resources for health and health services in Wales, 'Targeting Poor Health', recommended a 'dual strategy' for tackling health inequalities in Wales by action both within and outside the NHS. The review recommended the provision of equity training grants (to increase awareness and understanding of health inequalities and inequities in access to health care) and advocacy grants (to stimulate new action locally to address unmet needs).

The Welsh Assembly Government set up a pilot programme to assess the potential value of these grants which were aimed at health professionals and their partners outside the NHS. The pilot funded 25 projects in three Local Health Board areas between December 2003 and March 2004. An independent evaluation clarified the mechanisms driving the programme and assessed the potential of Equity Training and Advocacy Grants to address health inequalities.

The programme provided small pots of funding to raise awareness amongst health professionals about health inequalities and also stimulated some new local action.

This report presents the findings from the evaluation and describes the sorts of projects that were funded, the key crosscutting findings, and suggest what the main challenges might be to the future of such a programme.

Keywords: health advocacy; health inequalities; inequities in access to healthcare; health care professionals.

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[1] The following document is available from the Public Health Strategy Division at the Welsh Assembly Government: 'Equity Training and Advocacy Grants – learning from the pilot programme (2005).

Executive Summary

The pilot programme

The Welsh Assembly Government developed a pilot programme to assess the potential value and usefulness of equity training and advocacy grants, which were recommended by Professor Townsend in his report *Targeting Poor Health*. The programme, which comprised 25 individual projects, was piloted in three Local Health Board areas – Carmarthenshire, Cardiff and Denbighshire between December 2003 and March 2004.

Programme aims and objectives

The overall aim of the programme was to increase awareness and understanding of health inequalities and inequities in access to health care (equity training) and to stimulate new action locally to address unmet needs (advocacy). The specific objectives were:

- To support local action that increases awareness and understanding among local health professionals and practitioners of severe unmet health needs
- To enable health professionals and practitioners to engage in multidisciplinary discussions that lead to the identification of unmet health needs and local solutions
- To support new action that helps to inform and influence local action (such as advocacy for health) to help people with health needs that can only be met through collaboration between services and organisations outside the NHS.

Evaluation

The Cardiff Institute of Society, Health and Ethics (CISHE) at Cardiff University were commissioned by the Assembly Government to undertake an independent evaluation of the programme. The overall aim of the evaluation was to examine the pilot programme to assess the feasibility of meeting stated objectives, to clarify the mechanisms driving the programme and to assess potential effectiveness. The aim was to assess the programme's achievement of the stated objectives, to clarify the mechanisms driving the programme and to assess potential effectiveness. By commissioning the evaluation prior to the start of the pilot, the evaluation was able to run alongside implementation. It comprised a two-pronged approach:

- *Overall programme evaluation* –a baseline review of the vision, rationale and programme design together with a case study approach focussing on a number of projects in each area.
- *Individual project self-evaluation* – each project was required to undertake its own individual self-evaluation with advice and support provided by the evaluation team.

Lead organisations and partnerships

Most projects were led by the statutory sector and there was some change in ownership between the application and project delivery. The roles of partners varied between and within projects with different partners being called on for their expertise at different stages of project delivery including piloting research tools, involvement in training delivery, and support for organising community events. Partnership working included the use of existing networks

and the formation of new relationships and links. Most projects were able to cite benefits of working in partnership with a range of groups and organisations.

Project activities

Seventeen of the 25 pilot projects were based around an event, a series of events or a training package for health and social care professionals. In line with the programme's aims, some projects made time for health professionals to be freed from their normal duties to undertake investigative work into local health inequalities and inequities in access to health care.

In addition to training and research based activities, some projects set about achieving equity and advocacy work in other ways. In these cases, projects were focussed on trying out different ways of breaking down the barriers for accessing health services for different minority groups. For example, one project provided cards to the homeless with information on relevant local care services, with a second card about the key health professional responsible for their care. Another project provided maternity support and guidance for the Somali community and put in place an interpreter in maternity clinics to support midwives in their work.

Project costs

The average estimated cost of each project was £4,206. In addition to the explicit project costs outlined in the project application forms projects also encountered a number of hidden costs of contributions in kind particularly in terms of time provided by partners to provide specific expertise.

Timescales

The short timescale of the pilot programme, which was outside the control of the programme team, meant that applicants had relatively little time to prepare and submit proposals. The timescale also meant the time needed to set up projects and get the delivery partners on board was short. Project leaders did not necessarily want more time in terms of day allocation, but a longer time to allow links to be set up.

Programme outcomes

Longer term outcomes and impacts can only be hinted at based on evidence put forward by the projects but the true impacts of the pilot programme's project will not be felt until much further down the line.

Outcomes for project participants - health care professionals

All projects involved health care professionals in some way whether as training course attendees, participants in multi-disciplinary discussions, or partners involved in delivering project activities. At one level health care professionals extended their knowledge about a certain health inequality issue. In some cases this led to changes in their skills and working practices, or there was evidence to suggest that this would happen in the longer term. At another level health care professionals' involvement meant they were able to activate new local action to change the delivery of a particular health care service.

Outcomes for project participants – other groups

Projects also engaged with local community groups including young people, black and ethnic minorities, people with learning disabilities, people with mental health problems and the

homeless. These groups were often formed into health advocates who were encouraged to engage in a dialogue about their specific health needs and the barriers they face in engaging health services.

Case study projects alluded to community groups being involved in a process of empowerment as a result of their engagement in the programme's projects. Project leaders also talked about the educational benefits for those involved in the programme in terms of widening their knowledge and skills base.

Outcomes for other groups

The sphere of influence of the pilot programme extended beyond immediate project participants to encompass a wider group of health professionals within the teams of those directly involved.

Outcomes for project leaders & their organisations

Throughout the programme project leaders and other staff became entwined in the awareness raising process and the breadth of their knowledge, experiences and skills was expanded. Links established with partner organisations look set to continue beyond the lifespan of the pilot.

Evidence suggests that one of the legacies of the pilot will be a sense of ownership fostered amongst project leaders. During the course of the programme, several practitioners became advocates in their own right and these 'project champions' were keen to see the findings from the projects put into practice.

Additionality

There is evidence that the application process itself resulted in additional benefits to applicants in terms of their own professional development. Some projects reported that the activities may have been taken forward without funding for the pilot but it would not have included all the elements that the programme allowed. Other projects may have gone ahead without the pilot funding but it would have been at a later stage.

Conclusions

The original aim of the programme was 'to increase awareness and understanding of health inequalities and inequities in access to health care and to stimulate new action locally to address unmet needs.' Reflecting on project outcomes the programme has drawn on a relatively small amount of funding (about £105,000 overall) to raise awareness about a multitude of local health inequalities at a number of levels. The potential sphere of influence of the pilot programme is considerable with scope for the benefits to extend from the immediate group of participants and project personnel to wider teams and organisations.

The programme achieved its aim of stimulating new local action with a number of ideas being taken forward to the next stage of development. A good deal of this new local action would not have been stimulated without the relatively small pots of funding accessed through the pilot programme.

Developing multi-agency working was another key feature of the programme at the project conception and design stage particularly collaborations between services and organisations outside the health service.

One of the more deep-rooted principles upon which the pilot programme was established was the need to encourage health professionals to take on an informal advocacy role and for it to become one of the 'ordinary expectations of professional practice.' This was a

challenging difference to make within a short timescale with limited resources and will require a much more strategic view of the role of health professionals. However, in working towards this, the programme has provided exemplars of what can be achieved and how health professionals can stimulate action outside their mainstream roles. The projects undertaken as part of the pilot can be promoted as creative and diverse case studies of identifying and developing an understanding of local health inequality issues.

It is important that the action that has taken place as a result of the programme is not lost so that service developments and improvements in access to services, changes in working practice and partnership working, and awareness of health inequalities continue and, where possible, are built upon as part of implementing Local Health, Social Care and Well-being Strategies.

Taking the programme forward

Programme design

Stakeholders emphasised the experimental nature of the programme and their realistic expectations of what could be achieved within the limited timescale and with a limited resource. Identifying and understanding health inequalities was seen as the key focus of the programme with the expectation that advocating for health inequalities might become part of the wider role of health professionals.

Stakeholders anticipated project level outcomes being sustainable after the programme had been completed. This was linked to the expectations about the programme facilitating partnership working both within and outside the health service. However, the sustainability of outcomes was balanced by concerns regarding recommendations about resources that might arise.

Delivering project activities

A number of lessons about the effective delivery of activities emerged from the pilot programme and these should be built on during the next phase. The main lessons learnt related to the importance of targeting delivery at the right level and creating the right experience for awareness-raising to be maximised.

A central resource for learning from the programme would be an effective way of ensuring good practice is captured and is accessible to others. This may be through new or established mechanisms for dissemination within the health and allied services such as a website which could incorporate wider learning from other initiatives.

Engaging health professionals

Forty per cent of projects reported some difficulty with engaging health care professionals. The nature of the difficulty included lower numbers of participants than anticipated, the cancellation or postponement of sessions because of very low numbers and the absence of key groups or professionals that the project had originally targeted.

In some cases recruitment or making the link with health professionals was the issue. In other cases, there were problems in releasing staff and the new GP contract made it difficult for one project to identify which GP practices would be delivering a particular service. As well as difficulties *engaging* with health professionals a number of projects also encountered difficulties *identifying* the appropriate personnel to involve in projects.

Engaging with health professionals is a fundamental issue that needs to be addressed strategically if the Equity Training & Advocacy Grants Programme is rolled

out to other areas. Suggestions include tools to help navigate local health services. Opportunities to link action with Continuing Professional Development activity could be explored and the use of Action Learning Sets as a framework.

Setting up the programme

The programme was set up and implemented by a core team within the Public Health Strategy Division of the Welsh Assembly Government. The team drew on expertise from other departments and stakeholders to ensure that the programme was in line with other health policy agendas.

In taking the programme forward it will be important to continue the partnership working between agencies that has been initiated by the pilot. It is paramount that decisions about the future programme are taken in conjunction with agencies both within and outside the health service, incorporating the statutory, voluntary and community sectors.

Role of Local Health Boards

The three NHS Regional Directors were each asked to put forward one LHB area within their regions that they thought could quickly get up to speed with this programme and selected areas where some previous work on tackling health inequalities was underway.

The NHS Directors cited some difficulties in engaging with LHBs with the main issue being timing. There was a willingness on the part of the LHBs to get involved in the pilot but involving them at an earlier stage would have enabled them to make appropriate plans.

Although the LHBs were involved in the design of the programme, queries were raised about their specific role and responsibilities. It is paramount that the LHBs and other key local players are integral to, and supportive of, such a programme in the future. At the same time, one of the unique features of the pilot programme is that it allowed ground level practitioners to take the initiative and bring to the table issues which might not necessarily be a strategic priority.

Consideration needs to be given to who would be best placed to take a lead in driving the whole approach forward at a strategic level. Co-ordination could take place at the national, regional or local level, taking into account all the relevant players and in particular, the roles of the LHBs, NHS Trusts, and the health, social care and well being partnerships.

A balance needs to be struck between ensuring a strategic focus for the programme and providing opportunities for practitioner creativity, which was considered to be one of the refreshing aspects of the pilot programme and something that should be encouraged. Highlighting opportunities for practitioner creativity in national and local strategies will help incorporate the philosophy of equity training and advocacy into other ways of working.

Programme guidelines should be given strategic approval at a senior level but it is important that details of the programme filter through to practitioner level.

The timescales were clearly an important factor in the pilot programme. Any future programme should be planned and executed with a longer timescale.

The application process

Discussions with case study projects about how they found out about the pilot programme suggested variation in dissemination methods between and within LHB areas. There is

scope to improve the dissemination of programme guidelines to ensure they reach the target audience with adequate time for application submission.

Project applicants commented that they found the electronic format designed by the Assembly useful and easy to use. Applicants were able to access support and guidance in the Assembly. Case study projects gave positive feedback on this support and praised the programme for having a designated team available to answer queries in the run up to application.

Feedback from pilot projects highlighted the importance of having a dedicated team to deal with queries during the application stage and to ensure overarching consistency in aims and objectives. It is important that this continues to be an integral feature of any future programme.

Research ethics

The evaluation team were alerted to concerns amongst some projects, especially those undertaking research based activities, about the need to gain ethical consent before embarking on their research, which typically involved surveying the health needs and opinions of patients and health professionals. For some project leads this was the first time they had undertaken such research and inevitably they were unsure about where to seek help.

Ethical considerations need to be factored into such programmes in the future. These need to be triggered at the point of project conception so that timescales for ethical approval can be factored in. This needs to be backed up by Assembly guidance and support on where best to turn for practical advice at a local level.

Sustainability

The view amongst project leaders was that the pilot programme had acted as a catalyst towards activating change. Steps, in some cases several steps, had been taken towards improving access to services but something else was needed to continue that momentum and ensure changes were actioned. In several cases the responsibility had been handed over to health professionals themselves.

Establishing strategic responsibilities for the Equity Training & Advocacy Grants Programme at the outset will help to ensure that outcomes are more sustainable in the longer term. This will help foster the climate for sustainability which includes providing ongoing support for change and the wider dissemination of lessons so that they become embedded within organisations.

Evaluation

Consideration needs to be given to the possibility of a minimum data set for tracking the actual scale and scope of project activities. However, it will be important not to lose sight of the diversity of project activities and projects should be encouraged to supplement the minimum data set with their own individually tailored self-evaluation measures.

Workshop-based guidance on self-evaluation should feature in any future programme. This has the dual benefit of raising skill levels amongst programme participants as well as providing essential opportunities for networking between projects.

1 Introduction

1.1 This chapter provides the context for the Equity Training and Advocacy Grant Programme, (from herein known as 'ETAG'). It describes the background and context for the pilot programme, provides an overview of the evaluation, and concludes with an outline of the rest of the report.

Background to the Equity Training and Advocacy Grant Programme

1.2 This section sets the overall context for how the ETAG programme was initially conceived and subsequently developed. Later in this report we refer to how the pilot programme matches up against its original guiding principles.

Origins of the programme

1.3 The programme has its origins in the Townsend report 'Targeting Poor Health'[2]. The report presents the findings of the review of the arrangements for allocating resources for health and health services which was set up by the Health and Social Services Committee of the National Assembly for Wales on 16 February, 2000. The Review, headed by Professor Peter Townsend of the London School of Economics and Bristol University, 'examined the resource allocation process in the context of the performance of the NHS in tackling poor health and addressing health inequalities.' The main aim of the Review was to 'recommend a means of resource allocation to distribute, and audit the distribution of, health service resources in accordance with health need, building on the basis of previous allocation.' The report also recommended that a 'dual strategy' be adopted by the Welsh Assembly Government to tackle both inequalities in health experience and inequity in access to health care. This dual strategy would include action within and outside the NHS.

1.4 One of the recommended strands of work from the Townsend review was the development of ETAG. Equity Training Grants were recommended to enable the creation of opportunities for health professionals to 'review the need for changes in practice' and 'identify severe unmet health needs'. The emphasis on 'inter-professional' equity training was also highlighted in the report (see Box 1.1).

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[2] Targeting Poor Health: report of the Welsh Assembly's National Steering Group on the Allocation of NHS Resources. Available at http://www.wales.gov.uk/healthplanonline/health_plan/content/townsend-report-e.htm

Box 1.1

Equity training grants (Vol 1 of 3, pg 12 &13)

"We urge professional bodies to review in the public interest, the changing problem of health needs, especially in relation to the principle of "equity of access". To support this NHS Wales need *to ensure that professionals have the opportunity of taking time to review the need for changes in practice*, including receipt and organisation of information about practice areas and conditions. There must be *specific recognition in the funding arrangements* for professional training of the need for members of professional bodies, hospitals, health centres and other organisations *to be freed to meet and identify severe unmet health needs*, especially of those with low income and/or living in conditions where they lack social support and access to public and private services. This needs to include a *strong focus on inter-professional sessions* with the specific objective of achieving equity in professional practice. Accordingly, we recommend the provision, whether in the general NHS budget or additionally, through instruments such as the Health Inequalities Fund of training grants for "equity in public service." *(emphasis added).*

1.5 The review also recommended advocacy grants (see Box 1.2). The review panel recognised health professionals often take on an informal advocacy role on behalf of their patients and they envisaged this becoming part of their mainstream role which is 'built into the expectations of professional practice'.

Box 1.2

Advocacy grants (Vol 1 of 3, pg 23).

"*Professionals and volunteer workers advise patients or clients occasionally or frequently about, for example, their housing or income*. Doctors are often expected to supply information to Councils or the Department of Social Security, on behalf of ill or disabled patients who consult them. Often they advise and not only supply information. We believe this function could be built into the expectations of professional practice. We therefore propose that an "advocacy grant" should be introduced on an experimental basis for 3 years *to enable health professionals to meet to pool their experience of unmet health needs* – the responsibility for which lies outside the health care system, and *to enable them to make representations for change to the appropriate external bodies*. This is only one of the possible measures to call attention publicly to this wider advocacy role that in our view *needs to be part of the ordinary expectations of professional practice*. Provision must be made for professionals to meet to *contribute their expertise* to the wider agenda." *(emphasis added).*

The pilot programme

1.6 Following the recommendations of the Townsend Review the Welsh Assembly Government set up a pilot programme to assess the potential value and usefulness of the equity training and advocacy grants. Funding of up to £150,000 was identified to support the pilot programme in three Local Health Board (LHB) areas. The Minister for Health and Social Services, Jane Hutt, announced the ETAG programme on 9 September 2003 and organisations were invited to submit proposals by 24 October 2003. Project implementation took place between December 2003 and 31st March 2004.

1.7 Altogether 73 applications were received and a total of 26 projects were initially awarded funding. One project was not able to deliver so 25 projects were funded and completed. The overall cost of the programme was £105,140 (excluding evaluation) – an average cost of £4,206 per project. The breakdown between the LHB areas is as follows:

- South East Wales, Cardiff LHB – 11 successful projects out of 33 applications. Total funding was £43,400

- Mid & West Wales, Carmarthenshire LHB – 11 successful projects out of 32 applications. Total funding was £48,140

- North Wales, Denbighshire LHB – 3 successful projects out of 5 applications. Total funding was £13,600

1.8 There were also three applications received from outside these pilot areas – one from Ceredigion, one from Pembrokeshire and one from Swansea. These applicants were subsequently informed of the geographical restrictions of the pilot programme.

Programme aims and objectives

1.9 The overall aim of the programme, outlined in the Guidance for Applicants drawn up by the National Assembly, was to increase awareness and understanding of health inequalities and inequities in access to health care (equity training) and to stimulate new action locally to address unmet needs (advocacy). The specific objectives of the programme were stated to be:

- To support local action that increases awareness and understanding among local health professionals and practitioners of severe unmet health needs

- To enable health professionals and practitioners to engage in multidisciplinary discussions that lead to the identification of unmet health needs and local solutions

- To support new action that helps to inform and influence local action (such as advocacy for health) to help people with health needs that can only be met through collaboration between services and organisations outside the NHS.

1.10 The pilot programme was set up and managed by the Public Health Strategy Division within the Welsh Assembly with ongoing guidance from the Townsend Standing Committee, the group set up to take forward the recommendations of the NHS Resource Allocation Review.

The evaluation

1.11 Researchers at the Cardiff Institute of Society, Health and Ethics (CISHE), Cardiff University, were commissioned by the Welsh Assembly Government to undertake an independent evaluation of the equity training and advocacy grant pilot programme.

1.12 The research methods were informed by theories of change and realistic evaluation, in order to test the way in which underlying theories of the programme and the contexts in which the programme operated, could affect outcomes.[3,4] Underlying realistic evaluation is the assumption that the contexts within which programmes operate are crucial to their outcome. Focussing on processes addresses what works, for whom and in what circumstances.

1.13 The overall aim of the evaluation was to examine the pilot programme to assess the feasibility of meeting stated objectives, to clarify the mechanisms driving the programme and to assess potential effectiveness. The team at the Welsh Assembly were keen to have an evaluation in place from the start, to run alongside programme delivery. Conducting evaluations alongside pilot implementation was highlighted in the recent Wanless Review[5] as a way forward for tackling the difficulties in evaluating public health interventions.

1.14 The specific objectives of the evaluation were:

- To provide a critique of the overall programme design
- To understand how the programme works in practice
- To identify what changes are required to maximise the potential effectiveness of the programme
- To identify realistic outcomes/impacts given the time available to projects and associated data collection requirements and how these may be applied if the programme is rolled out across Wales

[3] Connell J, Kubische , Schorr L and Weiss C eds (1995) New Approaches to Evaluating Community Initiatives: Concepts, Methods, and Contexts. New York, NY: The Aspen Institute.

[4] Pawson R and Tilley N (1997) *Realistic Evaluation*. London; Thousand Oaks, Calif; Sage.

[5] Wanless D (2004) 'Securing Good Health for the Whole Population, Final Report.'

- To assess the self-evaluation plans proposed by projects and to offer limited support during the course of the programme

- To assess whether the proposed programme is feasible/practicable and acceptable to applicants.

1.15 At the centre of our approach was recognition that our key role was in helping to optimise the design of the scheme, with the focus of the evaluation on context, process and implementation, rather than on summative assessment and outcomes, which would be best addressed by the individual project self-evaluations.

Evaluation approach

1.16 In response to these evaluation requirements the evaluation team adopted a two pronged approach as follows:

- *Overall programme evaluation* – this consisted of an initial baseline review of the vision, rationale and programme design together with a case study approach focussing on a number of projects in each LHB area.

- *Individual project self-evaluation* – each project was required to undertake their own individual self-evaluation. The evaluation team provided advice and support for the project self-evaluations.

Overall programme evaluation

1.17 We conducted a baseline assessment of the design and implementation of the programme through interviews with key stakeholders including those in the Public Health Strategy Division team at the National Assembly, members of the Townsend Committee, and representatives from the National Public Health Service. It was important that this group of stakeholders were consulted at an early stage ideally before their expectations had been influenced by ideas from project participants. This initial round of interviews can thus be seen to represent early expectations of the programme and stakeholders' views of the sorts of activities the programme might support.

1.18 The case study approach focussed on three projects in each LHB area. The nine case studies selected from across the pilot programme reflected the range of project activities, lead

organisations and target/participant groups. The applications from all successful projects were reviewed and the main selection criteria applied was as follows:

- **Lead organisation** – this varied between projects and was likely to have an impact on the way in which the project was delivered and the type of approach adopted. We ensured a selection of the following in each LHB:
  - *Statutory* – we selected at least one in each LHB
  - *Voluntary* – we ensured there was at least one voluntary group in each LHB.
- **Project activity** – there was some variation in the sorts of activities that projects proposed within and between LHB areas. For selection purposes and using information provided in the initial applications, projects were classified as follows:
  - *Training* – projects that focussed on delivering one or multiple training or awareness raising sessions.
  - *Research* – projects that focussed on undertaking and disseminating research or exploratory work
  - *Other activities* – there were also some projects which did not fit easily into the above categories and were facilitating equity training and advocacy in some other way. For example, one project in Cardiff advocated for the health needs of homeless people through the provision of health information cards.
- **Target groups** – the list of nine case studies included a range of the following target groups:
  - *Population groups*. For example, Black and Minority Ethnic groups, victims of domestic abuse and the rurally isolated
  - *Specific health groups*. For example, people suffering from arthritis, mental health problems and incontinence.

1.19 At the outset it was made clear to case study projects that we did not wish to detract from their main purpose of delivering the project, and we aimed to collect information at minimum inconvenience to them. Each case study consisted of the following key components:

- Interviews with the project lead and others involved in delivery at the start of the project and follow up interviews towards the end of the project

- Review of key documentation including the initial application form and documented minutes from partnership meetings

- Observation of a selected project event (where appropriate).

1.20 In total 23 people were interviewed as part of the case study evaluation, an average of 2.5 per case study project. The overall evaluation also incorporated a national review meeting for all 25 project leaders and other local stakeholders. This provided a useful opportunity to feedback preliminary findings from the evaluation and for a wider group to confirm or challenge key findings.

Self-evaluation support

1.21 Support and guidance for projects carrying out their own self-evaluations consisted of an initial half day workshop held in each of the three pilot areas, together with follow up support by telephone and email. Further details about the self-evaluation support is presented in Chapter 5.

1.22 The individual self-evaluations were designed to feed into the final reports for the National Assembly. These were designed to capture the key outputs and achievements of the programme and have been drawn on as an additional data source throughout this evaluation report.

1.23 Nine of the 25 (36%) reports submitted by end of May 2004 were described as interim rather than final end of project reports. Outstanding tasks included delivering all or some of the training sessions, producing reports which were included as part of their original aims and objectives and hosting community meetings. The anticipated finish dates ranged from completion in ‘the next few weeks’ to completion by June with a couple putting forward outline completion dates for September.

1.24 Reasons for delays in project completion was attributed to a number of factors, some internal and others beyond the control of project leaders. These included a delayed start due to the time needed to identify project staff; managing pre-existing staff commitments over the same time period, and difficulties around engaging health professionals in planned activities and events (discussed more in Chapter 4). One project also cited the multitude of other activities

taking place at the same time as one of the reasons for the delay in project completion. This included the plethora of other ETAG events that were planned for the same three month time period in the pilot LHB areas.

Outline of this report

1.25 The next chapter of the report looks more closely at the concepts underlying the ETAG programme including a consideration of how this programme sits alongside other initiatives in the UK.

1.26 The rest of this report discusses the key findings emerging from the evaluation tasks outlined above. Initially we discuss the overall programme design (Chapter 3), followed by a discussion of project level activities and delivery (Chapter 4). These two chapters are important in describing how the programme works in practice and provide a critique of the overall programme - two of the key objectives of this evaluation as identified above.

1.27 Chapter 5 looks in more depth at the self-evaluation and Chapter 6 focuses on programme outcomes drawing on the case study material and the project level reports. The final chapter draws overall conclusions about the ETAG programme and provides advice for the future direction of the programme – its future design and implementation as well as the role for existing structures in the National Public Health Service. The key advice points are highlighted in bold throughout the report and are summarised in the final chapter.

2 Conceptualising the programme

Introduction

2.1 Stakeholder and participant expectations of the ETAG programme are summarised at the start of this chapter. These provide an understanding the programme's potential from the perspective of those most closely allied with its design and implementation.

2.2 A review of similar schemes elsewhere was undertaken as a discrete task within this evaluation and the key lessons to be learnt are presented below. This provides an insight into how similar schemes have been conceptualised and implemented elsewhere.

Stakeholder expectations of the pilot programme

2.3 Overall, the programme was welcomed by stakeholders as an experimental exercise to test out what could be achieved with relatively small amounts of funding over a limited timescale. This experimental undertone was initially expressed in the Townsend recommendations (see Box 1.2) and was echoed in the expectations of stakeholders.

'This is experimenting with the concept…to test out the usefulness of using relatively small amounts of money to stimulate some action....' (Stakeholder)

2.4 Stakeholders were realistic about what a programme like ETAG could achieve. At the very least it was felt that this programme would focus on identifying health inequalities and reasons behind them, even if it was not possible to directly address the underlying issues:

'This programme is not necessarily about solving problems because it's only a small fund, but it's certainly about identifying them... If a GP practice was to do some local work they may find that one of the issues is not medical but it could be a housing issue…the purpose of this programme is to help them actually explore that in more detail and find out exactly what the problem is rather than address it.' (Stakeholder)

2.5 However others envisaged the programme going a step further to ensure that projects were likely to stimulate some action as a direct result. The identification of issues and possible solutions resonates back to the calls for advocacy for change in the original Townsend review.

'It's making sure that whatever the projects are it's not just a set of talking shops with no active outcome at the end of it so that it's not seminars or conferences where people can just stand around networking and at the end of it they go home. If there are seminars or training where people can get something out of it and then take it back into the community and make sure that people then have a better health care system.' (Stakeholder)

2.6 Longer term expectations were reflected by stakeholders who talked about these sorts of activities being 'part the job' of health professionals and challenging the very nature of existing professional practice. Again this echoes back to the Townsend Review and the need for activities to become part of the 'ordinary expectations of health professionals.'

'It's about allowing health professionals time to think about their work in general and sharpen up their equitable values. It's about rising above the established authorities and asking whether they can counter inequalities.' (Stakeholder)

Expectations of project level activities

2.7 From the early stages stakeholders were expecting a diverse range of project activities and this is reflected in the examples included in the Guidelines for Project Applicants. This ranged from 'practical action by a GP practice to respond to needs of patients through partnership with other local organisations' to 'multi-disciplinary sessions and/or training events that are designed to identify and explore issues relating to inequalities.' The expected project outputs were also varied and included 'recommendations to the LHB' or 'positioning reports showing the status of health alongside other local issues.' The key trend was that stakeholders expected project outputs to be sustainable in the longer term.

'What we're trying to achieve, in a nutshell, is some form of action which lasts after the initial action…it could be an increased awareness of issues, it could be further action or something that stimulates further action.' (Stakeholder)

2.8 Stakeholders also hoped that the projects would involve a range of partners incorporating a mix of statutory, voluntary and community organisations. Again, this reflects back to the Townsend recommendations and calls for 'inter-professional sessions.'

'Where it really fits into Assembly strategy and policy is partnership working. This sort of programme is really another step forward in joined up discussion.' (Stakeholder)

2.9 As the above discussion illustrates the expectations of stakeholders about what the ETAG programme could achieve was on the whole very positive. However, there were some concerns raised at the local level about resourcing the outcomes and any suggested actions.

'One of our problems is that we've got a big financial deficit and one of our concerns is that some of these projects may well come through with issues that …we haven't got any resources to do anything about.' (Stakeholder)

2.10 Given these apprehensions about the sustainability of the activities and recommendations that might be generated by the ETAG programme it is important to consider the role of key local health economy players in the design of any future programme. The term health economy refers to all stakeholders involved in funding, delivering, and using health related services within a locality. So in addition to the obvious health players it can also include social services, local authorities, voluntary sector/faith based organisations working in health, other actors delivering ancillary support services, as well as local community groups and community leaders. The role of these local health economy players is discussed in more detail in the next chapter on 'Setting up the programme.'

Expectations of changes in service provision

2.11 Case study projects seemed to be clear of the sorts of impacts their projects could have in the longer term. For example, one research-based project envisaged that the work could go towards the setting up of satellite clinics and an overall more flexible service to deal with people suffering from a particular medical condition. Another felt that, in an ideal world, the project would lead to the development of a rolling programme of information and awareness raising. However, they were realistic about the degree to which about they would impact on service delivery. For instance lead organisations felt that they could raise awareness amongst health professionals and provide signposts for further information, but they recognised that it would be the health professionals themselves that needed to implement the skills or knowledge in their working practices. They saw their role and this programme as facilitating that process. This is in line with the expectations of stakeholders about the limitations of what could be achieved by the ETAG programme.

2.12 Projects also felt that there may be positive outcomes for the particular client or population groups involved. For instance opportunities were provided to raise their awareness of particular health and service issues, to build confidence and skills in self-advocacy, or to facilitate the development of a core group of users who could further develop some of the messages from the project.

2.13 A third tier of expectations centred on impacts for the lead organisations particularly in relation to building new or better links with other health professionals. This was particularly an issue for projects where the lead applicant was a voluntary organisation, but capacity building was felt to be a potential benefit for most of the case studies. Organisations also welcomed the opportunity to further links between other ETAG projects, one project stressing that it provided a worthwhile opportunity to link with a network of other organisations that they may not otherwise come into contact with.

Lessons from elsewhere

2.14 A discrete task within the evaluation of the ETAG programme was to undertake a focussed review of similar schemes in the UK, from which lessons may be learnt. This was an important task to find out how similar issues have been tackled elsewhere and the results of this desk-based review are presented below. A combination of internet searching using general search engines and specific searches on national health websites such as the Health Development Agency was used a starting point for this task. Discussions with programme participants and the evaluation team also provided leads into finding similar schemes. In any continuation of this programme it will be important for the following examples to be investigated so that key lessons can be learnt and a two-way sharing of information and good practice can be initiated.

Health inequalities training

2.15 The review identified a number of training schemes pitched at the interface between primary care and public health with an emphasis on tackling health inequalities and raising awareness of the wider determinants of health. The two examples below give a flavour of these sorts of schemes. The first is a multi-disciplinary scheme designed to build capacity whereas the second example sets out plans to formalise the public health function of General Practitioners.

Box 2.1 – Health inequalities training

Belfast Healthy Cities – Inequalities in Health Training Programme. Belfast Healthy Cities is a partnership based approach to improve the health and well-being of the people who live and work in Belfast. They are one of 49 Healthy Cities across Europe, and part of the European Healthy Cities Network. Belfast Healthy Cities have developed a capacity building programme which aims to assist statutory, voluntary and community organisations in promoting action to tackle inequalities in health. The programme was funded by Belfast Regeneration Office, the Eastern Health and Social Services Board and Belfast Healthy Cities between October 2002 and April 2003. The programme involved seven training days to identify current action. At each training day expert speakers presented current knowledge in each area. Topics included evaluation, definitions and determinants of health, Health Impact Assessment (HIA) and methods for community participation. Participants included representatives at a senior level from the statutory, voluntary and community sectors.
For further details see: www.belfasthealthycities.com

Public Health Development Office (PHD) Hampshire & the Isle of Wight – Practitioner Training. A scheme is being considered whereby established General Practitioners could be provided with public health training two days a week for a period of 6-12 months. Training would be based around a piece of work to be done in the practice and would be a practice priority. Links would be established with the public health team, the Primary Care Trust and the Local Strategic Partnership. Academic support would be provided through educational courses that might cover an understanding of the national context, the determinants of health, health promotion, basic epidemiology and stats, priority setting, project planning, multi-agency and team working, monitoring and review. Accreditation would be sought from the Faculty of Public Health Medicine and would be approved for GP training by the Director of Postgraduate General Practice Education (DPGPE).
For further details see: www.phdevelopmenthiow.org.uk/practitioners.htm

Self-help networks

2.16 Another set of schemes were aimed at raising awareness of health inequalities through support networks where information and practical advice is shared and links between interested agencies are facilitated. As the following examples illustrate these self-help networks can generate successful multi-disciplinary teams to take forward local health inequality issues, although there is a reliance on conscientious individuals to take the initiative and drive an issue forward. These are the sorts of networks that could shape part of a future ETAG programme as a way of sharing good practice and promoting networking between interested organisations.

Box 2.2 – Self-help networks

Health Voice Network (Department of Health) - A self-help network to enable more people to have more of a say in planning services that affect their health. The aim is for it to be used by staff who work in health and other services, community groups and organisations that provide advocacy, campaigning, education, finance information etc. It is co-ordinated by the Hub & Spokespeople Project/UK Health for All Network and funded by the DoH. One example is the Midlands Ethnic Health Network which comprises health care professionals, community and voluntary organisations, from the West Midlands, East of England and Trent Region who have an interest in reducing inequalities in health and developing a responsive health service to meet the need of BMEs.
For further details see: http://www.healthvoice-uk.net/

Health Action (Health Development Agency) - Provides practical help for all those working to reduce health inequalities by building on local experience and innovation. You can download tools to help in your work, take part in discussions or join email lists to share information. Health Action topics include: community involvement, health and employment, health and housing, and partnership development.
For further details see: www.healthaction.nhs.uk

Broadening the role of health professionals

2.17 The review also uncovered a number of ad-hoc examples where health professionals have looked beyond their normal role and ways of working in order to tackle local health inequalities. The first example below shows a health professional becoming an advocate for improvements to health care services for the travelling community. The other examples illustrate different ways in which primary care practices have improved service delivery through engagement with the local New Deal for Communities (NDC) partnership – the vehicle designed to support partnership based neighbourhood renewal in England.

Box 2.3 – Broadening the role of health professionals

On the road to good health – Award Winning HDA project. A health visitor in Ferryhill Clinic County Durham became aware that the travelling community was poorly served by local health services. They undertook research and produced a book 'Be Healthy, Be Happy' which featured pictures and a range of child health issues. The research uncovered some interesting findings such as the poor uptake of whooping cough and MMR vaccines as a result of the influence of the media.
Funding came from a variety of sources including User Involvement in Care Award from the Foundation of Nursing Studies, Sedgefield and Darlington health promotion units and Local Sure Start project.
For further details see: www.hda.nhs.uk

Supporting GPs – Aylesbury New Deal for Communities (NDC) Partnership. On the Aylesbury estate in Southwark, South London, four GP practices were not initially engaged with the NDC programme, despite providing many services that complemented those in the NDC delivery plan. Now there is an integrated system linking GPs with the NDC and with one another. A GP practice project manager was appointed in September 2001, jointly funded by Southwark primary care trust and the NDC. They work in two different practices four times a week and at the NDC office one day a week. With their help, GP practice files – constantly changing because of the transient population – have been updated. Cervical screening programme records have been overhauled, enabling one GP practice to achieve its national targets. A new register of carers has also been funded by NDC. Once a week carers' outreach workers support patients who are themselves carers.
For further details see: http://www.neighbourhood.gov.uk/ndcannualreview.asp?pageid=114

Support not pills – Hull Deal for Communities (NDC) Partnership. This is a partnership project run by Hull Preston Road NDC and local GPs. Many of the problems dealt with by GPs have an underlying non-medical cause – for example, problems around employment, relationships, debt and so on. GPs often prescribe medication such as anti-depressants because they are not aware of where patients can access the sort of help and support they need. This 18 month pilot project employs two health support workers. In one year it made 250 referrals to statutory and voluntary agencies. The project has a steering group made up of residents, project staff and health workers.
For further details see: http://www.neighbourhood.gov.uk/ndcannualreview.asp?pageid=114

Action learning sets - a framework for addressing health inequalities

2.18 An action learning set is a concept designed to encourage self-directed learning, promote a broader role for health professionals while at the same time contribute to Continuing Professional Development (CPD). As a framework it therefore has the potential to be an attractive option for health professionals who might be discouraged to take part in other initiatives because of the absence of accreditation.

2.19 Action learning sets can be defined as 'a process by which common needs or issues are first identified and then met within a group through shared learning and/or through external expertise. Groups will commit to attending regular sessions over a defined period of time.'[6] Box 2.4 summarises two examples of how learning sets have been targeted at the interface between public health and health practitioners.

Box 2.4 – Action learning sets – a framework for addressing health inequalities

Department of Health and the Faculty of Public Health Medicine – pilot learning sets. The learning set model was tested out in three regions in 2000-2001 – West Midlands, South West and Eastern regions. The target groups were public health specialists and primary care practitioners and managers with an interest in public health. The aim was to ensure that both primary care and public health professionals developed a pattern of working that ensured the public health function was fully integrated into primary care groups and trusts. One of the outcomes from the pilot was a toolkit summarising the experiences of the three regions.
For further details see: http://www.fphm.org.uk/policy_and_consultations/Policy_PDF_docs/learning_set.pdf

Institute for Public Health Research & Policy (IPHRP), University of Salford – Reducing health inequalities in the North West: Building organisational capacity. This was a three year project initiated in 2000 commissioned by the then NHS Executive North Wets Regional Office R&D Directorate, in collaboration with the University of Liverpool. The project works with six local health networks building their capacity to tackle health inequalities through local interventions.
For further details see: http://www.iphrp.salford.ac.uk/Projects/Reducing%20Health%20Inequalities.htm

2.20 There are a number of ways in which ETAG activities could fit within the framework of an action learning set. The action orientated nature of learning sets fits with the ETAG approach of trying to identify ways of tackling health inequalities and the drawing of external expertise matches up with a number of pilot ETAG programmes where experts from the statutory, voluntary and community sectors have been brought in to share their knowledge and experiences. It will be important for any future ETAG programme to build on the foundations already laid by learning set activities and take its evolution a step further. The multi-disciplinary element of ETAG needs to be captured within the action learning sets thus

[6] 'Learning Sets – a tool for developing a multiagency, multiprofessional approach to public health.' Toolkit designed for the Faculty of Public Health Medicine by the Public Health and Primary Care Group, Public Health Resource Unit, Oxford University. December 2001. http://www.fphm.org.uk/policy_and_consultations/Policy_PDF_docs/learning_set.pdf

securing representations from statutory, voluntary and community partners will be important. Ensuring the focus is on local issues also needs to be a priority. One feature of action learning sets is their time-limited nature so it will be important to incorporate opportunities for sustaining the outcomes in the longer term. The nurturing of learning set champions will be one means of ensuring the longevity of issues raised. One of the key next steps for ETAG programme managers will be to explore the mechanisms for integrating ETAG into action learning sets and making accreditation available from each of the appropriate professional bodies.

2.21 The following example illustrates the way in which ETAG activities could fit within an action learning set framework. This builds on some of the initial expectations that stakeholders had about linking GPs and other health professionals into local health inequalities and the wider determinants of health. This example could be a one-off project or part of a series where professionals within a local health network bring specific inequalities problems for exploration to inform understanding and action.

Box 2.5 – Hypothetical example of an action learning set

- **Learning set champion –** this might be a local GP who is keen to find out more about the local housing issues affecting patient's mental health.
- **Learning set participants** - the GP will have contacted a small number of local key experts and stakeholders to investigate the problem and suggest local action. Examples of other participants might be a relevant Local Authority Housing Department officer, a representative from the Housing Association, the Communities First Co-ordinator, a local district nurse and health visitor, and local voluntary representatives concerned with housing.
- **Pooling of expertise –** one or two meetings will be held to pool knowledge of the local housing situation and how it may affect the mental health of local people. If necessary gaps in knowledge will be identified and followed up in-between meetings.
- **Wider networking and awareness raising –** key findings from the initial review could be shared with other health professionals in the practice, linking with other practices and perhaps secondary care teams at the local hospital. Other representatives could also disseminate the initial review within their own organisations. Feed-back from the representative organisations would inform follow-up action.
- **Follow up action –** the result of the review and discussion with other health professionals might be a positioning report about the links between housing and health and suggested practical solutions. The initial project champion might join the Communities First Partnership Board as a way of ensuring this report is placed firmly on the local agenda. This might provide a route in to identifying other local health inequalities.

Chapter summary

- *Stakeholder perceptions* – Feedback from stakeholders emphasised the experimental nature of the programme and their realistic expectations of what could be achieved within the timescales and with a limited resource. Identifying and understanding health inequalities was seen as the key focus of the programme with the expectation that advocating for health inequalities might become part of the wider role of health professionals.

- *Project level expectations* – Stakeholders anticipated project level outcomes being sustainable in the longer term, after the programme had been completed. This was linked to the expectations about the programme facilitating partnership working both within and outside the health service. However, the sustainability of outcomes was balanced by concerns about resourcing recommendations that flowed from ETAG projects. Additional outcomes that were anticipated at the early stage of the programme included capacity building for project leaders and their organisations and self-advocacy for client groups.

- *Lessons from schemes elsewhere* – A range of other schemes were identified where the focus was on raising awareness amongst health professionals about health inequalities. This included training schemes on generic health inequality issues, self-help networks for enthusiastic individuals and organisations to exchange information and practical advice, as well as one-off examples of practitioners working outside their normal role to advocate for change at a local level. Future programmes should build on the knowledge gained through these schemes. Action learning sets, as a concept, appear to offer an appropriate framework to take the ETAG programme forward and they are already an established mechanism for linking ETAG-type activities to Continuing Professional Development.

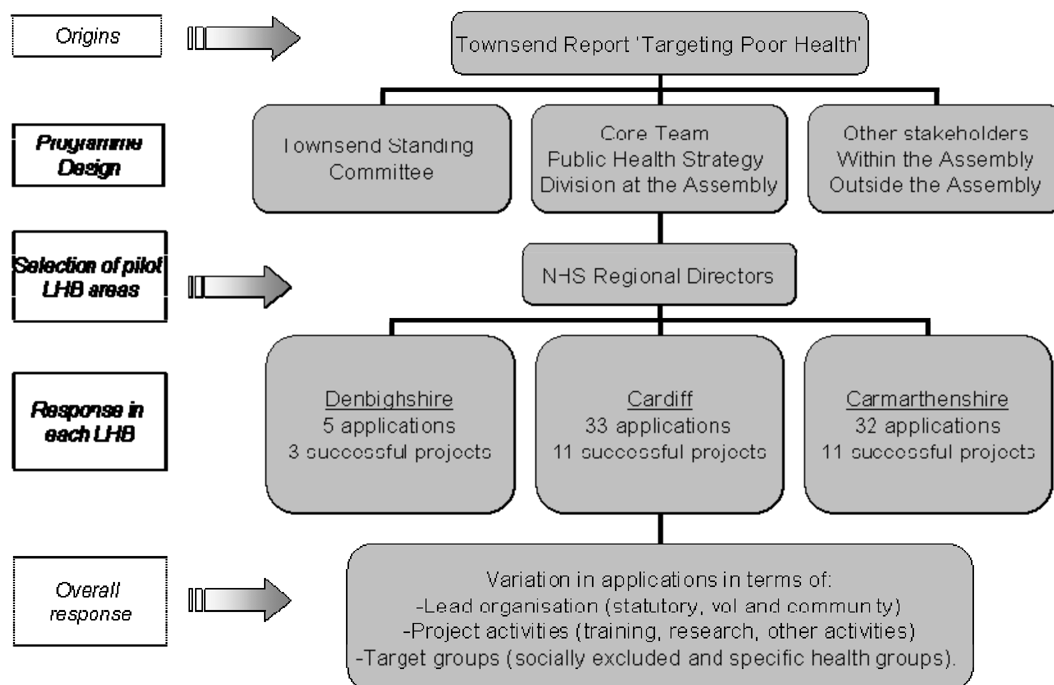
3 Setting up the programme

Introduction

3.1 Reviewing how the ETAG programme was set up and implemented was a key focus for the evaluation. Drawing on the views of stakeholders and project leaders, this chapter provides information on how the programme was set up and implemented as well as a critique of the process and key lessons for future grant funded programmes.

How the programme was set up

3.2 As an overview for this section the following flow chart presents the key stages between translating the Townsend recommendations into a grant funded programme and delivering the 25 successful pilot projects.



3.3 The programme was set up and implemented by a core team within the Public Health Strategy Division at the National Assembly. The team drew on expertise from other health related departments within the Assembly to help administer the mechanisms for a grant funded programme. They also drew on the expertise of stakeholders involved in the local health economy to ensure that the programme was in line with other health policy agendas. There were some changes in team personnel throughout the programme but this seemed to have a limited effect on continuity with comprehensive case notes logged at each stage which ensured there was a full track record of previous decisions and communications.

3.4 In driving the programme forward it will be important to continue the partnership working between agencies that has been initiated by the pilot. It is paramount that decisions about the future programme are taken in conjunction with agencies both within and outside the health service, incorporating the statutory, voluntary and community sectors. Highlighting opportunities for 'practitioner creativity' in national and local strategies will help incorporate the philosophy of ETAG into other ways of working.

3.5 Designing the ETAG programme presented opportunities for working with other partners involved in public health notably the NHS Trusts and other Assembly departments. These stakeholders were invited to comment on early drafts of the guidelines and in total 18 of the 26 stakeholders who were invited to comment did so in some way or agreed to participate in the future and indeed some of these stakeholders went on to help with programme dissemination.

3.6 The team at the Assembly devised an electronic template for completion of applications which included a series of expandable boxes which could be enlarged for more writing space. This was accompanied by a set of guidelines which explained what was required in each section.

Selecting pilot LHB areas

3.7 The three NHS Directors in North Wales, South Wales and, Mid and West Wales were key to the selection process. They were each asked to put forward one LHB area within their regions that they thought could quickly get up to speed with this programme. Our discussions with the NHS Directors showed that they generally selected areas where some previous work on tackling health inequalities was underway.

'The selected LHB was the only one really willing to give this a go and the pilot fitted what they were doing anyway…the pilot was sort of building on what they had already done.' (Stakeholder)

'We were aware that x were making some inroads into some of the wider agenda. All the LHBs are up and running so to be honest we could have selected any of them…I think there are some areas of severe unmet need in x and we had pretty reasonable confidence that this LHB would make a good job of the process.' (Stakeholder)

3.8 The NHS Directors consulted as part of this evaluation cited some difficulties in engaging with LHBs with the main issue being timing. LHBs were still in their relative infancy and there was some reluctance to get involved in this programme in addition to everything else they were involved in.

3.9 Identifying the right person within the LHB was also an issue. Initially the ETAG programme was passed onto the LHB Chief Executives but this was often passed onto someone else within the LHB for co-ordination which included the Director of Development and Performance Management and the Head of Health Promotion. There was a willingness on the part of the LHBs to get involved in these sorts of initiatives but involving them at an early stage would enable them to make the appropriate plans.

'Broadly speaking we would support it there's just different ways it could be planned in advance so that we're able to respond appropriately and also to make sure its making most effective use of the money.' (Stakeholder)

Role of the local health economy

3.10 Although the LHBs were implicated in the design of the programme, concerns were raised about their specific role and responsibilities. Looking beyond the ETAG programme and in light of the concerns raised in the previous chapter about ensuring the recommendations flowing from ETAG projects could be acted upon, it is paramount that the LHBs and other key players in the local health economies are integral to and supportive of such a programme in the future. While at the same time, one of the unique features of ETAG is that it allowed ground level practitioners to take the initiative and bring to the table issues which might not necessarily have a strategic priority. The following discussion explores the opportunities for involving local health economy players at a number of different stages of programme design and implementation.

3.11 Feedback from stakeholders and LHBs themselves suggests that the programme design might have benefited from involving them at an earlier stage as they may have been able to make some useful contributions to the scale and format of the grant funded programme. LHBs identified the importance of matching funding with local priorities, as the following examples illustrate:

'If they had been going for one bid it would have been much easier to manage and orchestrate, than manage a number of organisations putting in smaller bids… There is a bit of weariness about bidding for money because you have to put a fair amount of effort into these things and in a lot of cases people aren't getting a lot back from it…even for a £5k bid there was still a fair amount of effort to put in.' (Stakeholder)

'If we were going to do some sort of consultation or advocacy work then we'll do that on a large scale or try and do it through partner agencies…so then small pieces of work, small local projects is quite a lot of our time for quite small returns.'(Stakeholder)

3.12 Involving the LHBs and others in the local health economy in drawing up the ETAG guidelines might also have been a worthwhile exercise and a means of avoiding confusion and concerns at a later stage.

'For us as an organisation it's not been clear from the outset what the expectation from the Assembly was that the LHB's involvement should be and as a consequence then we haven't specifically taken an active role with it. So our involvement has been around specific people who have approached us having received the information. If appropriate we've then supported proposals or suggested adaptations to them... We weren't involved in putting together the guidance in any way. So then following that we just had the guidance which didn't implicate us as having any particular role which I think caused us some confusion at the time because it was presented as being piloted by the three LHBs but we couldn't see where our specific role was.' (Stakeholder)

3.13 In one case where the Assembly did consult a LHB during the latter stages of programme design, it was regarded as mutually beneficial for both parties. More of this face to face discussion and dialogue is to be encouraged in formulating grant funded programmes in the future.

3.14 There was also uncertainty over the role of the LHBs and others during the implementation of ETAG and the level of support they were expected to provide to project participants.

'We are now getting requests to assist them to implement those projects which is fine at one level but as an organisation we literally don't have the capacity to meet those demands for help…we are a very small organisation and at the end of the day these are very small bits of funding and it's a question of prioritisation for us as an organisation, we've got an awful lot on our agenda and quite a small team...we tend to work big picture rather than small scale…'Where the individual projects fit into the agenda of work that we're taking forward then they will get our support. Where projects are working outside of that then that's going to be very difficult for us to dedicate time so it will work on a project by project basis.' (Stakeholder)

3.15 With any similar initiatives which are implemented within LHB areas it will be important for the Assembly to consider the role of the local health economy in more detail, consult with them during the design stage and assign specific responsibilities which are adequately resourced.

3.16 **Important consideration needs to be given to who would be best placed to take a lead in driving the whole approach forward at a strategic level. Key questions need to be asked about whether co-ordination is best placed at the national, regional or local level, taking into account all the relevant players in the local health economies in particular the role of the NHS Trusts, the LHBs and the health, social care and well being partnerships. Consideration should be given to project ideas that do not fit with strategic plans and the programme should not lose sight of local innovation.** It is essential that the future management of the programme builds on the lessons learnt from the pilot and appropriate roles and responsibilities are negotiated and clarified for all involved.

3.17 From the pilot programme it has been found that there are benefits to be gained from ensuring key players from the local health economy are integral to the programme design, the prioritisation of local issues, the assessment of applications and supporting implementation. Integrating those with local level intelligence of the most pressing health inequality issues will help to ensure that the programme has commitment at a strategic level which will help with all aspects of support, implementation and follow up actions. **At the same time, a balance needs to be struck between ensuring a strategic focus for the programme and providing opportunities for practitioner creativity – one of the refreshing aspects of the ETAG programme which should be encouraged. As a way forward, a group of decision makers from the LHBs, Trusts and the voluntary sector should be convened to plan the way ahead and ensure ETAG links in with local strategies.**

Dissemination of guidelines

3.18 The official launch of the ETAG programme and the Ministerial announcement was held on 9 September, 2003 at Ely Bridge Surgery, Cardiff. Professor Townsend and Professor Julian Tudor Hart, a retired GP and an authority on health inequalities, joined the Minster at the launch. This was followed with a Ministerial announcement of the 25 successful applications at Ty Elli Surgery in Llanelli on Thursday 11th December, 2004.

3.19 The team at the Assembly disseminated the guidelines to the stakeholders who had originally been consulted about the programme together with a wide range of organisations within each of the three LHB areas. This included the NHS Trusts, NPHS Directors, Primary Care practices, Heads of Midwifery, Heads of Nursing, Heads of Health Visiting, Health Alliance partners, pharmacists, dentists, opticians, mental health teams, disability groups, voluntary organisations (umbrella groups), ethnic minority groups, Local Authorities and carers' organisations. They also responded to individual queries and requests for application packs – 75 in total.

3.20 At a local level there was some variation in the way in which the programme guidelines and application forms were disseminated and applications supported by the LHBs. As with the earlier discussion about the involvement of the local health economy, a lack of clarity about their role meant they were unsure of how to proceed regarding promotion and pre-application support.

3.21 Discussions with case study projects about how they found out about the pilot programme also reflects this variation in dissemination methods between and within LHB areas. Box 3.1 highlights some examples. Improvements to the scale and scope of programme promotion will enable a wider range of agencies to access ETAG activities. Clearer protocols for promoting the programme need to be identified at the outset. Initial dissemination also needs to be followed up, to make sure guidelines have reached the target audience.

Box 3.1

Finding out about the programme

- One project found out about ETAG through the monthly District Nurse meetings held at the NHS Trust. They reported that this was a good forum for sharing information about relevant National Assembly initiatives.
- A project author described the limited promotion of the programme at a local level which proved difficult when they tried to draw together partners and local champions to take the project forward.
- One project found out about the ETAG programme after scanning a number of web sites for funding opportunities. They found information about ETAG on the National Assembly web site but this was only about a week before the applications were due to be submitted.
- Project applicants in one area could not remember where they heard about the ETAG programme. Two of the applicants thought that they found out about it through one or more e-mail groups.

3.22 There is scope for improving the dissemination of programme guidelines to ensure they reach the target audience, giving adequate time for application submission. Protocols need to be set up at a local level to ensure the guidelines are given strategic approval at a senior level but it is also important that they filter through to practitioner level. A strategy for reaching target groups should be agreed at the outset. Clearer guidelines and a short glossary of terms would also benefit applicants.

The application process

3.23 Project applicants commented that they found the electronic format designed by the Assembly useful and easy to use and the end of project report was set up using a similar template and format. One applicant felt that the format enabled them to describe the project in their own terms:

'From my perspective I liked the freedom to describe the aims and objectives and how and why you are going to do things. Certainly what we are dealing with is a complex set of issues so you need the freedom and space to describe that complexity. In some applications they may say 'write in no more than 200 words why you want to do this'. (Project applicant)

3.24 Most applicants found the guidelines easy to understand though one felt that they were extremely confusing. Some projects also felt that it was useful to include a checklist in the guidelines as a marker for which criteria they were hitting and where they needed to focus more attention. The inclusion of examples in the guidelines was also welcomed by project applicants as they felt this gave a real sense of what the Assembly were hoping to achieve and gave them confidence that they were on the right track.

'It gave a list of things that you had to meet and then it gave a few examples of projects and I thought that was really useful. The little list of things, set of bullet points…that was useful because you could score your idea against that and say ok, I haven't met that, how would we meet it? But then the list of examples was useful because you sort of thought hold on, it doesn't need to be something huge, in fact quite the contrary, it needs to be a very discrete project.' (Project applicant)

3.25 Alongside the guidance applicants were able to contact the team at the Assembly for informal support and guidance. Case study projects gave positive feedback on this support and praised the ETAG programme for having a designated team available to answer queries in the run up to application submission. This, for one applicant, compared favourably with some other grant funded programmes they had been involved in.

'I think it depends whether, in terms of writing grants whether there is a designated team to that particular grant scheme. If there isn't then quite often you're left floundering because there isn't anyone there to pick up on it. They might be there when it comes to the assessment of the grant itself, when it gets to panel stage but there's usually a hiatus between whoever sent the paperwork out…but then there isn't always a contact point between the admin and the panel…so you're left floundering between the two if there's anything you want to know...there's not always someone there to guide you.' (Project applicant)

3.26 One project applicant suggested that in future this support and guidance could be supplemented with additional guidance on the financial and budgeting structure for projects:

'… It would have been nice to have had someone to ring really or with an email, who would be able to say have you thought about the costs and this is how you could structure it in. And if it is that you're ending up with somebody who's already in a full time post and you're gonna end up paying them twice for their time then you can get round this by doing whatever…so a bit of practical advice from someone who is experienced, that would have been very useful…'. (Project applicant)

3.27 **Feedback from pilot projects highlighted the importance of having a dedicated team to deal with issues arising especially during the application stage. It is important that this continues to be an integral feature of any future programme to ensure overarching consistency in aims and objectives.** An extension of the functions of this resource might include specific guidance and support for financial and budgetary issues.

Research ethics

3.28 During implementation the evaluation team were alerted to concerns amongst some projects, especially those undertaking research based activities, about the need to gain ethical consent before embarking on their research, which typically involved surveying the health needs and opinions of patients and health professionals. For some project leaders this was the first time they had undertaken such research and inevitably they were unsure about where to seek help. **Ethical considerations need to be factored into such programmes in the future. These considerations need to be triggered at the point of project conception so that timescales for ethical approval can be factored in. This needs to be backed up by Assembly guidance and support on where best to turn for practical advice at a local level, which might vary between the health professions and the voluntary sector.**

3.29 A related issue is approval from the other organisations involved at a project level. This might include seeking approval from various departments or organisations who will be engaged in

the project in some way. Triggers at the application stage are needed to ensure that the necessary approval is gained at an early stage.

Assessment of applications

The selection panel

3.30 In the early stages of drawing up the ETAG programme it was anticipated that the assessment panel would include representatives from all stakeholder groups. The Assessment of Bids Document (September 2003) proposed a single panel meeting to assess the bids which would include Professor Townsend (or another representative of the Standing Committee), and representatives from each of the three LHBs, the WLGA, the WCVA, the Equality Policy Unit, HPD Research and Evaluation or WORD, the Evaluation Project Team, and members of the Public Health Strategy Division. However, in practice, the actual selection panel was a much tighter group consisting of three representatives from the Public Health Strategy Division and an independent representative from a different National Assembly department. It was felt that this tighter panel was more appropriate given the short timescale for the programme. Project applications had to be submitted by 24 October and the Minister announced the 25 successful projects on 11 December. This gave the team seven weeks to assess applications, notify successful and unsuccessful applicants and set in place the administration for payment of grants. However, in light of the preceding discussion about the role of the LHBs and the need to match up funding with local priorities it might have been useful to have the LHBs' input at the selection stage.

'Our view is that the LHB should have a defined specific role in terms of assessment of proposals so that we're actually outside of the bidding process but particularly because some of the proposals that have been funded aren't necessarily things that we know what the agenda is. And we don't necessarily need any advocacy around those issues whereas other things we might have felt were in more need to be done…one of the weaknesses of the scoring system they used is that you can write a good quality bid in an area where there isn't necessarily a need. We did decline input into the assessment process because we felt it was a bit of a conflict of interest for us to do that when we were involved as a partner in some of the bids but for the future I would suggest that the LHB needs to be outside the bidding process but part of the assessment...this is obviously geared towards very local needs and the Assembly doesn't necessarily have the detail of what's already gone before and what needs to be done.' (Stakeholder)

Selection criteria

3.31 Drawing on the assessment criteria used in other Assembly grant funded programmes, a proposal assessment sheet was drawn up for evaluating the applications based on five key criterion: aims, objectives and project rationale; focus on severe unmet health needs; partnership approach and multidisciplinary working; monitoring and evaluation, and overall project soundness.

3.32 All applications were assessed by at least two members of the selection panel and where there was a difference in ratings of more than six points the application was subject to a third round of assessment. Scores for all applications were ranked by area and a cut off point was agreed.

3.33 Overall, members of the selection panel found this a robust and transparent process for selecting successful projects. On reflection they commented that the aims and objectives criteria seemed to be the most important and if using this framework again they would include an automatic cut-off if the application did not clearly meet the aims and objectives criteria.

3.34 This process also allowed the panel to provide constructive feedback to unsuccessful applicants. All unsuccessful applicants received notification and were invited to receive individual feedback. In some cases the panel provided an overview of the selection process and individual feedback on why the proposal did not meet the criteria. The main reasons for unsuccessful applications were:

- The proposed activities were not seen to be influencing health care professionals
- The proposal was for funding a short term service provision – this was the most common reason for failure
- Requests for funding longer term projects
- No confirmed partnerships.

3.35 It will be important for any future ETAG guidelines to be firmed up in light of these reasons for failure and to ensure that similar pitfalls are avoided wherever possible.

Chapter summary

- *Developments in partnership working* - Setting up and designing the programme presented opportunities for joint working within the Assembly, with members of the local health economies and with organisations outside the health service.

- *Programme guidelines* - Ethical considerations need to be factored into such programmes in the future. The Assembly needs to clarify its role on this and provide guidance for applicants where appropriate. It will be important for any future ETAG guidelines to be firmed up in light of the reasons for unsuccessful applicants to ensure that similar pitfalls are avoided wherever possible.

- *Role of the local health economy* - It is vital that those involved in the programme at a local health economy level are clear about the aims, objectives and format of the programme and should be consulted at the early stage of programme conception. Most pertinent to this programme is the role of the LHBs. Their integration is vital if they are to fully sign up to the programme aims and objectives and play a role in taking forward project recommendations. However, at the same time it is important that this strategic focus does not over-dominate and prevent practitioners taking the initiative to lead a project. Creativity about new ways of working still needs to be encouraged.

- *Programme dissemination* – There is scope for improving the dissemination of programme guidelines to ensure they reach the most appropriate personnel with adequate time for application submission. Protocols need to be set up at a local level to ensure the guidelines are given strategic approval at a senior level but it is also important that they filter through to practitioners.

- *Application process* - Most projects felt the guidelines were user-friendly and there was strong support for having access to the programme team at the Assembly in the lead up to application submission. This could include a series of triggers at the application stage to ensure that appropriate ethical approval is sought and authorisation obtained from all organisations and departments implicated in the project. A central support unit could also provide guidance for structuring budgets and identifying ‘hidden’ costs.

4 The projects

Introduction

4.1 This section of the report reviews the activities undertaken by the 25 successful ETAG projects. This includes a discussion of how and why project participants decided to get involved, a description of the lead organisations, links with other programmes and projects, partner involvement and the range of activities undertaken. This section also explores how projects engaged with health professionals – a cross-cutting theme which raises some important issues for the future implementation of the programme. This chapter focuses on the feedback from case study interviews with applicants, project leaders and key partners. Examples are included throughout this chapter to illustrate the breadth of activities undertaken.

Project rationale

4.2 The ETAG Application Guidelines requested information about the rationale of proposed activities. Examples included the following:

- Projects that had already identified a gap in service provision or a need for change and were seeking to move on the development of services through this programme:

  - ➢ A project from Carmarthenshire NHS Trust to establish a proactive focus on incontinence with a view to early intervention and prevention – this project recognised that 'at the present time, management of incontinence is a fragmented service…this project would provide time and resources to identify the extent of the problem and establish solutions, with a view to moving towards a preventative role.'

  - ➢ A project from Carmarthenshire to improve access to primary and secondary health care for people with learning disabilities highlighted that very little was known about 'the actual health status of people with learning disabilities in Carmarthenshire' although there is 'a plethora of evidence of additional health needs of people with learning disabilities.'

  - ➢ A project from Cardiff to improve services to people with mental health problems who have a physical illness. The application highlighted that there is a significant

amount of anecdotal evidence that people with mental health problems have difficulty in seeking and gaining appropriate treatment of physical illnesses.

- Projects that were seeking to enhance the mechanisms for socially excluded groups to feed into the improvement and change in service provision:

  - Denbighshire young people's equity project to recruit and train young people to evaluate community family planning services – they set out in their project rationale that there was currently 'no formal mechanism for engaging young people in the evaluation of the health services they use.'

  - Denbighshire's 'listening to children' project aimed to 'address participation of children in a primary school which serves wards in Rhyl with the highest levels of deprivation in Denbighshire.'

- Projects where the lead had expertise in a particular area of health inequalities and had developed awareness raising mechanisms for other professional groups but wanted to extend their scope to health and social care professionals:

  - The Rural Stress Information Network's (RSIN) project to raise awareness of health and social care professionals of the causes, symptoms and effects of rural stress - RSIN had extensive anecdotal evidence of health professionals being faced with rural stress issues in high proportions but these groups were identified as a gap in their current awareness raising strategies.

  - Carmarthenshire Domestic Abuse Forum's project to raise awareness of domestic abuse and address related health issues – the Forum had worked to raise awareness and address the 'high number of partner on partner and repeat incidents locally.' This project targeted awareness raising at health and social care professionals.

  - Cardiff's South Riverside Community Development Centre project aimed to stage a number of culturally appropriate events for Black and Minority Ethnic Communities and health professionals that would facilitate communication and give health professionals and organisations a greater awareness of the communities that they may potentially have as clients.

4.3 As the above list illustrates ETAG provided the opportunity for organisations to work with new groups and in new areas but in most cases the project was led by an organisation with a

track record in dealing with a specific area of health inequalities. Further details about lead organisations are presented in the next section.

Lead organisations

4.4 Looking across all 25 successful projects the majority (15) were from the statutory sector, in most cases the relevant NHS Trusts (12 projects), or the LHB (1 project) and the Local Authority, Social Services (2 cases). Nine lead organisations were from the voluntary sector and one lead organisation was from a community group – South Riverside Community Centre in Cardiff. This dominance of the statutory sector reflects the dissemination of the programme guidelines which was strongly biased towards the statutory services, especially those in the health sector, although the team at the Assembly had worked at engaging the voluntary sector. It is important to maintain this mix of organisations as project leads as it fits with the original Townsend recommendations for action within and outside the NHS and the need for 'inter-disciplinary working'.

4.5 In some cases the lead applicants were not always the lead partner. For example, the Denbighshire young people's equity project was originally drawn up by the NPHS but this was handed over to a Public Health Practitioner based at the NHS Trust for day to day project management. In another Denbighshire project, the LHB took the lead in authoring the application but after announcement of the success of the application it was decided that the Education Department within the Local Authority were best placed to take the project forward. The change of personnel in the transition between project application and project delivery caused some issues in that it took more time for the delivery lead to put the application into practice. For future grant funded programmes it will be important for those involved in delivering the project to have an input into the initial application wherever possible. This will help with taking ownership of the project from an early stage and will help formulate more appropriate means of implementation and delivery. Applicants should be encouraged to identify 'project champions' at an early stage.

Partner involvement

4.6 The end of project reports provided details of partnerships including names of all partners worked with, categorising them into statutory, voluntary and community. The discussion which follows is based on an analysis of 25 end of project reports received by end of May, 2004. There was some discrepancy in the way in which projects reported on their partnership links with some not clarifying the sector or whether they were new or existing partners. Therefore, secondary categorisation has been undertaken in some cases. In addition, some

projects have named organisations whereas others have listed a number of partners within each organisation. For analysis purposes each listed partner has been included in the counts. This is an issue requiring clarification in any future monitoring of ETAG activities.

4.7 Overall 130 partners were listed in the end of project reports with an average of 5.4 per project. This ranged from 1 partner (two projects) to 17 partners (one project). The sectoral breakdown for partner organisations is as follows:

- 96 statutory – including LHBs, Trusts, Local Authorities, Police
- 20 voluntary organisations – including youth projects, voluntary services councils, and other umbrella voluntary organisations
- 6 community – user groups, community development centres and local residents
- 8 other – including partnerships consisting of partners from a range of sectors, and private sector/independent organisations.

4.8 Interesting comparisons can be made with the partners listed in the original application forms. Overall, projects listed 89 partner organisations, an average of four per project ranging from one partner (in one projects) and 8 partners (in one project). The majority of partners listed in the applications were in the statutory sector (72), with 13 in the voluntary sector, 1 in the community sector and 3 in other sectors.

4.9 There was a change in the number of partner organisations for 23 out of the 25 projects. Fourteen projects saw an increase in the number of partners worked with. In most cases this was an increase of between one and five partners but one project linked with an additional 15 partners. In six projects there was a small reduction in the number of partners between the application and the final report (just 1 or 2 fewer partners). In three projects the overall number of partners remained the same even though there were changes in who was actually involved.

4.10 The following examples illustrate the changes that took place in partnership arrangements between the original application and the end of project report:

- New partners brought in to help with particular aspects of the project:

  - additional youth organisations were brought in to help with recruiting young people as part of the review of family planning services by young people in Denbighshire

  - the NSPCC was brought in to deliver training on setting up a school council as part of the 'Listening School' project in Denbighshire

  - Health visitors were brought in to help deliver training in the Carmarthenshire project to improve health visiting services to families with pre-school children.

  - a voluntary organisation concerned with homelessness contributed ideas about the provision of information cards to homeless people in Cardiff to improve access to local care services.

- Specific partner details not known at the application stage:

  - three of the four primary care settings had not been identified at the application stage for the Carmarthenshire project to improve health care for people with learning disabilities.

  - specific hostel and refuge organisations were not named in the original application for the project to provide homeless people with health cards in Cardiff.

- New partners uncovered during the course of the project:

  - a wider range of partners came on-line during the course of the project for the gypsy and traveller project in Cardiff.

  - the Cardiff based project to raise awareness of smoking cessation amongst midwives made contact with new partners during the course of the project including Health Promotion Dublin and Sure Start.

4.11 The partnership arrangements also varied between projects with some holding informal discussions with partners while others held more formal partnership meetings at key intervals. The roles of partners varied between and within projects with different partners being called on for their expertise at different stage of project delivery. For example:

- **Piloting research tools** – the incontinence research based project in Carmarthenshire called on partners in the local GP practices to check over research tools before disseminating to a wider groups of practices. The project lead sought feedback on the phrasing of the questions in order to encourage a better response.

- **Input at project conception and completion** - the Denbighshire based project which recruited young people as evaluators of family planning services was originally drawn up by a Specialist Registrar in the NPHS. During the implementation phase, the project author adopted a hands-off role while the project lead and project co-ordinator managed the day to day delivery. The original project author became more involved at the end of the project by attending a feedback session with the young people and also took on responsibility for taking the project recommendations forward.

- **Involvement in training delivery** – the Rural Outreach Service in Denbighshire helped to deliver training alongside the main project lead – the Rural Stress Information Network (RSIN). The Rural Outreach Service was able to bring an added layer of experience and expertise in identifying and dealing with rural stress issues at a local level in Denbighshire.

- **Involvement in designing community events** – one project received free training from partners located in the university. This training was on the use of participatory methods to engage with black and minority ethnic communities and to obtain information on their health service experiences. The partner also helped facilitate the events as the objectives of her project dovetailed with those of the ETAG project.

4.12 Partnership working in the ETAG programme included the development of existing networks and the formation of new relationships and links with most projects being able to cite benefits of working in partnership with a range of groups and organisations:

> *'The main benefit has been awareness raising about this sort of work and raising the awareness that there are two people who have had a go at making it work.' (Project leader)*

4.13 There is already some evidence that partnerships formulated and developed during the ETAG programme have been sustained into the future. For example, one project enabled someone new in-post within a local voluntary organisation to establish a working relationship through the ETAG project that would be sustained beyond the project.

4.14 Projects typically sought partner agreement at the application stage but this was often in the form of a verbal agreement. Some felt that there was insufficient time to involve partners in any other way. A way forward might be to formalise the partnership arrangements at the application stage so that all partners are clear about their specific roles.

4.15 **The main challenge to partnership working has been the time to establish new networks and formalise the partnership working. In the future it will be important for the initial application form to include more detailed information about partners, including their roles and their commitment, so that these networks can take shape at an earlier stage.** For example, as well as listing partner organisations it might be worth listing the appropriate personnel and making their contribution to the project more explicit. This may help partner organisations engage from an earlier stage with a clear idea of expected roles and responsibilities. However some projects emphasised that this is time-consuming and should therefore be factored into the time allowed for the application process.

Links with existing projects/programmes

4.16 The ETAG programme generated opportunities for working with existing networks and programmes and built on the work already done by some organisations in terms of tackling health inequalities. For example, the South Riverside Community Development Centre in Cardiff built on the work undertaken by the Assembly funded SHARP (Sustainable Health Action Research Project). Another project built on an idea developed from a Patient and Public Involvement exercise with rough sleepers.

4.17 In some cases, projects were adapting projects and activities that they had used with other groups and professionals. For example, Carmarthenshire Domestic Abuse Forum utilised and tailored a well established training package that had been used with other professionals and groups. The design of some ETAG projects was also influenced by projects and programmes undertaken elsewhere, as illustrated by the following examples:

- The young people's equity project in Denbighshire was influenced by several developments in England and one of the key bid writers had a wealth of experience in young people's sexual health services at a UK level. This project modelled its approach on a project developed by the HIV Centre in Sheffield.[7]

- The Carmarthenshire based project to improve access to primary and secondary care amongst people with learning disabilities built on experiences of a Wrexham based

[7] Murray L Undercover in Sheffield. A Young People's Sexual Health Evaluation Scheme. Phase 1 report. Centre for HIV and Sexual Health, Sheffield. July 2003.

project running screening and health promotion for people with learning disabilities. The project manager in Carmarthenshire met with the Wrexham project lead to discuss what had been done, to see examples of materials used and to find out about their experiences of engaging with GPs.

Description of project activities

4.18 The wide variety of project activities has been something which has characterised the ETAG programme from the start. Project leads were enthused to find out about other projects because they were all so different in their approach and methods and it is difficult to categorise projects without losing sight of this diversity. The following typology is therefore used purely for organisational purposes in order to introduce a sample of the range of projects undertaken. Project activities will be explored under the following headings:

- Training/awareness raising based activities
- Research based activities.
- Other activities - different ways of breaking down the barriers to accessing services.

Training-based activities

4.19 Seventeen of the 25 pilot projects were modelled around the setting up of an event, a series of events or a training package for health and social care professionals. These aimed to raise awareness about a particular area of health inequalities in order to inform their future working practices. In some cases a training package had already been developed by the organisation and had been used with other professional groups. In these cases the programme was tailored to fit the specific needs of health and social care professionals. The following vignettes were produced following project observations and illustrate some of the different training sessions funded through ETAG.

Box 4.1

Examples of training based activities

Rural stress awareness training. Two 3.5 hour training sessions were hosted in Denbighshire – one in Ruthin and one in West Rhyl. Each event was facilitated by the ETAG project lead and one of the partner organisations – the Rural Outreach Service, Denbighshire. Both sessions were represented by a cross-section of health and social care organisations including the statutory and voluntary sectors as well as service users. The session was interactive with the discussion shifting from recognising stress in individuals and others, through to information on the services that can help. There were several opportunities for group work including one to one discussion about ‘niggles’ experienced in the last 24 hours, case study scenarios where participants were asked to formulate an action plan and throughout the workshop there was interesting debate and discussion between participants and facilitators. The training also incorporated RSIN’s own ‘Help at Hand’ video which is a short

drama showing a farming family under stress. This was a powerful tool which was used to illustrate the 'ripple' effects of rural stress on members of the surrounding community.

Raising awareness on domestic abuse for health professionals. Two full day training sessions were facilitated in Carmarthen and Llanelli attended by a range of health professionals including district nurses, midwives, school nurses, health visitors and A&E nurses. The workshop was oversubscribed by around 30%. The day focussed on what is domestic abuse, the signs to look for and how to deal with such issues when they arise with patients. The workshop also looked at domestic abuse effects and its causes and informed health professionals of routes of support and advice. Interactive elements included a group work exercise to brainstorm participants' perceptions of domestic abuse and case study work using scenarios. The local Women's Aid group gave a presentation on the local refuge and the Domestic Violence Officer (DVO) also attended to discuss their role. The facilitator established confidentiality at the start of the session which enabled participants to talk more openly about their experiences of dealing with patients with domestic abuse issues. The attendance of the Women's Aid workers and the DVO was useful as it made the links with partners better established. Some of the participants commented that they had done bits of training on domestic abuse previously but this was the first time they had done anything quite so structured. One participant commented that they had encountered patients with domestic abuse issues and wanted to find out the best way to deal with them. Following on from the workshop, the coordinator is now in regular contact with many of the professionals and has helped them on cases involving domestic abuse. Many colleagues who could not attend have contacted the coordinator asking if further sessions will be run.

Raising awareness of working with Black and Minority Communities. Three events were staged with different black and minority ethnic (BME) communities in the area: Somali women; the elderly BME population; and BME women. A range of health professionals were also invited to attend these meetings in order to listen to what community members had to say. The events were set up in consultation with representatives from the groups involved in order to ensure that they were culturally appropriate and were likely to be attended by the targeted communities. The BME women's event only involved women throughout the process, through planning to delivery. Lunch was provided in the middle of the events and transport was organised where necessary. The events facilitated discussion through participatory tasks, to identify problems faced by BME communities in their experience of accessing health care. In these sessions they identified the key issues, put them in order of priority and then ranked them in terms of their importance to key sub-groups within the community.

Research based activities

4.20 In line with the original aims of the ETAG programme, some projects sought time for health professionals to be freed from their normal clinical and caring duties to undertake investigative work into local health inequalities and inequities in access to health care.

Box 4.2

Examples of research based activities

Establishing a proactive focus on incontinence with a view to early intervention and prevention. A district nurse in Carmarthenshire investigated local issues surrounding incontinence both from the demand and supply perspectives. This included questionnaires to the public and health professionals. The findings were collated in the form of a report and disseminated this to local health professionals. The project lead is also planning to produce a user-friendly guide to incontinence for health professionals which will include contact details for local sources of help and support.

Recruitment and training of young people to evaluate community family planning services – The project recruited young people as evaluators to conduct an evaluation of community based family planning provision in Denbighshire. Their findings were collated in the form of a report which made recommendations about the future provision of the service. The project leads are also trying to raise awareness about this project as an example of good practice in participatory methods of engaging different sections of the community and they have already presented their work to the Denbighshire Public and Patient Involvement group.

Review of provision of primary and secondary health care for people with learning disabilities – This involved a senior nurse based at Pembrokeshire & Derwen NHS Trust working with a Health Advocacy Group of people with learning disabilities at the Resource Centre in Carmarthen. They were asked about their experiences of accessing primary and secondary health care and the key findings that emerged were fed back to GP surgeries in the county.

4.21 Advocacy was an integral element of these sorts of projects with health professionals producing reports and other research outputs which were fed back to service delivery agents. This was done in the form of a report that was disseminated to all interested organisations and this was often backed up by a face-to-face meeting to discuss the findings.

Other activities

4.22 In addition to training and research based activities ETAG projects also set about achieving equity and advocacy work in other ways. In these cases the project was focussed around trying out different ways of breaking down the barriers for accessing health services for different minority groups. The following examples give a flavour of these other activities:

- A project to provide cards to the homeless with information on relevant local care services, and information on a second card about a key health professional responsible for their care. With regard to the latter the cards provided a means by which health professionals could access the client's last key health worker if that person was willing to show that card.

- A project to provide maternity support and guidance for the Somali community put in place a Somali interpreter in maternity clinics to support midwives in their work. The interpreter was also able to accompany midwives on home visits. This support made the maternity service more accessible to Somali women and enabled midwives to focus their resources more effectively.

Changes from the original application

4.23 All projects were asked to reference any changes from the original applications in their end of project reports. Time constraints and changes in project personnel were the main reasons for changes to planned activities. In most cases there was not a sea-change in the nature of the activities being proposed. Instead it was mostly a change in the detail of the activities as reflected in the following examples:

- *Partner organisations* – one project made presentations about their work to a wider group of organisations than originally anticipated. This included the LHB, the Public and Patient Involvement Group (PPI) and a local youth project.

- *Additional elements added* – one project had originally planned to target primary care teams but during the course of the project contact was also made with a secondary care team at a local hospital and an additional awareness raising forum was facilitated.

- *Level of resources* – some projects supplemented their original budget with additional time and resource. For example, in one project the time for the project co-ordinator had been accounted for in the original application but in practice this was supplemented by time from the overall project lead and time from the line manager at the NHS Trust. In another project the failure to secure staff replacement meant that the project leads had to conduct the work on top of their existing professional duties. However they also identified a student working within the multi-agency team, with an interest in the project focus, who was able to do much of the labour intensive work.

- *Development of initial ideas* - in one project regular meetings between the partners helped to refine their ideas about the product they hoped to develop to help a population group particularly excluded from access to basic health services.

4.24 The changes highlighted above confirm the importance of including the project leader in the application process wherever possible so that they have a chance to think about operationalising the project from an early stage. It was also important for the programme team at the National Assembly to be kept up-to-date with these changes in delivery so it was imperative that the lines of communication were kept open throughout the whole programme.

Project outputs

4.25 The nature and scale of project outputs can be gleaned from the end of project reports. Training related outputs including the number of sessions and the number of participants formed the largest types of outputs reported. However, other, non-training related outputs were also generated by ETAG activities and these are also presented below.

4.26 The end of project reports did not easily lend themselves to the quantification of project outputs. The reporting requirements for projects need to be further clarified setting out key monitoring and evaluation criteria. **Consideration needs to be given to the possibility of a minimum data set for tracking the actual scale and scope of project activities. However, it will be important not to lose sight of the diversity of project activities and projects**

should be encouraged to supplement the minimum data set with their own individually tailored self-evaluation measures. In support of this, workshop-based guidance on self-evaluation should continue to be provided as part of the overall programme. This has the dual benefit of raising skill levels amongst programme participants as well as providing essential opportunities for networking between projects. Further details about the self-evaluation are presented in Chapter 5.

Training outputs

4.27 Seventeen out of the 25 projects reported some sort of training event or awareness raising seminar as an ETAG output. The number of events undertaken was 58, with an average of 3.4 events per project. This ranged from one event (four projects) to 8 events (1 project). The duration of events ranged from half a day to three days. The most popular training events were either half a day or 1 day duration (4 projects each). Three projects reported facilitating a two day event and one project conducted a three day event.

4.28 Quantifiable information on project participants was available across 13 projects. Based on this group, 567 participants were identified, an average of 44 per project. This ranged from 10 people engaged in two events to 141 people involved in 8 events. Of these projects gave descriptions about 431 participants which allowed for their classification into participant types. The summary breakdown of groups of participants is as follows:

- Primary health care professionals – 28% (122) – mostly health visitors (76)
- Secondary health care professionals – 9% (41)
- Other health and social care professionals including social services, LHB members and health promotion workers – 51% (220). Within this the largest group consisted of 141 residential care workers which were targeted by the Arthritis awareness project in Carmarthenshire
- Non-health statutory such as the police and youth workers – 1% (3)
- Voluntary sector participants – 3% (13)
- Community groups and service users – 5% (21)

- Others – 3% (11).

Other outputs

4.29 Not all projects included training or awareness raising sessions as one of their project objectives. In these cases a variety of other outputs were identified in the end of project reports as follows:

- A project which aimed to demonstrate the necessity of developing professional practice to address the specific health needs of children placed in Carmarthenshire from out–of-county placements led to the creation of a database of children in out of county placements and a review of communication systems within health and social service departments. The project also undertook initial work to develop a protocol for information sharing.

- A project to pilot a maternity Arabic advocacy service in Cardiff led to the provision of daytime access to an Arabic interpreter. For example, the advocacy worker provided 72 community visits with midwives postnatally. During these visits the advocacy worker worked with many health professionals including obstetricians, midwives, and health visitors.

- A project to pilot a Somali antenatal community drop-in clinic in Cardiff enabled 12 antenatal drop-in sessions. Altogether 64 women were seen, 50% of whom had no or very little understanding of English.

- A project to investigate the need for, and potential benefits of, a flexible palliative intermediate care team produced a literature review, a review of existing community services and a survey to Practice Managers of every GP practice in Carmarthenshire.

What was learnt about delivering project activities?

4.30 A number of lessons about the effective delivery of activities emerged from the pilot programme and these should be built on during the next phase. **Creating a central resource for ETAG learning will be an effective way of ensuring good practice is captured and is accessible to others. This may be through an established website which could incorporate wider learning from other initiatives including Communities First, Inequalities in Health Initiative and Healthy Living Centres – all of which may have**

attempted to tackle issues relating to inequalities in access and experience of health services. Pre-existing websites should be investigated to see if ETAG resources can be added. In addition, opportunities for face to face exchange of information should also be included. The following discussion gives a flavour of the sorts of learning captured.

Targeting delivery at the right level

4.31 The importance of targeting awareness raising activities at the appropriate level of seniority within the health sector was highlighted. This was seen as an effective way of ensuring action was taken forward to address the relevant health inequalities. The first example below illustrates the benefits of pitching at a senior level with a plan of action being formulated immediately. The second example illustrates some of the difficulties of identifying and engaging with personnel at a senior level, particularly for project leaders outside the NHS.

- A meeting was facilitated with the Director of Nursing and a group of Senior Sisters in which they identified a plan of action to take on board what they had learned and how to take things forward. In particular they would include learning disabilities awareness in their health care assistants training in future. The project leader reflected on this prompt action:

  'They were into solving their problems quite quickly…I think their meetings are quite high profile with the Director of Nursing and I think they're expected to think on their feet.' (Project leader)

- The project had real problems in engaging health professionals at the right level and wasted a great deal of time. This has meant delay of the final session which is specifically aimed at disseminating to health professionals. They wanted to involve people who are not the usual suspects and for whom the targeted communities are not an explicit concern. In particular they wanted to involve GPs and senior managers within the health service as a whole, but could not find the appropriate routes in:

  'One thing that I wanted to do at the outset was to get a spread of health professionals with a whole series of different responsibilities as well. I wanted to get some senior managers in at some point and I never got anywhere near that…. So maybe there could have been a greater willingness at a higher level to be a bit more open minded. They thought they had it [the issues relating to the target group] tied it up already. As soon as I said 'community' it was like 'go away', you know. You felt

like you were on a pinball machine. Just being knocked around from one place to another until you eventually end up back where you started.' (Project leader)

Creating the right experience

4.32 A number of project leaders were experienced in facilitating training or awareness raising sessions and they recognised the importance of creating the right sort of experience to maximise the learning for health care professionals. This ranged from tailoring the material to the target audience and responding to individual needs through to ensuring the venue and set up was conducive to discussion and networking and was culturally appropriate for the target audience.

4.33 One project emphasised the importance of creating a 'nice' experience for participants, and a good deal of effort was made to ensure that the food was acceptable and that the venue provided a pleasant environment.

'The thing I tried to demonstrate is that when you are brining people together in these situations you need to make people feel comfortable. So you need to make it a social activity and not a sort of academic activity. Probably the largest part of funding the events was the food. [In terms of the venue] there was a consensus coming out of all of the groups was to go for something like a leisure centre. It had a lot of advantages. It was neutral. It was not associated with any community and also it's got all the facilities there, it is fully disabled accessible... It is clean. There is nothing more off-putting coming into an environment where people immediately think 'this is dirty. I don't want to go in there.' (Project leader)

4.34 In one project this was particularly important given the serious nature of the topic they were discussing:

'…plus the fact that it is quite a depressing subject I think it's important to lift it at dinner time…I thought it was important…and it was important that they had time afterwards to ask questions.' (Project leader).

4.35 The same project leader also commented on the variety of tasks within the session which included listening to presentations, groups work discussions and video snippets.

'I think the delivery has to be aimed correctly. I think that's really important to make sure the delivery is aimed at the right pitch and from reading the evaluation everybody was happy with the way it was pitched…it is a quite difficult subject and I wanted to try and make it as

varied as possible. I didn't want to just be up there talking…and it was important to have the video side of it and the case study in the afternoon…' (Project leader).

Engaging health professionals

4.36 Given the nature of the project activities outlined above, engaging with health professionals whether for awareness raising sessions or as part of an investigation into a particular health inequality issue, was a key element of all ETAG projects. However, this was an issue not really addressed at the application stage with very few projects making reference to *how* they would engage with these groups. It would have been useful to have included a section on this in the initial application form prompting projects to think about this at an early stage.

4.37 The extent of the difficulties with engaging health care professionals can be drawn from the end of project reports. Ten out of 25 (40%) of projects reported some difficulty with engaging health care professionals. The nature of the difficulty included lower numbers of participants than anticipated, the cancellation or postponement of sessions because of very low numbers and the absence of key groups or professionals which the projects had originally targeted. Four projects referred to difficulties engaging all types of health care professionals and six projects noted difficulties with particular groups – in four of these cases it was general practitioners.

4.38 The end of project reports also gave some insight into the reasons behind the difficulties. In some cases recruitment or making the link with health professionals was the issue. In other cases links had been made but organisational restraints over releasing staff was the main barrier. Other external factors, beyond the reach of project leaders were also cited as barriers to engagement. For example, the announcement of the new GP contract made it difficult for one project to identify which GP practices would be delivering a particular service which was the focus of their ETAG work.

4.39 Engagement with other groups was also raised as an issue with four of the 25 projects. This included difficulties engaging with certain sections of the community such as young people and residents from a particular neighbourhood, as well as more general difficulties engaging all members of local communities in meetings and getting patient feedback. However, through a process of self-reflection project leaders were able to comment on how they managed to overcome these difficulties and how they would do things differently in future. Partnership links seemed key to overcoming the difficulties of engaging with different groups – with project leaders relying on pre-existing networks and forging new ones in order to get communities on board.

4.40 In tackling this issue of engagement with health professionals projects looked towards the LHBs and NHS Trusts for help, guidance and local contacts. The most success in terms of engaging with health professionals appeared to be where there were prior links with these groups and where projects engaged with these groups from an early stage. For example, in Denbighshire young people's equity project, the Head of the Family Planning Services was named as a partner when the initial bid was put together and they were very positive about the young people evaluating the family planning services. Their positive involvement from the start meant that all the family planning service staff were made fully aware of the project and bought into the project from the outset.

4.41 Engaging with health professionals is a fundamental issue which needs to be strategically addressed if the programme is rolled out. Suggestions include tools to help navigate local health services. Opportunities for linking ETAG activities with Continuing Professional Development (CPD) also need to be explored including using Action Learning Sets as a framework. Key lessons from the pilot should be pooled for future reference and training days on how the health service works and who is involved might be another means of engaging health care professionals.

4.42 The concept of action learning sets has been used as a tool for raising awareness of health inequalities amongst multi-disciplinary groups elsewhere. The concept needs to be further explored and its applicability to ETAG negotiated with the appropriate professional bodies.

What was learnt about engaging health professionals?

4.43 A number of projects did successfully engage with health care professionals and indeed many of those who experienced difficulties at the outset managed to identify mechanisms for breaking through and engaging with some sectors. Building on the experience gained through the pilot will be one means of addressing this issue in any future initiative.

4.44 Building on previous collaborations with health care professionals was an effective means of making in-roads to this group. One project leader reflected on their experiences as a district nurse as a key factor in the positive response to a postal questionnaire to review health care professionals experiences and expertise in dealing with incontinence.

'The reason that the GPs filled it in was because I've been a district nurse in the area for seven, eight years…I think I've probably worked for all the GPs in xx. So I've had a fantastic response rate from …I think because they knew who I was.' (Project leader)

4.45 There is also evidence that the type of approach to raising awareness needs to be adapted for different groups of health professionals. During the course of the programme, some project leaders gained an insight into what sort of approach would be most likely to work with health care professionals, especially those whose time was highly restricted. Taking training into primary health care settings was identified as one key mechanism for engaging with these groups. One project made successful in-roads to primary care practices during the pilot programme by attending lunch time sessions at local GP practices.

4.46 As well as difficulties *engaging* with health professionals a number of projects also encountered difficulties *identifying* the appropriate personnel to involve in ETAG projects. A suggested way forward would be to provide simple tools which would help project leaders navigate their way through the health sector a suggestion put forward by the following project leaders.

'I think it would have been useful if we could have had some kind of framework kind of a way of knowing who to contact, whether they are community health councils or the LHBs because the structure, which is the other thing I found out, is very complex within the health sector and I would have found it useful if we could have had something which said this is what the structure is in Carmarthenshire, this is how it operates…and having a sort of matrix or whatever for knowing who is what and how things linked into each other, maybe that would have been useful.' (Project leader)

'Certain things [could have helped]. More centralised information points within the health service where people have at least generalist information so you can be fed to the right person. It doesn't seem to exist in any way whatsoever. You're locked into particular services area, particular institutions, particular areas of work and people operate with quite narrow parameters a lot of the time.' (Project leader)

4.47 The above comments are from project leaders who were within the voluntary sector but the tool could also have benefits for NHS professionals and local authority service providers as well. Evidence from the evaluation suggests that multi-agency events through programmes like ETAG can also facilitate better links between health professionals within the NHS. For instance in one project an event that they organised led to hospital workers being connected to a community based service which could have the potential for improving care for a particular group of people after they left hospital.

Project costs

4.48 Based on the 25 successful application forms the average estimated cost of each project was £4,206. In some cases original budgets were scaled back by the Assembly to fit in with the overall programme costs and in other cases it was scaled back by projects on the basis that they needed to reduce their activities to fit in with the timescale. The biggest project cost related to personnel costs for the project facilitator. Other costs included the cost of facilitating training sessions, administration and travel expenses.

4.49 In addition to the explicit project costs outlined in the project application forms projects also encountered a number of hidden costs of contributions in kind particularly in terms of time provided by partners to provide specific expertise. For example one project benefited from participatory training and event facilitation which were both provided free of charge through partner organisations. Another project reflected that the cost outlined in the original bid only referred to the time inputs from the project co-ordinator. However, in practice, this was supplemented by time from other personnel within the NHS Trust. A Public Health Practitioner was heavily involved during the early stages of the project with the recruitment of the project co-ordinator and she was also drawn into the project throughout especially during the co-ordinators' non-ETAG days. This worked out at approximately one day per week over the three months. Also, the time of the Senior Nurse Manager, Public Health at the NHS Trust was not costed in the original bid but she provided support and overall management to both the lead and the co-ordinator throughout the project. The project also drew on the resources of a voluntary organisation for use of office and meeting space. Projects commented that these sorts of hidden costs need to be highlighted at the application stage so that a more robust and realistic budget can be put forward which takes account of all those involved.

Timescales for project delivery

4.50 **Further thought needs to be given to the timescales and timing of ETAG activities. There needs to be recognition of the time needed to set up projects especially where projects are proposing to work with different groups for the first time.** A further benefit of having a greater strategic focus for the programme will be the overview of other local issues or events that might have implications for ETAG delivery. It will be important that timescales are effectively co-ordinated at a local level which might include staggering ETAG activities to avoid over-concentrations of activity with similar groups.

4.51 The three month timescale for delivering ETAG activities served to galvanise some projects into getting off the ground and achieving most project objectives over a relatively short period. However, the timescales for both the setting up of the pilot programme and for

individual projects to deliver their activities were highlighted as problematic from a number of different perspectives. There was limited time for applicants to prepare and submit their proposals. This was even more limited in some areas where dissemination meant that some projects only found out about the programme the week or day before the deadline. In terms of quality of applications this had implications in terms of time available for engaging with potential partners and checking viability with delivery associates.

4.52 The timescale for project delivery also had implications for the time needed to set up projects and get the delivery partners on board. Projects leaders did not necessarily want more time in terms of day allocation, but a longer time period to allow links to be set up. Projects experienced some difficulties in appointing an appropriate person to deliver the project within the short timescale. This issue was accentuated where infill was needed to cover staff involved in delivery, especially where they had to find cover for a highly specialised role. Any future programme should ensure that the feasibility of delivering a project is considered in depth before the funding period commences which in some cases might mean a delayed start but would ensure delivery time is focussed on project activities rather than set up activities.

4.53 In their applications some projects envisaged being able to deliver over a longer timescale beyond the end of March 2004 with the result that they had to be scaled down. This had several implications in terms of project delivery and the approach adopted. For example, the young people's equity project in Denbighshire commented that the way in which they involved schools and colleges in the project might have been different if they had more time. The project facilitator commented that a face to face approach would have been preferable to contacting staff by telephone and email and might have helped with communicating the project aims to them.

4.54 Another knock on effect of the limited timescale for the project was linked to the recruitment of health professionals. This was particularly the case amongst those organisations that did not have previous experience of working with health and social care professionals and were making inroads to these groups for the first time.

4.55 Where projects are engaging with members of the public, time may also be a factor in developing trust, particularly with groups of people who are least likely to trust the health service or people associated with it. Building up a successful event which included community members requires sensitive handling which cannot always be rushed.

4.56 The actual timing of the ETAG programme also needs to be thought through strategically in the future. Policy changes such as the new GP Contract had implications on the delivery of

some ETAG projects. For example one project was uncertain which GPs to focus training on until it was clear which ones were likely to provide an enhanced service to the target population group. In addition, the scheduling of activities within the pilot area could also be improved so that activities are not so concentrated over such a short period. As one project leader noted, scheduling had implications on recruitment for the ETAG project:

'Because of the number of projects in Carmarthenshire with this ETAG, we were all targeting the same people and I think there was this feeling that a couple of people said they couldn't do it because they were going to other workshops during that month of March. So it was them having to prioritise in a way …' (Project leader)

Chapter summary

- *Project rationale* – There was some variation in project rationales. Some projects had already identified a need for changes to service provision but were looking to try out ideas in practice and take the development of those ideas a stage further. Whereas other projects were aiming to enhance the mechanisms for socially excluded groups to feed into changes in service provision in the longer term.

- *Lead organisations and partnerships* – Most projects were led by the statutory sector and there was some change in ownership between application and project delivery. The identification of project champions at an early stage is a key first step and action should be taken to involve them in preparing applications wherever possible.

- *Description of project activities* – Training based activities were a feature of most ETAG projects although others included research based activities and alternative mechanisms for breaking down the barriers to access health services. The diversity of activities undertaken is one of the programme's strengths and projects have illustrated a multitude of ways of facilitating equity training and advocacy work.

- *Project outputs* – Estimates suggest that 58 training events were conducted, involving approximately 567 participants. Improvements to data monitoring and collection will ensure more robust quantification can take place in future. A variety of other outputs were also reported including enhanced communication systems, the establishment of protocols to enhance service provision and advocacy worker support for specific groups.

- *What was learned about delivering projects* – The pilot programme highlighted a number of good practice learning points which should be captured for future reference. With relation to project delivery the main lessons learnt related to the importance of targeting delivery at the right level and creating the right experience for awareness raising to be maximised.

- *Engaging health professionals* – This was a significant issue for the pilot programme and needs to be addressed in the future. Tools to help projects navigate their way around the health care sector is one practical suggestion and the potential to link ETAG activities to Continuing Professional Development also needs to be explored in more detail.

- *Costs* – During the course of the programme projects identified a number of hidden costs which were not identifiable at the application stage. In some cases a considerable amount of time and resources was given in kind and this needs to be made more explicit in future funding rounds.

- *Timescales* – The tight timescales caused a number of difficulties for projects both in the setting up and delivery of activities. In addition, the timing of the ETAG programme also caused a number of issues with clashes at a local level.

5 Self-evaluation

Introduction

5.1 One of the evaluation objectives specified in the terms of reference from the Welsh Assembly was to 'assess the self-evaluation plans proposed by projects and to offer limited support during the course of the programme.' The evaluation team decided to invest some additional time at the front end of the programme in order to facilitate a self-evaluation event in each of the pilot LHB areas. The aim was to bring together those involved in the programme to discuss and advise on their self-evaluations and clarify that projects would receive limited additional support on evaluation issues. It was envisaged that the event in each LHB would maximise the coherence of the individual self-evaluations, maximise the ability for common context, process and outcome measures to be collected in each project, generate good-will and co-operation between project teams and the national evaluation team, and minimize the extent of problems and questions that the self-evaluations might encounter further down the line.

5.2 Further details on the self-evaluation events and the response from the participants are presented below. This is followed by a discussion of the nature and range of self-evaluations that were undertaken by the ETAG projects. This chapter concludes with a discussion of the way forward for incorporating self-evaluation into pilot initiatives.

The self-evaluation events

5.3 The workshops, held between 23rd January and 2nd February were attended by 26 participants with 23 of the 25 projects represented. Self evaluation material was provided for projects that were unable to attend. The workshops included presentations by the evaluation team, group work tasks for participants and a member of the Welsh Assembly was available to answer queries about the overall programme. Each workshop was evaluated and the overall response was very positive. Overall participants welcomed the opportunity to network with other projects and found the tasks useful in focussing their plans for project delivery and self-evaluation. The workshop evaluations revealed some useful insights into what participants learnt from the event and what they would have liked to have changed about the workshops.

Learning from the workshop

5.4 Feedback from the three self-evaluation events revealed that participants had learnt about evaluation and were clearer about the ETAG evaluation process. At one level they gained a clearer insight into what was expected of their ETAG self-evaluations and at another level they picked up on techniques and methods that they could incorporate into their own evaluation plans. The following comments illustrate the range of responses to the question 'what have you learnt from this event?'

- *'useful to focus thinking on specific points required for a thorough evaluation'*
- *'clarified the whole process. Made me focus on how my evaluation would take place.'*
- *'New evaluation techniques i.e., participatory evaluation.'*
- *'How to logically plan an evaluation format. Good, clear advice.'*

5.5 Learning about other projects and other lead organisations was a further theme running through the post it comments as the following examples illustrate:

- *'projects – overlaps – useful networking – possible future joint working potential.'*
- *'I thoroughly enjoyed the opportunity to share information and glean ideas from people involved in other projects.'*

Changes to the workshops

5.6 An additional question included in the post-it evaluation was 'what would you change about the workshop?' There were two main themes to emerge from this question. Firstly, participants felt they would have benefited from more opportunities for networking between projects. For many organisations it was the first time they had met the other organisations so more time to get up-to-speed with project and evaluation plans would have been welcomed, as the following comments highlight:

- *'more time to get to know other projects first. Would have liked to hear evaluation methods and ideas from everyone.'*

- *'Short introduction of projects at outset of workshop.'*

5.7 The other main change that was called for related to the timing of the self-evaluation workshop. Two participants in the final workshop held in early February said it would have been useful to have had the session at an earlier stage as they were already underway with their project planning. The aim was to convene the sessions as close to the start of the ETAG programme as possible but logistics and preparation meant it was not possible to hold them all as early as anticipated. Given this feedback from participants it will be important for any future pilot initiative to build these sessions into the planning at an earlier stage.

Longer term impact of the self-evaluation workshops

5.8 Feedback from the case studies highlighted the longer term impacts of the self-evaluation workshops on helping project leaders think about how they would plan and implement their own self-evaluations and how they would communicate their plans to other project team members. For example, one project co-ordinator drew on the self-evaluation workshop to train other colleagues and identified ways in which the evaluation tools would be useful in future years.

'I've kept all of the evaluation stuff. The multi-agency strategy planning and advisory group has a 5 year strategy and I can't remember if it is next year or the year after the key task for our group is to evaluate health services for [the client group] and so this is going to be very useful. So all the stuff that you [the evaluation team] went through and have given us will prove to be very useful. And this work obviously that we are doing will form part of it. And that was a complete by the by. It wasn't planned at all so it will be very useful.' (Project leader)

5.9 The next section turns to look at the resultant self-evaluations that were undertaken by ETAG projects.

Self-evaluations undertaken by ETAG projects

5.10 The project final reports included a section on 'evaluation methods' and these have been drawn on, together with feedback from the case studies, to provide an overview of the key features of projects' self-evaluations.

5.11 As with the range of project activities undertaken, the project self-evaluations were equally as complex and multi-perspective incorporating elements of self-reflection by the project leaders and key partners, and evaluation feedback from project participants. Project leaders put in

place a number of tools for monitoring project outputs. This included registration forms designed to quantify numbers of participants, organisations, level of previous background knowledge or experience in a subject. This helped them keep track of project outputs and helped them tailor the training to more specific needs.

5.12 Questionnaires were used as an evaluation tool either at the end of a training session or at the end of a period of engagement. These were kept short and simple and were mostly closed questions with space for extra comments where relevant. Some projects, especially those that worked with a group of participants over an extended period of time, made use of both pre and post questionnaires to track changes in skills and knowledge levels amongst participants.

5.13 Some projects, especially those delivering a training session, drew on the participatory evaluation approaches introduced during the self-evaluation workshops. This included post-it evaluations and target evaluations which were seen as a quick and easy way of gauging an impression of the training delivered. Other methods included feedback forums where project participants reflected on their experiences in a group setting and one to one interviews. The nature of the evaluation was tailored to the type of project and to the experiences of the project leaders involved.

5.14 Projects also drew on a wide range of methods to evaluate different aspects of their projects. For example, one project used short questionnaires to evaluate primary care practices' views on learning disabilities after meeting with them, time for open discussion was built into the meeting with the secondary care team, and a video transcript was used to reflect on the advocacy work with a group of people with learning disabilities. So again, tailoring the evaluation to the target audience was key and obtaining evaluation feedback from a variety of perspectives was a good means of ensuring triangulation of research methods.

5.15 In providing guidance for project self-evaluations the evaluation team at CISHE were looking towards fostering ongoing evaluation plans beyond the timescale for the projects which would encourage projects to track the impacts of their activities further down the line. In some ways it was hoped that this would encourage sustainability of activities and impacts beyond the programme end date and this was taken on board by a small number of projects. There were some issues about thinking longer term given that the funding term ended at the end of March 2004. There were some examples of follow up evaluation work being completed within the timescale of the project. These captured slightly longer term outcomes of the projects. For example:

- The arthritis awareness project in Carmarthenshire and Denbighshire issued follow up questionnaires to care home managers several weeks after the training event to ascertain

if there had been any changes in their working practices. At the time of submitting the report to the Assembly, 10 of the 28 care home managers had returned their forms. Of those, 70% have noticed a difference in the way that staff work with people who have arthritis, 50% have discussed changes in working practices with their staff, in consequence of the training, and 90% would like more of their staff to attend the workshops.

- The project to raise awareness of rural stress in Denbighshire did a follow up with training course participants, three weeks later. To date they have received a 50% response rate with participants reporting they found the training useful and they would implement what they had learned. Participants reported on specific examples of ways in which they had disseminated the information within their organisations.

- One Cardiff project is planning to do an impact evaluation 6 months after delivery to assess the effectiveness of the information cards they have developed for homeless people.

The way forward for self-evaluation

5.16 The above discussion has highlighted the different ways in which the supported self-evaluation usefully contributed to the overall ETAG programme. The support for the self-evaluation, and in particular the local events proved useful in introducing the evaluation and suggesting ways forward for individual self-evaluation plans. This was particularly useful for those project leaders who were undertaking an evaluation for the first time. However, the self-evaluation events also served a dual role and provided a useful forum for initiating networking between projects. As the feedback from the events highlighted, it is important for these sorts of events to be held as early as possible in the programme so that the evaluation can be clarified and links between projects fostered at an early stage.

5.17 The self-evaluations that were put in place by projects certainly matched the range and diversity of ETAG activities. Therefore, in addition to the minimum data set recommended in the previous chapter as a means of capturing common project outputs across the programme projects should continue to be supported in undertaking their own self-evaluations.

Chapter summary

- *Self-evaluation workshops* - The workshops, held between 23rd January and 2nd February were attended by 26 participants with 23 of the 25 projects represented. The workshops were well received and participants welcomed the opportunity to network with other projects and found the tasks useful in focussing their plans for project delivery and self-evaluation.

- *Self-evaluations* - Project self-evaluations were complex and multi-perspective incorporating elements of self-reflection by the project leaders and key partners, and evaluation feedback from project participants. Project leaders put in place a number of tools for monitoring project outputs.

- *The way forward for self-evaluation* – Self-evaluation as a means of encouraging projects to capture the diverse range of activities should be encouraged and workshop-based guidance on self-evaluation has proved to be an effective support mechanism.

6 Programme outcomes

Introduction

6.1 This section of the report focuses on the outcomes or intermediate impacts of the ETAG programme. What are the changes in skills, knowledge or behaviour that projects affected in working towards their overall aims and objectives? Longer term outcomes and impacts are hinted at during this section based on evidence put forward by the projects but the true impacts of ETAG activities will only be truly felt much further down the line. This section considers outcomes at a number of different levels:

- Outcomes for project participants – health care professionals and other groups
- Outcomes for project leaders and their organisations
- Outcomes for wider groups, not directly involved in the ETAG programme.

6.2 Outcomes for project participants were well reported in the end of project reports. However, projects were not always as explicit about the outcomes on project leaders and their organisations. The ripple effects of the ETAG programme and the often unanticipated outcomes were captured during the case study work.

6.3 Towards the end of this section the discussion also turns to look at the important issues of additionality, sustainability and in particular what is needed to sustain outcomes beyond the end of the programme.

Outcomes for project participants

Outcomes for project participants - health care professionals

6.4 Health care professionals were the main group targeted by the ETAG programme. All projects involved health care professionals in some way whether as training course attendees, participants in multi-disciplinary discussions or partners involved in delivering project activities. At one level health care professionals extended their knowledge about a certain health inequality issue. In some cases this led to changes in their skills and working practices,

or there was evidence to suggest that this would happen in the longer term. At another level health care professionals' involvement in ETAG meant they were able to activate new local action to change the delivery of a particular health care service. Examples of each of these types of outcomes for health care professionals are presented below.

Increased awareness about health inequalities

6.5 Evidence from the case studies suggests that project activities were successful in raising awareness of particular health inequalities. The following discussion highlights the different ways in which awareness was raised.

6.6 At one level projects increased knowledge about unmet needs. For example:

- A project to establish a proactive focus on incontinence undertook a survey of patients which showed that 71% were not aware of the continence services available in Carmarthenshire. The project also conducted a survey of health care professionals which showed that 72% admitted they did not have the skills and knowledge necessary to manage this condition.

- A project to address the specific needs of children placed in out of county placements established a database which led to the identification of children that had been previously overlooked in terms of their health needs. The project also identified gaps in the communication systems between agencies.

- A health facilitation project for people with learning disabilities worked with primary care teams and through this they identified the need to include people with learning disabilities in the provision of generic services.

- A project to identify the health needs of the gypsy and traveller community reported that each of the workshops identified key issues with regard to the provision of health care - barriers to health care, maternal mental ill health, safety and child health.

6.7 Projects also raised awareness about specific health inequality issues – amongst health care professionals and other groups. For example, a project to raise awareness of asylum seekers reported that across the four sessions held between 86% and 100% of attendees said their knowledge of the subject had improved. The project to provide smoking cessation training to midwives and health visitors reported an increase in the knowledge of health professionals -

100% felt the training had provided them with knowledge they could apply to their practice and 93% felt the training had increased their confidence in discussing smoking.

6.8 The following examples include some more detail on the specific ways in which awareness and understanding was developed:

- **Raising awareness about different forms of help available outside the NHS** – one project reflected on the evaluation forms completed by project participants 'it is clear that participants were previously unaware of other help available outside the NHS to alleviate stress, and were impressed with the range of what was available. The Directory of Rural Support was recognised as a valuable resource tool in identifying other help.'

- **Increased awareness of different approaches to tackling unmet health needs** – the Carmarthenshire project aimed at raising awareness of person centred planning recorded participants' knowledge before and after the training event. Before the training 85% said that they had poor knowledge of these approaches. Following the training over 90% felt that their knowledge of person centred planning and how it can describe people's needs was very good or excellent.

- **Awareness of local services available within the health sector –** a Cardiff based project reported that 85% of the 31 participants attending the training session agreed or strongly agreed that training had increased their awareness of local smoking cessation services.

- **More in-depth training –** the Carmarthenshire project to raise awareness about domestic abuse issues recorded that 98% of the staff who attended the workshop had not received any in-depth training on the issue previously.

Changes in behaviour and working practices

6.9 It was not anticipated that changes in working practices or changes in service delivery would be achievable within the project timescales but some projects were able to report on *actual changes or actions* directly following their interventions:

- **Improved health care information for the homeless** - A project to improve access to health services for homeless people focused on the development of a small card, providing personalised information on the client's last key health care contact and a

folding laminated map providing information of local health and related services. This is something that rough sleepers in Cardiff had all ready identified as something that they needed and service providers have sometimes faced difficulties in providing appropriate care without access to information on the client's health care history. The project lead felt that the idea could be applied to other population groups.

- **Improved primary and secondary care services for people with learning disabilities** - A health facilitation project for people with learning disabilities reported that one primary care team was already beginning to identify people with learning disabilities who were registered with the practice. Also, the secondary care team decided that in the future training on learning disability awareness would be given to health care assistants as part of their induction package.

- **Improvements in Somali maternity services** – A pilot project of a Somali antenatal community drop-in clinic reported a number of discernable impacts on the working practices of midwives. Eg, the project had reduced the number of home visits with an interpreter enabling midwives to target resources into one area and there was also a point of contact for midwives where there was a communication problem. The project also reported benefits for women – they were less isolated and less dependent, and more able to actively participate in their pregnancy.

- **Widened opportunities for access to palliative care** - A project to investigate the need and potential benefits of a flexible palliative intermediate care team reported that the population of the Llanelli localities and Gwendraeth Valley now have the opportunity to receive support via the Hospice At Home team and funding is now going to be sought to enable the team to be extended across Carmarthenshire.

- **Health care professionals involved in taking forward local rural stress initiative** - As a result of attending training on rural stress some members of the workshop became members of the local rural stress initiative in Carmarthenshire. In addition participants requested to be on the RSIN mailing list to receive updates via newsletters.

6.10 One project was able to undertake *follow- up evaluation work* within the timescales of their project and was able to report evidence of changes in working practices or service delivery beyond the initial project implementation. The arthritis awareness project received follow up evaluation responses from 10 of the 28 care home managers. Seven noticed a difference in the way that staff work with people who have arthritis and nine said they would like more of their staff to attend the training.

6.11 Other projects were able to report on the *anticipated changes* that were likely to happen further down the line. Projects anticipated a range of 'hard' and 'soft' changes:

- **Recommended changes to family planning services for young people** - A project to review the family planning clinics for young people produced a list of recommendations to changes to services which they presented back to the Family Planning services.

- **Improvements to health visiting service for families** - The project to improve the help that the Health Visiting Service can offer to support families with pre-school children with behaviour, psychological and emotional difficulties reported that all attendees agreed that they would go on to use the resource pack.

- **Review of working practices and approaches in primary care teams as a result of diversity training** - A project which delivered multi-professional diversity training for primary health care teams ran three courses and participants highlighted ways in which the training would influence their future practice. Eg, several were planning to go back to review their registration protocols and put issues of cultural diversity higher up their practice agendas. Others were keen to be more proactive in the use of interpreters. One GP said the course was pushing him to rethink some surgery procedures, especially the appointment system. There was also evidence of more softer changes in the way in which health professionals approached their clients For example, a Practice Nurse said 'it has helped me approach people more sensitively and with greater understanding' and some of the receptionists said they would put more thought and understanding into dealing with patients.

- **Easy reference guide as a tool for more effective incontinence management** - A project to establish a proactive focus on incontinence identified the need for an easy reference handbook for health professionals to effectively manage incontinence and were looking to set up a group to take this forward.

- **Improvements in practice and communications to better address needs of looked after children -** A project to address the specific health needs of children placed in Carmarthen from out–of-county placements identified the need for resources to keep the database updated. Bids were put forward to the Trust for funding for a clerical support and another full time specialist health visitor for looked after children. Also a protocol for information sharing between the local authority and health agencies was being developed.

- **Further improvements to primary and secondary care services for people with learning disabilities** - The health facilitation project for people with learning disabilities reported that all primary care teams requested information on the additional health needs of people with learning disabilities - which they received. The secondary care team felt it would be useful if individuals with the skills to work with people with learning disabilities were identified, so that they could be called on in the in-patient or out-patient situation.

Outcomes for project participants – other groups

6.12 In addition to engagement with health professionals ETAG projects also engaged with local community groups including young people, black and ethnic minorities, people with learning disabilities, people with mental health problems and the homeless. These groups were often formed into health advocates who were encouraged to engage in a dialogue about their specific health needs and the barriers they face in engaging health services. It is important that the outcomes for these groups are reported alongside the outcomes for health professionals. Ensuring the continued engagement of these groups will be key to the success of any ongoing ETAG programme and involving them in the process needs to be matched with informing them of the outcomes and changes to services as a result of their involvement.

6.13 Case study projects alluded to community groups being involved in a process of empowerment as a result of their engagement in ETAG. For example, people with learning disabilities were formed into a health advocacy group which met five times during the project. It was a very powerful experience for them and the first time they had been given this sort of opportunity:

'Their views were very valid and you could see they could do with somewhere to put those views, they needed a bigger forum to feed their views into….they may belong to self-advocacy groups although none of them really talked much about that as such…but they certainly had not had the opportunity to talk about doctors before…and it was something that had been done to them rather than them having input into what happens. They understood very well that there was nothing available specifically for people with their kind of difficulties at the doctors.' (Project leader).

6.14 Project leaders also talked about the educational benefits for those involved in the ETAG programme in terms of widening their knowledge and skills base. One project leader reported a raised level of awareness amongst people with learning disabilities as a result of their participation in the health advocacy group:

'*What we tried to do in every session was education for the people themselves and part of it was their opinions about things…they're not generally empowered about what they can do about their own health needs. It's something that happens at a level above them with parents with carers and it is very much done to them as it would be with children… but you could see how people's awareness was raised just in those five sessions.'(Project leader).*

6.15 In another example a project leader talked about the outcomes for the young people evaluators and the fostering of a genuine interest in their own health needs and those of other young people - 'It's given them a voice to actually change things.' It has also given young people the 'chance to do something different' and 'they all seemed genuinely interested in what they were doing.' They also realised, without any prompting, that it was difficult for young people to access the services. This was endorsed by some of the statements made by the young people in the feedback sessions. The young people also appreciated being remunerated for their time and in some cases the vouchers made a significant difference to their quality of life. They were also keen to get their certificates and wanted to include them in their portfolios and CVs.

Outcomes for wider groups

6.16 The sphere of influence of the ETAG programme extended beyond immediate project participants to encompass a wider group of health professionals within the teams of those directly involved. Identifying the most relevant and influential health care professionals and ensuring dissemination takes place is vital to ensure this wider scope of ETAG is maintained. The following examples illustrate some of the ways in which ETAG messages were disseminated to wider groups:

'We also had the Chair of the Community Health Council with us as well and she was very aware that she would be feeding this back to her local health council but also would disseminate that back to the health councils in Wales where there's about 20 in Wales altogether and the disseminating of information following on.' (Project Leader).

'A lot of them, like the midwives, who are working on the wards will actually take the packs back to the wards…so they've got something to refer to as well.' (Project Leader).

'I was speaking to [the project co-ordinator] the other day and he was saying that already there are other areas that have contacted him saying we're thinking of doing a similar thing can you share your experience, what was your training pack and that was certainly one of the aims initially was to start to create a resource of experience that can be shared…'. (Lead applicant).

'[The District Nurse, the Health Visitor and a trainee nurse] went to the UK forum [for their client group] a few weeks ago where they showed the draft as it was then. And everybody was absolutely chuffed and thought that the [the initiative] was a really good idea.... The forum is for nurses and health visitors... If [the initiative] it became UK wide it would then become even more useful. We'll have to think about that. Start small but definitely look big is my motto.' (Lead applicant).

6.17 In some cases projects reported on the dissemination that participants planned for after the ETAG event. For example:

- A project to provide smoking cessation training to midwives and health visitors reported that 93% agreed that the information could be disseminated to colleagues.

- A project to raise awareness of arthritis reported that many stated they would be passing information onto colleagues. Follow up evaluation has showed that 50% have discussed changes in working practices with their staff.

- A project to facilitate rural stress awareness workshops reported that following the workshops 100 copies of RSIN Rural Stress Support Directory have been disseminated via two participants. The project also reported that their evaluation showed that participants would use the handouts with their agencies in tandem with the video.

Outcomes for project leaders & their organisations

6.18 Project leaders and their organisations were another group to achieve outcomes from the ETAG programme. Through the course of the programme project leaders and other staff become entwined in the awareness raising process and the breadth of their knowledge, experiences and skills was expanded as the discussion below illustrates.

'*I think it has been great for me because I have been able to say to other members of the team ' right you run with it' and although I have known what is going on and I have done lots of sort of driving of the ideas, they have run with it and that it really important in terms of their professional development and so that has been really good and they have been able to take the credit. It was really good at the ... conference, one of the health visitors who has worked for many years on one of the sites, she gave a really fantastic presentation and she was a really strong advocate for the group and it was really good to see that and she would have never have had that opportunity before. So that has been really good for me to see people*

being able to take things, because I am usually the 'front man'. ... It gives me confidence in handing things over.' (Lead applicant).

Subject knowledge & professional development

6.19 Project leaders and facilitators were in the main experts in their own fields at the start of the programme and this expertise meant they were well positioned to co-ordinate and facilitate awareness raising amongst health care professionals. However, several of the case study projects reported an extension of that expertise during the course of the programme. For example, one project leader in Carmarthenshire was trained and had experience as a learning disabilities nurse but still gained a lot from the project at a personal level:

'I found it quite interesting. I haven't had many opportunities to have a good old look at how the health needs of people with learning disabilities are being met or not met so it was quite a revelation actually, quite a revelation to put it in black and white, some of the obvious inequalities in their healthcare and it was also really enlightening that people with learning disabilities themselves had definite opinions about what made a good doctor or a bad doctor and what they were relating to and the insight from people with down syndrome that people find them hard to understand...'. (Project leader).

6.20 Another project said that the events that they facilitated with the targeted communities highlighted priorities which contradicted the original expectations of the lead organisation.

'Considering that about three quarters of [this population] have really poor English, we were expecting language and communication to be streets ahead in terms of the problems they have. And it wasn't. It was high, second highest, but the highest one was about doctors not listening – particularly GPs. The conclusion from that is that even if language wasn't a problem, the doctor still wouldn't be listening. So the problems they were having with the doctors wasn't that there was a language problem. It was the attitude of the doctors. (Lead applicant/Project leader)

6.21 Case study interviewees made reference to the importance of 'project champions' as leaders with the right level of skills to take projects forward:

'I think we were very fortunate in recruiting xx as the actual facilitator for the evaluators. And I think I would want, if you were doing a similar project, try and encourage people to think more creatively about who might be suitable because in that initial who might be the sort of person to do this job, we had the potential to actually miss xx but fortunately the recruiting process as it happened allowed him access to applying and I don't think this

project could have actually happened if we hadn't had somebody who had the skills to do this – he really was crucial.' (Project applicant).

6.22 ETAG also presented project leaders with new and refreshing ways of working which added different dimensions to issues they were already familiar with. In one case the project leaders and co-ordinator cited outcomes in terms of professional development with greater opportunities for inter-agency and participatory ways of working. They were pleased to have the opportunity to do something different and become advocates for the client group.

6.23 An additional layer of increased knowledge and understanding was with regard to multi-agency working and furthering an understanding about different working cultures. This was the case for non-health professionals finding out about the structure and cultures within the health service and vice versa. One project leader commented on the insight gained through navigating her way through the complex web of health service structures in order to identify and recruit health professionals. During the delivery of her training she also gleaned an insight into the way in which health professionals formulate action plans in contrast to some other groups she had worked with such as those from the voluntary sector. This insight was important in helping her tailor future training sessions

Organisational outcomes

6.24 Another stream of unanticipated outcomes for the project leaders and their organisations were the spin-off benefits of links established during the course of the ETAG programme. A number cited ongoing links with project participants. For example, one project leader noted how the links made through ETAG supported the establishment of a local support network with key workshop attendees now attending the network meetings.

6.25 Another project lead reported that contact with one of the other ETAG projects had prompted initial discussions for future joint work to improve service delivery to a specific population group.

6.26 Other examples indicate an increased workload for project leaders and their organisations as a result of links made through the ETAG programme, increases which need to be anticipated at the outset of such a programme and adequately resourced:

- *'As a result of this, what I've also done. xx, who was at one of the first workshops I ran, she's the Sure Start health visitor….I ran a two hour workshop for Sure start*

volunteers and I've also run the same for Home Start volunteers as well.' (Project leader).

- *'It's quite surprising now because some health visitors are contacting me directly. If they've been dealing with somebody. Also I'm having direct referrals from them...normally it would be via x…but I'm starting to have health referrals too which is good.' (Project leader).*

6.27 Evidence also suggests that one of the legacies of ETAG will be a sense of ownership fostered amongst project leaders. During the course of the programme several practitioners became advocates in their own right and these project champions are keen to see the findings from the projects put into practice.

Additionality

6.28 As the above discussion has highlighted, the ETAG programme led to a number of positive outcomes, sometimes unanticipated outcomes, for participants, project leaders and wider groups. To what extent can these outcomes be seen as truly additional to what would have been achieved anyway? How much of a difference did the ETAG programme really make?

Additionality related to bid writing

6.29 Apart from winning the grant there is evidence that the application process resulted in additional benefits for the authors in particular benefits relating to their own professional development. One project applicant commented on the steep learning curve she experienced through working with and trying to engage partners from across the education and health sectors – people who she had not previously worked with. As a result of her experiences, in the future, she would try to act as more of a facilitator encouraging others to take ownership at an earlier stage. Another project felt that the application process highlighted the need for such a project and even if the project had not been funded it would have placed the issues at the centre of the organisation's agenda.

6.30 There were even benefits for those ideas that did not get to the application stage. One partner commented on the exercise of key staff at the LHB and Trust thinking through the ideas that could be taken forward.

'Just thinking raised people's awareness and highlighted some of the areas where further work is needed. Just the tabling of the guidelines had an effect – whether it is sustained or not is another matter but everyone was able to see areas where this could be useful. If some

similar monies came up then it might jog your memory and it might be quicker and easier to take things forward.' (Project applicant)

Project additionality

6.31 Some projects reported that the activities may have been taken forward without the ETAG funding but it would not have included all the elements that ETAG allowed. For example, without the ETAG funding the Denbighshire young people's equity project might not have been able to remunerate the young people as evaluators and the project leads were very keen to value the young people's input in this way. It was also important for them that they were able to appoint a facilitator to work solely on the project two days per week. They felt this was preferable to asking people to fit it in with what they were already doing.

6.32 Other projects may have gone ahead without ETAG funding but it would have been at a later stage. One project reported they would have looked to do this sort of project 'eventually' but not straight away. In other cases projects reported that they were looking to do these sorts of activities at some point but it would not have been a priority for this year, given their limited resources and capacity. One project leader commented positively about the way in which the small pots of funding kick-started activities.

"I think the timescale was too short. But it's amazing what you can do if you have a kick-start. And in fact what you can do without huge amounts of money, because lets face it these aren't exactly like winning the lottery. It's just small things that you can actually do and make a difference" (Project leader).

What is needed to sustain the outcomes?

6.33 Project leaders had a number of suggestions about how to sustain project outcomes in order to ensure the longer term impacts ensue. The following discussion presents a number of issues influencing project sustainability and also suggests a way forward for how these could be co-ordinated.

Ongoing external encouragement and support towards change

6.34 The view amongst project leaders was that ETAG had acted as a catalyst towards activating change. Steps, in some cases several steps, had been taken towards improving access to services but something else was needed to continue that momentum and ensure changes were actioned. In several cases the responsibility had been handed over to health professionals themselves. Their awareness of health inequalities had been raised and they should be better

equipped to counter inequalities. However, it was felt that there was a need for ongoing encouragement and support for health professionals to make the final steps into activating change. The following example illustrates how, left to their own devices, changes would not necessarily happen.

'In another practice they were arguing against having to increase their workload basically. You know, what a nice idea but we don't want to increase our workload. And all of them won't be able to do much unless somebody comes and helps them, no doubt about that. Left to their own devices, they're just so snowed under with their everyday work that it's difficult for them…They were quite frank…it's not a priority for them I think that's the problem. Unless somebody is employed who will raise their awareness it is not a priority for them to push the agenda for [the client group] forward. They've got so much else on that they won't push it forward unless somebody nudges them to do so. You can see that's the case. They're not doing that deliberately to be horrible but they just have this heavy agenda all the time of meeting diverse populations' needs.' (Project leader).

6.35 At another level reinforcement work is also needed to ensure that community groups continue to advocate for their own health needs. The view was expressed that equity training around the needs of specific population and client groups needs to be part and parcel of the basic professional development of health professionals. For instance it was argued that cultural awareness needs to be a part of training just as it is in the police force and not just a one-off event. Again it seems unlikely this would happen without ongoing support.

'For the [target group] it would have some impact on their knowledge of how they're thinking about their experiences of doctors and hospitals that they didn't previously have and their knowledge of different health situations that might be pertinent to them. But again, because they have developmental delay it needs reinforcing so they may still retain some of that now but unless that forum is kept up in some way within a few months they'll start to forget that they did that and how important that was for them at the time.' (Project leader).

6.36 A related issue is the start and finish nature of ETAG which meant project leaders were usually unable to continue taking forward the project or its findings. Ensuring there are dedicated personnel to take forward the outcomes of projects will be one of the key factors affecting sustainability. The following examples illustrate some of the frustrations experienced by project leaders with the ETAG programme coming to an end:

'*One of the problems I suppose is that I had a temporary contract and worked for a number of months in one job and kind of brought that to an end myself…so for me its been a piece of*

start and finish work as such. I know exactly what they need to do but whether they have any plans in place to do it or not I don't know.' (Project leader).

'At the moment the plan is that I'm doing it in my own time, which is quite difficult, so I haven't got anywhere with that. But I know basically what I want to do but its just doing it…' (Project leader).

Wider dissemination beyond immediate group of participants

6.37 Ensuring the ETAG messages are broadcast to the right people at the right level is another key ingredient to sustaining the programme outcomes and a good way of ensuring outcomes are embedded within organisations not just within the personnel who were directly involved. Projects cited longer term impacts where dissemination took place:

'I think as far as the impact of raising awareness it probably did better with the secondary care team - I think they'll hang onto it for longer because they're disseminating it to more people. And they instantly started to think about concrete changes they could make.' (Project leader).

Responsibility for sustaining outcomes – a way forward

6.38 Establishing strategic responsibilities for ETAG at the outset will help to ensure that the outcomes are more sustainable in the longer term. This will help foster the climate for sustainability which includes providing ongoing support for change and the wider dissemination of ETAG lessons so that they become embedded within organisations. Prompting applicants to identify links with local strategies could contribute towards sustainability after the project has ended. The more fundamental issue of responsibility for equality and equity also needs to be clarified and how ETAG fits within this.

6.39 One project author emphasised the importance of establishing stakeholder ownership in the project from the start, as a way of ensuring recommendations were acted upon:

'That was one of the initial steps really in the project, which is that the services or the stakeholders at the outset have a sense of ownership. Certainly the service lead who's actually changed during this project, but the consultant that leads this service does have a sense of ownership and is aware of the project…..' (Project applicant).

6.40 Outcomes from the ETAG programme have highlighted the need for sustained changes around listening to different voices, engaging with different communities and integrating that

into the way in which services are planned and delivered. In the future it will be paramount for projects to be embedded in the programme from the start so that the conditions for sustainability are assured. That is, by adopting a more strategic approach to the programme and tailoring the projects needed at a local level there will be ongoing support and encouragement in the longer term, there will be wider dissemination of ETAG messages within organisations, and there will be recognition of the increased workload that equity training and advocacy activities generate.

Chapter summary

- *Outcomes for health care professionals* – Outcomes for health care professionals included increased knowledge about unmet needs and greater awareness about local health inequality issues. In addition some projects were also able to report on actual and anticipated changes in behaviour in working practices.

- *Outcomes for other project participants* – In addition to benefits for health care professionals there were also positive outcomes for other groups involved in ETAG. ETAG empowered communities to advocate for their particular health needs and the educational role of ETAG activities was also important for some groups.

- *Outcomes for wider groups* – The dissemination of key ETAG messages beyond the original group of participants was an important step in making sure messages become embedded within organisations.

- *Outcomes for project leaders and their organisations* – Project leaders gained significantly from the ETAG programme in terms of their subject knowledge and professional development and their organisations also benefited from the links with a wide range of other agencies. Project leaders have emerged as champions for health inequalities and it is important that this sense of ownership continues to be nurtured.

- *Additionality* – The actual process of applying for an ETAG grant led to a number of benefits in its own right. It enabled a number of new issues to be put on the agenda and it was a learning process for practitioners who were applying for funds for the first time. The evaluation suggests that ETAG enabled a number of projects to get off the ground which otherwise might not have happened on the same scale, or at the same pace, if at all.

- *Sustaining the outcomes* – There are a number of key elements to ensuring the outcomes of the ETAG programme are sustained in the longer term. This includes ongoing encouragement and support towards change and ensuring wider dissemination beyond the immediate group of participants. A more strategic approach to the programme, involving key players from the local health economy might be one way of creating the right conditions for sustainability.

7 Conclusions & future guidance

Introduction

7.1 This final section of the report draws together overall conclusions in light of the preceding chapters. It is important to return to the original aims and objectives of ETAG and consider the extent to which these match up with the actual outputs and outcomes. Did the programme achieve what was expected? How did the programme match up with stakeholder expectations? How far do the resultant programme activities resonate with the original Townsend recommendations? In light of these conclusions, this final chapter also goes on to make recommendations for the way forward for the ETAG programme. This builds on the issues raised and lessons learnt throughout the whole report, and provides guidance as to what a future programme should incorporate so that outcomes and longer term impacts are maximised.

Conclusions

7.2 The original aim of the programme was 'to increase awareness and understanding of health inequalities and inequities in access to health care and to stimulate new action locally to address unmet needs.' Reflecting on project outcomes the programme has drawn on a relatively small amount of funding (just over £105,000 overall) to raise awareness about a multitude of local health inequalities at a number of levels. The potential sphere of influence of the ETAG programme is considerable with scope for the benefits to extend from the immediate group of participants and project personnel to wider teams and organisations. Some wider dissemination was undertaken as part of the pilot but this could be realised more fully.

7.3 The programme has also achieved its aim of stimulating new local action with a number of ideas being taken forward to the next stage of development. A good deal of this new local action would not have been stimulated without the small pots of funding accessed through ETAG. It is important that the momentum for change is maintained, which is difficult to achieve through a start and finish programme like ETAG.

7.4 Developing multi-agency working was another key feature of the ETAG programme at the conception and design stage particularly collaborations between services and organisations outside the health service. A good deal of headway has been achieved as a result of this

programme. New links have been forged and existing links have been intensified and strengthened but there is still some way to go especially with regard to breaking down the barriers between the statutory and voluntary sectors and linking with particular groups of health professionals. Learning from the ETAG programme has already identified a number of ways in which these links could more easily be fostered.

7.5 One of the more deep-rooted principles upon which the ETAG programme was set up was the need to encourage health professionals to take on an informal advocacy role and for it to become one of the 'ordinary expectations of professional practice.' This was a challenging difference to make within a short timescale with limited resources and will require a much more strategic overhaul of the role of health professionals. However, in working towards this cultural change, the ETAG programme has provided exemplars of what can be achieved and how health professionals can stimulate action outside their mainstream roles. The projects undertaken as part of the pilot can be promoted as creative and diverse case studies of identifying and developing an understanding of local health inequality issues.

Advice for the future

Driving the programme forward – role of the local health economy

7.6 In driving the programme forward it will be important to continue the partnership working between agencies that has been initiated by the pilot. It is paramount that decisions about the future programme are taken in conjunction with agencies both within and outside the health service, incorporating the statutory, voluntary and community sectors. Highlighting opportunities for 'practitioner creativity' in national and local strategies will help incorporate the philosophy of ETAG into other ways of working. (Paragraph 3.4).

7.7 Important consideration needs to be given to who would be best placed to take a lead in driving the whole approach forward at a strategic level. Key questions need to be asked about whether co-ordination is best placed at the national, regional or local level, taking into account all the relevant players in the local health economies in particular the role of the NHS Trusts, the LHBs and the health, social care and well being partnerships. Consideration should be given to project ideas that do not fit with strategic plans and the programme should not lose sight of local innovation. (Paragraph 3.16).

7.8 At the same time, a balance needs to be struck between ensuring a strategic focus for the programme and providing opportunities for practitioner creativity – one of the refreshing aspects of the ETAG programme which should be encouraged. As a way forward, a group of

decision makers from the LHBs, Trusts and the voluntary sector should be convened to plan the way ahead and ensure ETAG links in with local strategies. (Paragraph 3.17).

Setting up the programme

Promoting the programme

7.9 There is scope for improving the dissemination of programme guidelines to ensure they reach the target audience, giving adequate time for application submission. Protocols need to be set up at a local level to ensure the guidelines are given strategic approval at a senior level but it is also important that they filter through to practitioner level. A strategy for reaching target groups should be agreed at the outset. Clearer guidelines and a short glossary of terms would also benefit applicants. (Paragraph 3.23).

The application process

7.10 Feedback from pilot projects highlighted the importance of having a dedicated team to deal with issues arising especially during the application stage. It is important that this continues to be an integral feature of any future programme to ensure overarching consistency in aims and objectives. (Paragraph 3.28).

Research ethics procedures

7.11 Ethical considerations need to be factored into such programmes in the future. These considerations need to be triggered at the point of project conception so that timescales for ethical approval can be factored in. This needs to be backed up by Assembly guidance and support on where best to turn for practical advice at a local level, which might vary between the health professions and the voluntary sector. (Paragraph 3.29).

The projects

Partnership working

7.12 The main challenge to partnership working has been the time to establish new networks and formalise the partnership working. In the future it will be important for the initial application form to include more detailed information about partners, including their roles and their commitment, so that these networks can take shape at an earlier stage. (Paragraph 4.15).

Reporting requirements & self-evaluation

7.13 Consideration needs to be given to the possibility of a minimum data set for tracking the actual scale and scope of project activities. However, it will be important not to lose sight of the diversity of project activities and projects should be encouraged to supplement the minimum data set with their own individually tailored self-evaluation measures. In support of this, workshop-based guidance on self-evaluation should continue to be provided as part of the overall programme. This has the dual benefit of raising skill levels amongst programme participants as well as providing essential opportunities for networking between projects. (Paragraph 4.27).

Delivery of activities

7.14 Creating a central resource for ETAG learning will be an effective way of ensuring good practice is captured and is accessible to others. This may be through an established website which could incorporate wider learning from other initiatives including Communities First, Inequalities in Health Initiative and Healthy Living Centres – all of which may have attempted to tackle issues relating to inequalities in access and experience of health services. Pre-existing websites should be investigated to see if ETAG resources can be added. In addition, opportunities for face to face exchange of information should also be included. (Paragraph 4.31). Existing websites such as the Chief Medical Officer (CMO), the NPHS and the Wales Centre for Health might already have some information about health inequalities that ETAG information could complement.

Engaging health care professionals

7.15 Engaging with health professionals is a fundamental issue which needs to be strategically addressed if the programme is rolled out. Suggestions include tools to help navigate local health services. Opportunities for linking ETAG activities with Continuing Professional Development (CPD) also need to be explored including using Action Learning Sets as a framework. Key lessons from the pilot should be pooled for future reference and training days on how the health service works and who is involved might be another means of engaging health care professionals. (Paragraph 4.42).

Timescales for project delivery

7.16 Further thought needs to be given to the timescales and timing of ETAG activities. There needs to be recognition of the time needed to set up projects especially where projects are proposing to work with different groups for the first time. (Paragraph 4.51).

Sustaining outcomes

7.17 Establishing strategic responsibilities for ETAG at the outset will help to ensure that the outcomes are more sustainable in the longer term. This will help foster the climate for sustainability which includes providing ongoing support for change and the wider dissemination of ETAG lessons so that they become embedded within organisations. Prompting applicants to identify links with local strategies could contribute towards sustainability after the project has ended. The more fundamental issue of responsibility for equality and equity also needs to be clarified and how ETAG fits within this. (Paragraph 6.38).