WHAT IS THE MOST APPROPRIATE EVALUATION METHOD FOR THE HEALTHY FENLAND FUND?

Cambridgeshire Policy Challenges 2019

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Abbreviations

ABCD – Asset-Based Community Development

CCC – Cambridgeshire County Council

CCF – Cambridge Community Foundation

CCVS – Cambridge Council for Voluntary Service

CNC – Care Network Cambridgeshire

CPSL – Cambridgeshire, Peterborough and South Lincolnshire

HFF – Healthy Fenland Fund

IMD – Index of Multiple Deprivation

LSOA – Lower Super Output Area

ONS – Office for National Statistics

RT – Resilient Together

WEMWS – Warwick Edinburgh Mental Wellbeing Scale

1. Introduction

1.1. Project Brief

In March 2019, the third annual Policy Challenges collaboration between Cambridgeshire County Council (CCC) and the University of Cambridge was initiated to enable academic researchers from the university to work with the council to address policy issues using an evidence-based approach. Our team was set up to address the question:

What is the most appropriate evaluation method for the Healthy Fenland Fund?

The council has previously attempted to evaluate the Healthy Fenland Fund (HFF) but, as yet, have not been able to define the exact data, and thus process, required to evaluate the HFF effectively. Over a six-month period we therefore aimed to:

1) Understand the background to the HFF
2) Understand the challenges associated with evaluating similar programmes
3) Explore previous evaluations of similar programmes
4) Develop a framework that can be used to evaluate the HFF

1.2. Project Approach

A number of approaches were used to address our proposed question. We started with a **literature review** of documents relating to health in Fenland, for example the CCC Joint Strategic Needs Assessment Report 2017 and information on Cambridgeshire Insight, and the background to the HFF (section 2). We also reviewed documents relating to the rationale for evaluating both a project in general and an asset-based community development (ABCD) initiative (section 3). We then looked at evaluation reports for initiatives similar to the HFF coordinated by charities and other councils (section 4).

Based on contacts found during literature reviews and online searches, we contacted individuals who had previously been involved in the evaluation of programmes like the HFF to develop an understanding of the approach used by different organisations, and the factors that need to be considered when developing an evaluation framework for a health-focussed ABCD programme. We were therefore able to develop and examine **case studies** of related projects (section 4).

Another approach used during this research project was to pilot some of the **evaluation techniques** we had identified during our literature searches and discussions with those involved in similar projects. We therefore developed a **questionnaire** based on those used in similar evaluations and ran **focus groups** with individuals participating in HFF-supported groups/activities to determine whether these would be appropriate methods of evaluation in this case (section 5).

2. The Healthy Fenland Fund

- Fenland is the most deprived district in Cambridgeshire and is statistically similar to, or worse, than the national average for many health indicators.
- HFF is delivered by Care Network Cambridgeshire (CNC) and Cambridge Community Foundation (CCF) with the aim of building strong and resilient communities and improving health in Fenland.

2.1. Background

Fenland is the northernmost district of Cambridgeshire. In 2018 the reported population was approximately 101,500 individuals. 22.7% of the Fenland population is over 65, with this proportion of the population predicted to increase to over 30% in the next 20 years[1]. Levels of socio-economic deprivation are high in Fenland with 72% of the Lower Super Output Areas (LSOAs) receiving an Index of Multiple Deprivation (IMD) score in Deciles 1-5, representing the most deprived LSOAs in England[2]. Fenland has a higher children's deprivation score than both Cambridgeshire and the national average with 18% of children living in low-income families. Education is also a concern in this area where school readiness and GCSE attainment are lower than average. Only 50% of pupils achieve at least 5A*-C grades and 31% of working age people have no qualifications at all[3].

Deprivation and education are inextricably linked with health outcomes. Fenland is statistically similar to, or worse than, the national average for many key indicators of health. Life expectancy at birth, one of the strongest indicators of health, is significantly worse than average[4]. There is high mortality from preventable causes with 130 avoidable deaths per 100,000 people each year, compared to 20 in Cambridge City. A high proportion of the population describe themselves as having bad health and report long term activity-limiting disabilities or illness[5]. The prevalence of many chronic diseases including asthma, chronic obstructive pulmonary disease, coronary heart disease, diabetes and cancer is significantly higher in Fenland than national averages. Mental health and wellbeing are a particular concern, especially in children and young people, with high rates of depression recorded. Specific lifestyle behaviours reflect a general poor awareness of health. The average portion of fruit and vegetables consumed daily as well as rates of physical activity are significantly worse in Fenland than the national average. In accordance with this, the proportion of overweight and obese adults is high with

[1] Cambridgeshire Insight (2019). Population Reports: Fenland.

[2] Cambridgeshire Insight (2019). Deprivation – Interactive Reports: Fenland.

[3] Cambridgeshire Insight (2019). Child, Young People and Education – Interactive Reports: Fenland.

[4] Cambridgeshire Insight (2019). May19 PHOF Summary Cambridgeshire.

[5] Cambridgeshire County Council (2019). Joint Strategic Needs Assessment Summary Report.

70% of adults carrying excess weight. Smoking and alcohol misuse are also high in Fenland, with a significantly high rate of alcohol-related hospital admissions[6].

There are particular challenges when working with populations in Fenland. Fenland is a rural area. It is well recognised that rurality can affect the health of individuals and presents unique challenges to healthcare providers[7]. The major challenges to health in rural areas include poor public transport links, making it difficult for individuals to access healthcare services which may be a great distance from the home. A trend towards an older population, as young people leave in search of better career prospects, is also a challenge as older people tend to be in worse health and have greater need for health and care services. In addition, the difficulty in attracting and retaining healthcare staff is a growing concern. Finally, the lack of community support and increasing isolation felt by many in rural areas can also negatively impact health, particularly mental and emotional wellbeing. These challenges can all be observed in Fenland. Another unique challenge in Fenland is the growing migrant population and large transient population who can struggle to engage with the local community. The migrant population come from all over the world and from different socioeconomic backgrounds resulting in discrete migrant communities within the wider community. However, the largest migrant populations in Fenland are from the A8 countries, the eight poorer countries who joined the EU in 2004, including Poland and Lithuania. Migrant communities present additional healthcare challenges with higher rates of smoking and alcohol consumption. Poor dental care and sexual health have also been identified as areas of concern[8].

2.2. Programme structure

The HFF reflects an asset-based community development (ABCD) model. In ABCD initiatives, communities drive development themselves through identifying and mobilising existing assets, skills and knowledge of local residents and organisations. Communities are regarded as the primary building blocks for change which builds confidence as they are able to engage with decisions about their health in a self-directed and sustainable way[9,10].

The HFF consists of a grant fund of £75,000 annually for five years, administered by Cambridgeshire Community Foundation (CCF), and funded community development team provided by Care Network Cambridgeshire (CNC). These mutually dependent elements support the initiation or development of small groups or activities aiming to use community assets to improve health, wellbeing and community involvement in Fenland. Those accessing support may be

[6] Cambridgeshire Insight (2019). May19 PHOF Summary Cambridgeshire.

[7] Local Government Association (2017). Health and Wellbeing in Rural Areas.

[8] Cambridgeshire County Council (2019). Joint Strategic Needs Assessment Summary Report.

[9] Public Health England (2015). A guide to community-centred approaches for health and wellbeing.

[10] Improvement and Development Agency (2010). A glass half-full: how an asset approach can improve community health and wellbeing.

an existing group aiming to expand or a member of the public aiming to start a new group. While this programme aims to target all residents in Fenland, there is a focus on those most in need, for example migrant communities and those vulnerable to social isolation or mental health concerns.

Different procedures are used to award the grants, according to their value. CCF is responsible for providing grants of between £1500 and £5000 with applications reviewed quarterly. Grants of below £1500 are delivered directly by CNC and the Healthy Fenland administration team. Applying groups or activities must aim to address mental, physical or emotional health or increase involvement in the community and must demonstrate future sustainability to enable the groups to become self-supporting once the grant period has finished.

The community development team works to support local community groups or individuals to identify their needs and develop new ideas to address these needs. The team support the initiation and running of the group through providing training and assistance on budgeting, marketing/publicity, constitutional policies and signposting other individuals, groups or organisations who may be able to develop the ideas further. A key role of the team is to assist with funding applications. The team also identify community connectors, i.e. individuals and organisations with extensive local knowledge and connections, and community enablers, i.e. individuals who are able to identify and use community physical and social assets. Together, these individuals strengthen trust in the HFF team and resilience in the communities.

2.3. Desired outcomes

The main goals of the HFF are:

1) To build strong and resilient communities in Fenland who are able to identify their own needs and make decisions to address those needs.
2) To improve physical, mental and emotional health and wellbeing of communities in Fenland.

2.4. Why is an evaluation framework needed?

An evaluation framework for the HFF must be developed to assess whether the desired outcomes of the programme are being met and thus whether support for the HFF should be continued. There are specific challenges associated both with the evaluation of ABCD programmes and with the population targeted by the HFF. Furthermore, it would be beneficial to have a framework on which other programmes of a similar nature and in a similar area could base their evaluation or refer to for guidance.

3. Methods of evaluation

3.1. Project evaluation – the basics

- Evaluation procedures should be carefully planned at the onset.
- Three main aspects that need to be considered are implementation, mechanism of impact and context.

An essential part of implementing a programme is its evaluation. An evaluation is needed to: understand if the expected outcomes were met, assess which aspects were effective and which less so, establish the impact on the target population, and learn lessons for future interventions in related areas. When we set to establish an evaluation framework for the HFF, our first task was to perform a literature review to understand the basics of how projects are evaluated. It is important to note while assessing the strategy, that the evaluation should be proportionate to the programme. This means that the time and resources allocated to the evaluation should be on the same scale as the initiative.

Generally speaking, there are three types of evaluation: process, impact and economic. Process evaluation is focussed on how the programme was run, to understand what worked well and what worked less well; impact evaluation is focussed on changes the programme generated in the area it was implemented; economic evaluation is focussed on the costs/benefits of the project[11].

A progressive scale for evaluation has been proposed. The three types of evaluation above aim to increase knowledge of an initiative from different perspectives, and could be merged into a unified model[12]. Such a model contains five levels:

1) the intervention and its rationale are described in a logical and convincing way;
2) data collected demonstrates whether the desired outcomes were met in the target area;
3) data collected demonstrates that the measured improvement is definitely related to the specific initiative;
4) data collected shows the initiative strategy worked in at least two independent cases;
5) finally, there is a procedure in place to ensure continued positive results from further implementation of similar initiatives.

[11] The Magenta Book. Guidance for evaluation. HM Treasury. April 2011

[12] Puttick, P. and Ludlow, J. (2012) 'Standards of evidence for impact investing'. Nesta

A process evaluation fulfils the requirements of level one, an impact evaluation progresses through levels two and three, while an economic evaluation reaches level four. The progression from one level to the next increases the evidence collected and confidence in the final outcome. Considering the resources, nature and number of people involved in the HFF, we recommend the evaluation to be a mixture of process and impact, in particular complying with levels one, two and three of the proposed ladder.

The structure of the evaluation should be planned at the onset. To obtain an evaluation that is effective in explaining the results obtained from the implementation of a programme, it is crucial to establish the evaluation structure early on in the process. A number of aspects should be considered and they include:

- establishing the users of the evaluation itself and how the results will be disseminated;
- building a logic model of the intervention;
- asking specific questions, keeping the focus on three or four key aspects;
- identifying a suitable counterfactual population, to try to tease out the real effect of the programme from other factors occurring at the same time;
- recognizing enablers and barriers in a clear and formal way;
- deciding what type of data is more appropriate to judge the intervention and how to capture it;
- assessing the available information and decide what new data need to be collected.

Care should be taken to include within the evaluation the wider effects and unintended consequences of the project. It is important to make space for an estimation of additional positive or negative consequences, beyond the desired outcomes, that may result from an initiative. These consequences may be directly relevant to the people involved in the programme, but may also be experienced by other people living in the same or neighbouring areas. Examples of these include: displacement, substitution, leakage and deadweight. Displacement refers to the possibility that positive outcomes generated by the project are offset by negative outcomes, generated by the same project, elsewhere. Substitution refers to the possibility that the effects of the initiative on a particular group only occur at the expense of other groups. Leakage indicates whether the initiative benefited others outside of the target group. Finally, deadweight measures how much of the initiative outcomes would have occurred anyway, without the support of the project. We recommend that the deadweight, and possibly leakage, associated with the Healthy Fenland Fund are estimated during the evaluation.

Different frameworks can be used according to the interests of the evaluators. One of the first steps when planning an evaluation is to build a logic model; however, this can vary according to the aspects of the project considered most important. Some common frameworks that can be used include: theory-based evaluation, theory of change evaluation and realistic evaluation. Theory-based evaluation is

focussed on why and under what condition a specific change was observed. In this case, starting with the rationale of the intervention then observing the final outcomes, the evaluators challenge each assumption to see if it matched the observed outcomes. A theory of change evaluation is focussed on the links between the different parts of the programme. Here, the evaluators explore the combination of factors that created the observed outcomes, to enable a map to be drawn to demonstrate which factors at which level combined to produce the final outcome. Finally, a realistic evaluation is focussed on capturing the triggers the programme pulled to change certain behaviours, paying particular attention to the context within which the intervention occurred. Here, the evaluators want to understand the parts of the programme that worked best.

A number of methods to evaluate projects have been developed, each identifying important aspects to consider. In each case, the actual number of variables captured differs, but many, including the quantity and quality of the interventions, are common to most. For example, Steckler and Linnan (2002)[13] identified six priority areas:

- the context, i.e., local factors that influence implementation;
- the fidelity, i.e., the extent to which the intervention is delivered as conceived;
- the dose delivered, i.e., the level of intervention offered to participants;
- the dose received, i.e., the extent of participants' engagement in the intervention;
- reach and recruitment.

A second example is the Oxford Implementation Index[14] that is focused on four domains:

- the intervention design, i.e., whether core components are clearly specified;
- the delivery by practitioners, i.e., staff qualifications, the quality and use of materials, dosage administered;
- the uptake by participants;
- contextual factors.

A simpler approach, focussed on implementation, mechanism of impact and context, has recently been proposed. The MRC aimed to establish clear guidelines on how to evaluate complex interventions and published their conclusions in 2018[15]. In this approach, heavily based on a realistic evaluation, the first domain

[13] Steckler, A. and Linnan, L. (2002) Process evaluation for public health interventions and research, Jossey-Bass.

[14] Montgomery, P., Underhill, K., Gardner, F., Operario, D. and Mayo-Wilson, E. (2013b) The Oxford Implementation Index: a new tool for incorporating implementation data into systematic reviews and meta-analyses, *Journal of Clinical Epidemiology*, 66, 8, 874-882.

[15] Moore, G., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., Moore, L., O'Cathain, A., Tinati, T., Wight, D., Baird, J. 2018. Process evaluation of complex interventions. UK Medical Research Council (MRC) guidance.

(implementation) aims to understand what is delivered and how; the second (mechanism of impact) aims to understand how participants responded to the intervention, testing mediators and identifying unintended consequences; finally, the third domain (context) aims to understand how the obtained outcome was related to the context in which the intervention occurred, to predict whether the same results can be obtained in a different context. We recommend following this last approach, as it seems most flexible, while also able to capture sufficient information. Moreover, aspects such as fidelity and dose delivered appear constant during the HFF grant period, and the programme appears to be on target concerning the people reached.

3.2. Evaluating asset-based community development (ABCD) projects

- The HFF, as an ABCD initiative, is challenging to evaluate, due to its dual nature: community and health.
- A mix of qualitative (such as case studies and focus groups) and quantitative (such as surveys and statistical analysis) methods are recommended for this type of projects.

When deciding what type of strategy to use, the nature of the programme must be considered. As described in section 2.2., the HFF is an ABCD programme in which the community recognises its own needs in terms of health and wellbeing, and develops solutions with the support of local government. As an ABCD initiative, the HFF aims to prevent rather than resolve issues and considers what is already present and working in a community, rather than what is missing. Through mobilisation and participation, people take control and manage their own activities, experiencing positive health and social outcomes as a result. As such, for this type of project three interrelated factors should be considered equally: health (physical and mental) of the individual; community wellbeing, including physical, social and economic environments; and community strength, including leadership, skills, civic participation, community representation.

This multifaceted nature of the HFF makes it difficult to focus the attention of the evaluation. Demonstrating both changes in health outcomes and increased resilience and strength in the community will require multiple levels of evaluation.

Building the logic model is the first step in the evaluation process. A specific model for ABCD initiatives has been developed by Rippon and Hopkins (2015)[16]. It is based on the theory of change framework and is divided into four stages:

[16] Hopkins, T., Rippon, S. 2015. Head, Hands and Heart: asset-based approaches in health care – A review of the conceptual evidence and case studies of asset-based approaches in health, care and wellbeing. The Health Foundation, London.

1. reframing towards assets;
2. recognising assets;
3. mobilising assets;
4. co-producing assets and outcomes.

The first stage takes into account the changes in organisational culture and in individual practice needed to shift towards asset-based approaches. The second stage includes a concerted effort in identifying the assets in the community and building relationships between local people, to create a shared vision for the future. The third stage involves utilising the recognised assets to work together for an agreed purpose. The last stage concerns a true partnership between communities and public services, as an effective strategy to improve health and wellbeing in individuals. Aspects of this model may be used to shape the evaluation for the HFF.

A framework for evaluating ABCD initiatives based on a realistic evaluation has been recently proposed. As previously mentioned, a promising framework to evaluate the HFF is the realistic evaluation approach, which tries to explain "what worked, for whom, in what context" focussing on three domains: context, mechanism and outcome. Translating this for ABCD programmes was not immediately obvious, but Blickem *et al.* (2018)[17] propose using assets as context, methodology as mechanism and then assessing outcome. The individual and collective assets present in a community represent the background against which the initiative occurs; the mechanism of the intervention is the method in which the assets are located and connected; the outcome is the nurturing of positive relationships and the improvement of social networks.

It is challenging to capture changes resulting from ABCD initiatives. Another aspect that has to be considered early when developing an evaluation of an ABCD initiative is that the mechanisms to "measure" its success may not be immediately obvious. An example of an objective measure could be the use of the four indexes, related to wellbeing, annually measured by the Office of National Statistics: life satisfaction; worthwhile (feeling that what one does in life is worthwhile); happiness and anxiety. However, the local nature of ABCD initiatives and/or the limited number of people involved, makes it difficult to relate specific initiatives to any change registered in wellbeing statistics. Furthermore, summarising information through numbers or statistics fails to capture the spirit of ABCD projects. In these initiatives, the focus is on the people and how they connect. The evaluation should, therefore, involve meeting participants in their own environments and hearing their stories and different points of view.

Many different informal and creative methods have been used in collecting data for the evaluation of ABCD initiatives. These include, but are not limited to:

[17] Blickem, C., Dawson, S., Kirk, S., Vassilev, I., Mathieson, A., Harrison, R., Bower, P., Lamb, J. 2018. What is Asset-Based Community Development and How Might It Improve the Health of People With Long-Term Conditions? A Realist Synthesis. SAGE Open, 8(3), 1-13.

interviews, case studies, questionnaires/surveys, focus groups, capturing casual moments, photographs, people mapping and service use mapping. The use of maps and how they change across time is particularly indicative for these initiatives, which aim to connect people in a community and build relationships with the available services.

Complementing stories with numbers and statistics enhances the evaluation of an initiative. Focussing attention solely on stories, however, may give an impression of outcomes that is too subjective. Time and resources available may not allow sufficient interviews to be conducted with people from the area not connected to the programme or with people from different areas with similar characteristics, creating a lack of a control group, detrimental to the validity of the evaluation. Moreover, the use of numbers and statistics may be crucial to give a representative view of the entire initiative.

The commonly used evaluation techniques for ABCD initiatives have been identified in a systematic review of the literature[18]. This review demonstrated that, in the majority of cases (ten out of sixteen), a mixture of qualitative and quantitative methods were applied, even if in two cases the quantitative information was minimal. In two cases, the evaluation included surveys to collect data on health behaviour or engagement pattern, while only one case had health statistics from census incorporated. As previously mentioned, the use of statistics from census in ABCD initiatives is not always straightforward, due to the number and groups of people involved. Surveys, interviews and questionnaires are often conducted to capture a more representative group of the target population.

Paramount importance must be given to the context in which the initiative occurs. The approach must be tailored to the needs and characteristics of the target area and the results must be put into context within that specific area. What works well in one area, may not necessarily work as well in another area, and this can be better understood by recognising the associated statistics for example population demographics, rurality and wealth. We recommend a mix of creative methods and statistics, suited to the Fenland population, to obtain a clear overview of the HFF in the evaluation.

A final element to consider when evaluating ABCD initiatives is that it takes time to see change. While some programmes can deliver visible changes in a short time frame, this is often not the case for ABCD initiatives. Due to their intrinsic nature, focussing on what already exists in a local area and building relationships between people and services, it could take years before tangible outcomes, particularly changes to local health statistics, can be measured. Therefore, when conducting an evaluation, care must be paid in setting reasonable questions and outcomes at the outset, to ensure the true achievements of the initiative can be highlighted.

[18] Cassetti, V., Powell, K., Barnes, A., Sanders, T. 2019. A systematic scoping review of asset-based approaches to promote health in communities: development of a framework. Global Health Promotion. In Press.

4. Case studies: evaluations of ABCD initiatives in South-East England

- A mixture of qualitative (interviews, case studies, reflective diaries and people mapping) and quantitative (surveys) methods were used to evaluate real-world ABCD initiatives.
- Evaluating individuals in the same region but distinct from those involved in the initiative is a valuable tool for measuring the impact of an initiative on the population reached.
- An economic analysis should focus on social value gained and cost savings made by other services.

We conducted a search for asset-based programmes to have first-hand examples of how they are evaluated. To complement the theoretical knowledge acquired from the literature review, we sought and identified several organisations/ charities running comparable initiatives. We contacted them to obtain two sets of information: the framework or model used during their evaluations, in particular for health-focused projects, and lessons learnt from conducting those evaluations.

As a result, we managed to obtain the final evaluations of two initiatives run in South-East England. "Resilient Together" and "Fit as a Fiddle" are two distinct initiatives sharing the same ABCD approach, therefore their evaluations were a rich source of information when exploring evaluation methods for the HFF.

4.1 Resilient Together (Mind)

The approach and target population make the "Resilient Together" (RT) initiative and its evaluation particularly relevant. RT was a three-year ABCD initiative, delivered by Cambridgeshire, Peterborough and South Lincolnshire (CPSL) Mind with funding from CCC, aimed at improving wellbeing and resilience in two specific areas of Cambridgeshire: Southern Fringe (Trumpington) of Cambridge and Wisbech in Fenland[19]. CPSL Mind worked with independent researchers from Associate Development Solutions Ltd to complete an evaluation report for RT.

During the evaluation, a range of methods, both qualitative and quantitative, were used to probe the outcomes of the initiative. These methods include: surveys, interviews, case studies, reflective diaries and people mapping. Residents in the different regions, both those taking part and those not involved in the project, RT staff and local professionals external to the RT team were all included to consider the different points of view.

[19] Key findings of the final evaluation of Resilient Together project- highlight report 2019

A "community wellbeing and resilience survey" was used in Year 1 and Year 3. Created at the beginning of the initiative to obtain information about the wellbeing of the respondents, it was administered to participants at different stages of the programme to evaluate changes across time. Responses to the same survey were also collected from residents in the area not taking part in RT to try to understand the actual impact of participation on individuals involved.

Twelve 30-60 minutes interviews were conducted with different stakeholders. Four community residents, four RT team members and four local professionals external to RT were asked about their experiences and opinions concerning the project, to consider all perspectives. The interviews were tailored to the different stakeholders and had a semi-structured nature, to balance the need for focusing the interest of the respondent while giving space for the person to express freely their point of view.

Case studies were collected across the years. Motivation, activities and results for individual residents and community groups were recorded to show the variety of interests supported by the project.

Reflective diaries, kept by RT team members, were included. The daily experiences recorded at Year 1 (n=2) and Year 3 (n=1) were sifted and considered to document progress, areas of success, barriers encountered and actions taken.

"People maps" were created by an illustrator. To portray the connections between people, a map for Trumpington and a map for Wisbech were drawn at the beginning of the initiative and reviewed at 6, 9 and 12 months, to show the progress made and include the new associations.

The key message from the evaluation is the positive effect of ABCD initiatives on mental health and resilience. Increasing meaningful social connections in the community boosts confidence allowing residents to identify and use their community assets. The involvement in the community and the reduction in isolation and loneliness improves mental health and wellbeing of participants, while also raising awareness of the problem.

4.2. Fit as a Fiddle (Age UK)

Although on a much bigger scale, the desired outcomes and ABCD approach of Fit as a Fiddle are comparable to the HFF. Fit as a Fiddle was a national programme run between 2007-2012 by Age UK with funding from the Big Lottery Fund. The programme was delivered across nine English regions with two national projects and 24 regional projects. The main aim of the programme was to improve healthy eating, levels of physical activity and mental wellbeing in people over 50 through locally led projects.

An evaluation report was prepared by a team based at Ecorys and the Centre for Social Gerontology, Keele University. Research was undertaken between October 2010 and August 2012 during the second half of the programme's funding period. A mixture of desk-based research and primary research methods were used

to provide quantitative and qualitative evidence to assess the impact of the programme and interventions at national and regional level. Each region was evaluated separately then combined to give an overall evaluation.

A paper-based survey was completed by participants at the beginning, end and three months after their involvement with the programme. Surveys were adapted from those used in wider wellbeing evaluations, such as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWS), with additional questions about physical activity and healthy eating specific to Fit as a Fiddle's desired outcomes. A very small proportion of participants completed the surveys (881 out of approximately 375,000) and there was a marked decrease in the number of respondents for the three-month follow up survey. Statistical significance was calculated for responses and when all regions were considered together there were statistically significant increases in physical and mental health. Due to the relatively small number of responses it is difficult to determine whether this data effectively captures the experiences of participants as a whole.

A web- or paper-based survey was also completed by regional coordinators, project coordinators, volunteers and partner organisations. These surveys covered a range of themes including recruitment of participants, management of volunteers, volunteering activities conducted, e.g. mentoring, impact on volunteers and benefits to other organisations.

Case studies were used to add further detail to the quantitative data. One study from each of the 9 regions was completed and another 11 were selected to cover the variety of activities supported by the programme at a national level. The case studies enabled evaluators to hear stories from participants and project leaders about how projects had actually changed people's lives. While this qualitative evidence is essential to enable an understanding of the impact of the project on an individual level, this data is not statistically representative and the opinions of individuals may not reflect the views of the groups as a whole.

Interviews with both participants and stakeholders were conducted. 38 in-depth participant interviews were conducted by a team of specially trained community evaluators. Interviews were also conducted with key stakeholders including Age UK staff, volunteers, partner organisations, academic experts, funders and policy makers. These interviews were designed to assess the impact on each group involved in the Fit as a Fiddle programme and provide further detail on the administrative processes surrounding implementation of the programme.

Analysis of Age UK monitoring data enabled a full evaluation of the target population and characteristics of participants involved. Characteristics evaluated included age, gender, ethnic group and health status. A series of postcode maps showing beneficiary locations was also prepared.

Finally, an analysis of economic value was conducted. While a full cost benefit analysis was beyond the scope of the evaluation, evaluators followed HM Treasury guidelines when evaluating 'value for money' of the programme. Data collected during the projects enabled an exploration of the relationship between financial inputs and resulting outcomes. The cost per participant was calculated to assess the

efficiency of the programme. When considering the benefits of the programme, evaluators focussed on costs avoided as a result of the programme, for example cost savings made by other service providers due to reduced demand for services. Changes to the number of GP visits was investigated in one region. The social value of certain projects was assessed by ascribing financial values to social outcomes. The value from volunteering was explored through calculating the number of hours volunteers spent on projects and ascribing the financial value using an approach set out by Volunteering England[20]. An important point considered was whether the funded activities would have occurred without the support of Fit as a Fiddle, in line with point 3 on the progressive evaluation scale outlined in section 3.1.

There were some limitations to this evaluation. Data in this report was often gathered retrospectively and the counterfactual situation, what would have happened without the programme, has not been fully explored. A more comprehensive evaluation would also investigate changes within a population not involved in the programme as in the evaluation of RT (section 4.1). Email correspondence with the London Portfolio coordinator, Alice Westlake, provided insight into some of the challenges surrounding the evaluation of Fit as a Fiddle in London. The key issues raised were resistance from some participants to complete surveys, compounded by lack of time and resource on the part of local project officers. The fact that evaluators were removed from participants also meant it was difficult to ensure surveys were completed correctly. A high proportion of the groups were from disadvantaged backgrounds with many non-native English speakers making completion of surveys more of a challenge. Long term projects (>3 months) were also more difficult to assess using the surveys as projects had started before the evaluation began, meaning it was not possible to conduct a survey at the beginning of a project and assess improvements to health. It was suggested that, at least in London, face-to-face meetings between evaluators and project leaders/participants were a more effective way of collecting information than surveys.

4.3. Lessons learnt from case studies

The main lesson learnt from the evaluation of RT and Fit as a Fiddle is that a variety of methods are needed to capture data on a multifaceted ABCD programme. Quantitative surveys enable a relatively large amount of data to be gathered but do not capture individual experiences. Qualitative case studies and interviews provide a method for exploring individual outcomes in detail but may not reflect the wider views of other individuals involved. Incorporating both aspects into an evaluation framework is necessary to provide a full picture of the outcomes, significance and richness of an initiative.

Another lesson is the importance of including a comparable external population. Data about the general population in an area would help to extrapolate

[20] For an example see: https://www.volunteerscotland.net/media/254583/guidance_-_calculating_the_economic_value_of_your_volunteers.pdf

the real impact of an initiative on those participating. The evaluators of RT completed surveys with residents not taking part in RT but living in the same area enabling changes observed to be more readily linked to the intervention.

There were some key differences between the evaluations of RT and Fit as a Fiddle. Both projects outsourced the evaluation with slight differences in approach depending on the company chosen. The RT evaluation, by Associate Development Solutions ltd, focussed mainly on case studies and alternative methods of evaluation such as ‘people mapping’. There was a poor use of statistical analysis for some data and low ‘n’ numbers in some techniques, e.g. reflective diaries from only two individuals, leading to an overestimation of the success of the project. The Fit as a Fiddle evaluation, by Ecorys, focussed more heavily on numbers and statistics based on responses to surveys but the resistance to fill out surveys resulted in a relatively low number of responses.

5. Pilot evaluation of the HFF

Based on the information gathered through literature reviews and case studies, we wanted to pilot some of the evaluation techniques we had identified to see whether these would be effective methods to evaluate the HFF. We therefore developed a **questionnaire** and ran **focus groups** with individuals supported by the HFF to determine whether these would be appropriate methods of evaluation for these individuals.

5.1. Questionnaire

- Taking part in activities supported by the HFF increases the sense of belonging to the community and the ability to actively seek solutions to problems.
- Word of mouth, bring a buddy and advertisements in the local newspaper are the main ways participants learn about the existence of the groups and of the HFF.

We developed a questionnaire to assess the outcomes from the activities supported by the HFF. We wanted to collect feedback on the experiences of participants and group leaders involved in HFF-supported activities. We wanted to involve both participants and group leaders/committee members, to capture their different perspectives. We aimed to develop a comprehensive but short questionnaire to avoid discouraging people from filling it in due to its length. Here we discuss the development of the questionnaire and the preliminary data collected.

5.1.1. Development of the questionnaire

The questionnaire was broadly divided into four sections. Here we explain its rationale, Appendix 7.1 shows it in its entirety.

The first section consisted of general demographic questions. The demographic questions (including age group, gender and ethnicity) were mostly aimed at assessing the composition of the sample population. We also included questions about the role of the individual within the group and the duration of participation in the activity.

The second section aimed at evaluating the mental wellbeing of the respondents. As the questionnaire was not completed by participants before they were involved in HFF-supported activities we could not directly assess changes to mental wellbeing. However, we wanted to provide a snapshot of the current state of mental wellbeing of people participating in the activities and test whether this would be an effective measure in the future. During our research we found that most evaluations of mental wellbeing were based on a variation of the Warwick-Edinburgh

Mental Wellbeing Scale (WEMWS)[21]. As such, this section of our questionnaire follows the short WEMWS and consists of seven statements regarding positive thoughts and feelings. For each statement, five options are proposed to the respondents and a score is associated with each option: Strongly Agree=5; Agree=4; Neither Agree Nor Disagree=3; Disagree=2; Strongly Disagree=1. A sum of the scores from each statement gives an indication of the metal wellbeing of the respondent; this value can range between seven and thirty-five with high scores associated with good mental wellbeing. Scores can then be easily compared between individuals at different timepoints or between different groups of people, even those distinct from the current evaluation.

The third section probed deeper into the desired community and health outcomes of the HFF. The statements included in this section aimed to evaluate how the respondents perceived aspects of their health and social behaviour, after taking part in activities supported by the HFF. We followed-up some of the statements with open questions, to understand what they think they have gained from participation. To go deeper into the community aspect of the initiative and assess if better community connectedness is perceived, we included statements about self-confidence and actively seeking solutions to solve problems; while, to assess the health benefits, we included statements on aspects such as awareness of physical and mental needs, as well as changes to GP visits.

Finally, the fourth section consisted of three open questions about specific aspects of the HFF itself. Here, we were interested in understanding how the respondents learnt both about the group they were involved in and about the possibility of being supported by the HFF. We also wanted to understand how common it was for other family members to also participate in groups/activities supported by the HFF.

5.1.2. Results from the questionnaire

Twenty-eight questionnaires were completed and returned for consideration. These were completed by people participating in groups based in Wisbech (15 questionnaires) and in March (13 questionnaires) and included both group leaders/committee members and participants. Here, we present the most pertinent results from the analysis, further results are shown in Appendix 7.2.

Figure 1 summarises the general characteristics of the respondents. The number of group leaders to participants are well balanced, with 48% group leaders and 52% participants (Figure 1A). There was close to an even number of males (44%) and females (55%) (Figure 1B). Most respondents were older individuals, with only around 20% of respondents below 50 years (Figure 1C). With regards to this imbalance, it should be noted that these questionnaires were returned during focus groups run during the day, which may not have been convenient for working people

[21] Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., Stewart-Brown, S. 2007. The Warwick-Edinburgh Mental Wellbeing Scale (WEMWS): development and UK validation. Health and Quality of Life. 5, 63

or those with families. The final pie chart (Figure 1D) shows the length of participation in HFF-supported activities. Both short- and long-term memberships of groups are represented in the responses.

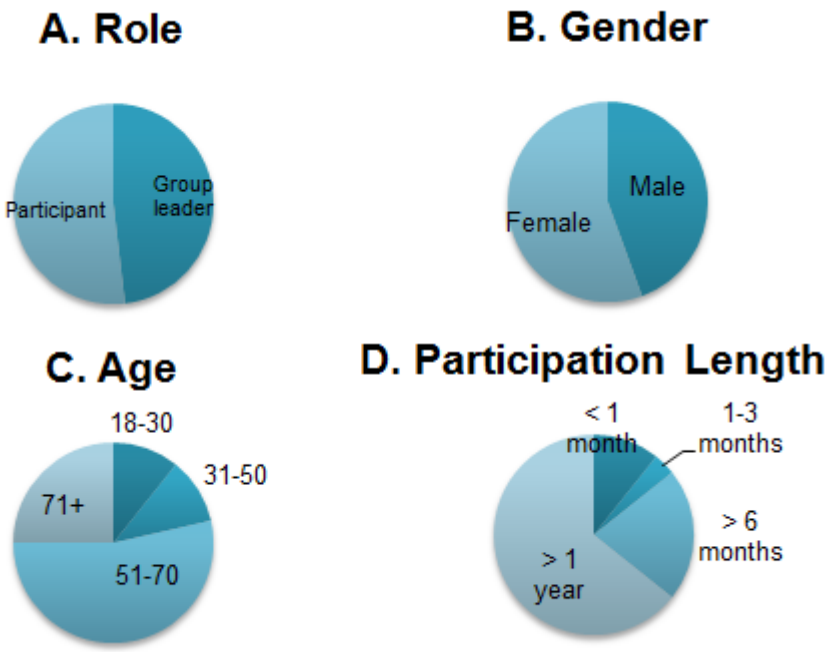


Figure 1. General characteristics of the respondents to the HFF questionnaire.

Results from the WEMWS illustrate good mental health on average for the respondents (Figure 2A). No significant difference is observed between Wisbech and March. No firm conclusions can be drawn on changes to mental wellbeing from prior to being involved in HFF-supported activities as we do not have that data. However, we made use of statistics collected by the Office for National Statistics (ONS) to gauge an idea about the wellbeing of Fenland residents in general. In fact, the ONS annually collects information about life satisfaction, worthiness, happiness and anxiety of populations in the UK. The question asked, in each case, is “On a scale from 1 to 10 how satisfied/worthy/happy/anxious were you yesterday?”, where high marks indicate high levels of satisfaction, worthiness, happiness and anxiety. Figure 2B depicts the results obtained for the Fenland district in the last 8 years. It is worth noting that these results show a picture similar to the one obtained from our questionnaire, suggesting that our sample population is a good representation of the Fenland as a whole. In fact, mapping our results on a scale from 1 to 10 gives an average value of 7.8 for the district. Moreover, the data obtained from these responses can be used as a baseline for comparison with follow-up questionnaires.

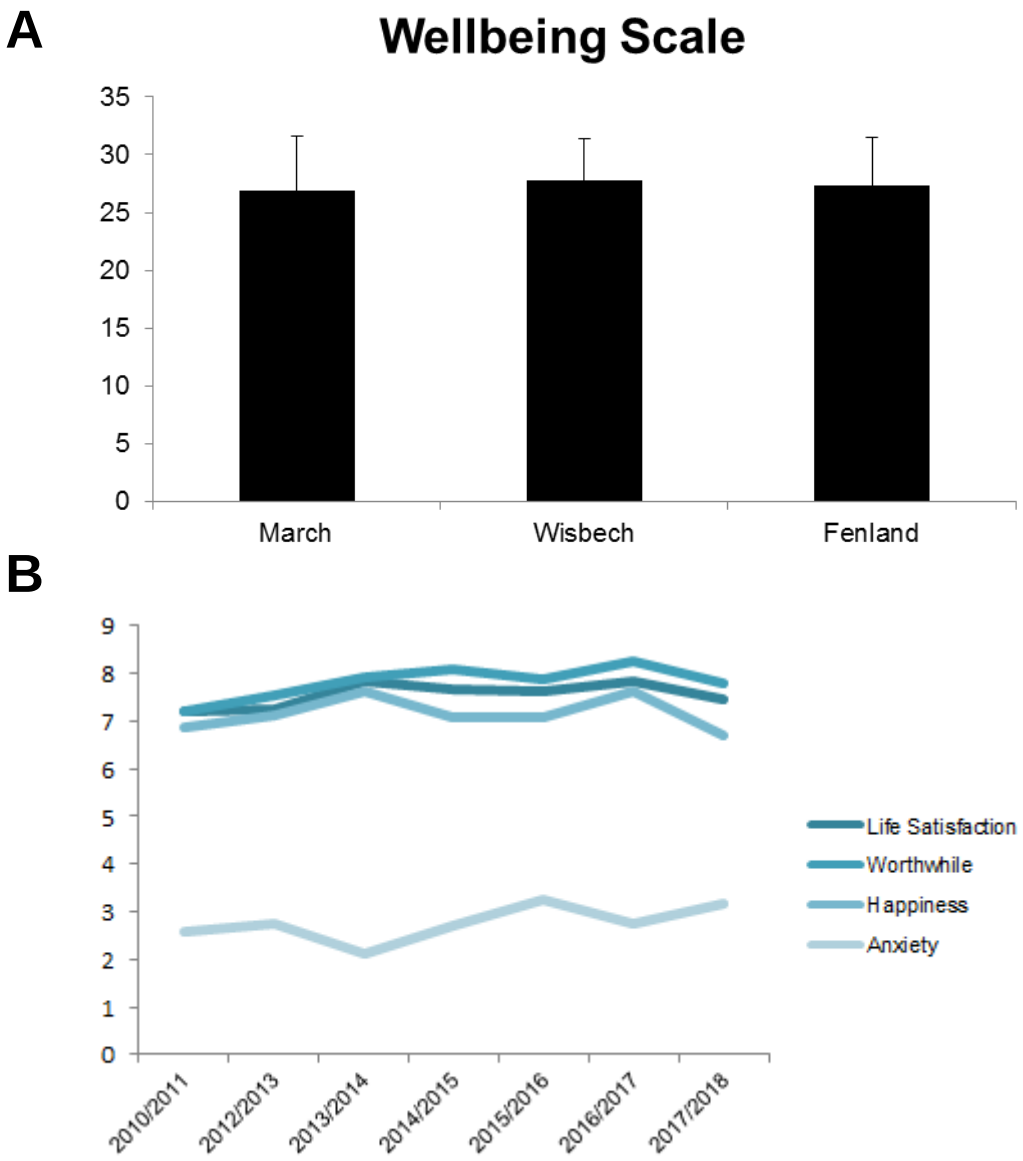


Figure 2. Assessing wellbeing in Fenland. A. *WEMWS test results for respondents in Wisbech and March* ***B.*** *Life Satisfaction, Worthwhile, Happiness and Anxiety in Fenland, according to data collected by the ONS.*

Overall the responses highlight strikingly positive effects on increasing the sense of belonging to the community. 97% of the participants agreed or strongly agreed with the fact that participating in activities supported by the HFF made them feel more connected to the community, as shown in Figure 3A. A positive consensus was also observed for the statement "I can identify concerns within my community and consider solutions", with 78% agreeing (Figure 3B).

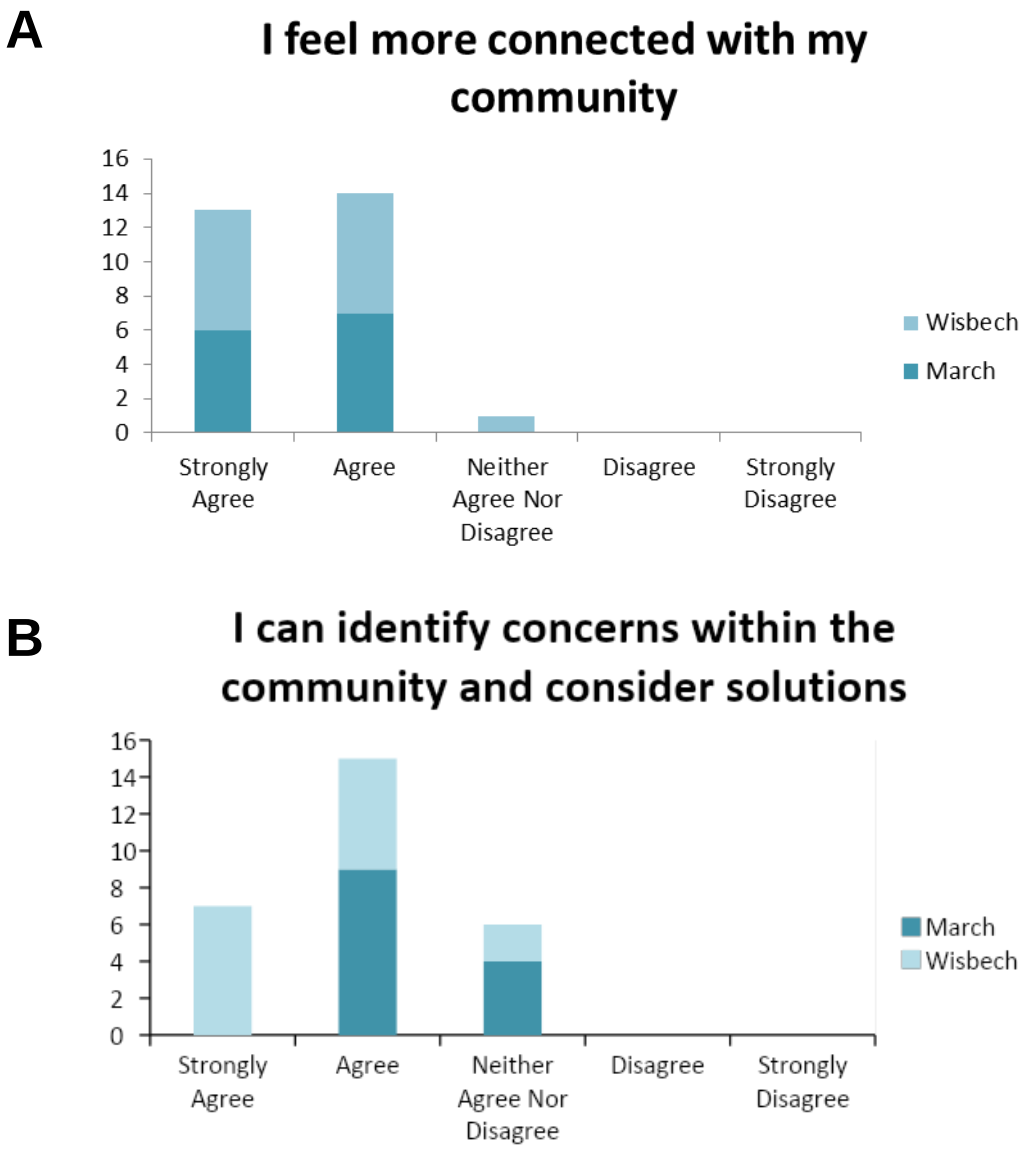


Figure 3. Attitudes towards the community by questionnaire respondents.

Perception of the health benefits is slightly more mixed. Respondents recognise positive effects on their health and well-being, agreeing with being more active (70%, Figure 4A) and more aware of their mental and physical health needs (58%, Figure 4B), as well as highlighting higher self-confidence and improved skills, as 68% agree in both cases (Figure 4C and 4D). However, there are no perceived effects to changes to use of services: for example 65% of respondents neither agreed or disagreed with the statement "The number of times I visited my GP has decreased". A potential beneficial question to include in future surveys would be 'What does healthy mean to you?' to help guide responses and understand whether people's responses change over the duration of their participation in the group.

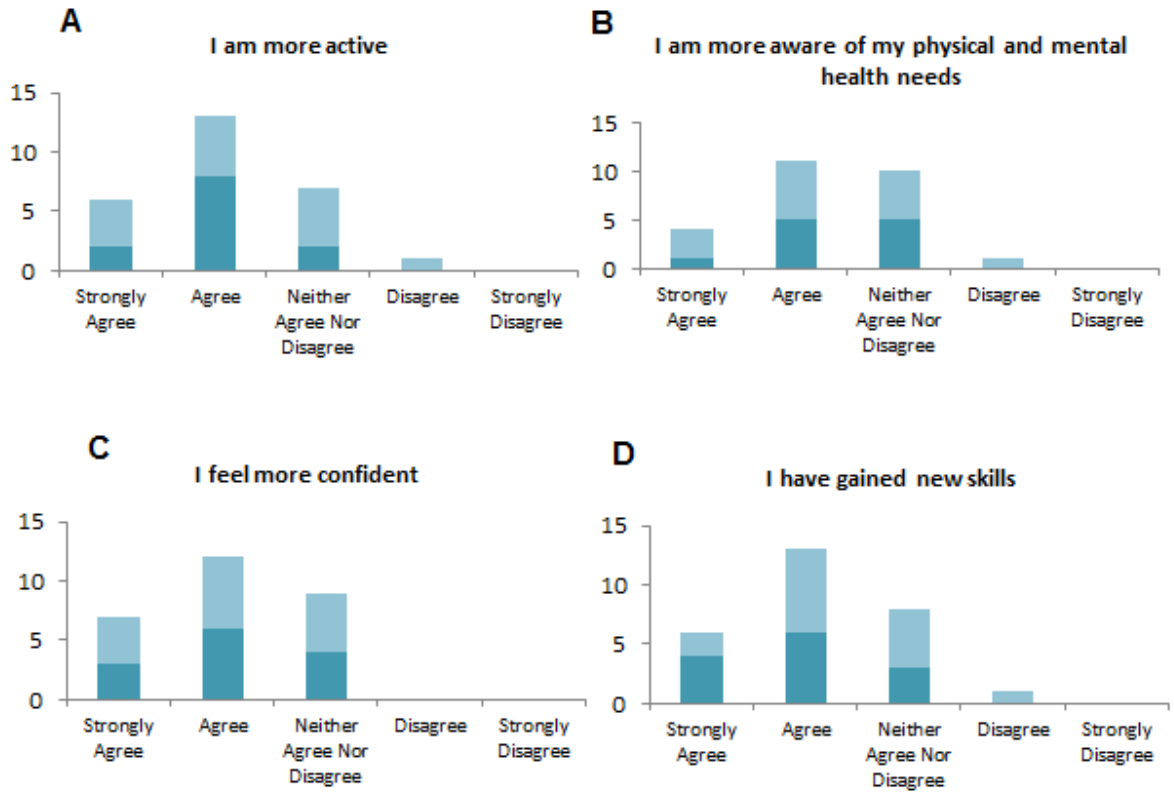


Figure 4. Attitudes towards health and wellbeing by questionnaire respondents. *Light blue columns refer to Wisbech, dark blue columns refer to March.*

People learnt about the existence of the group from three main sources: word of mouth, bring a buddy, advertisement in the local newspaper (Figure 5). When categorising responses to the open question on how individuals heard about the group they are part of, we differentiate between “word of mouth” and “bring a buddy” mainly through whether an individual heard through someone external to the group or whether the individual was brought into a group by a friend. Only one person mentioned social media (categorised here as “Others”), which may reflect the higher average age of respondents but seems pertinent as it mirrors the low level of engagement with HFF social media platforms.

Figure 5. How participants learnt about the group.

"Word of mouth" together with local authorities were the most common responses from group leaders/committee members, when asked how they learned about the HFF (Figure 6). This is in agreement with the lack of engagement with HFF social media platforms by the target population, and may encourage the HFF administrative team to think about additional ways to reach potential beneficiaries. Interestingly, some of the participants of groups who are now self-sustaining following initial support from the HFF stated they had 'only heard about [the HFF] today'. This fits well with the aims of the HFF as it demonstrates "empowerment" of the local communities, addressing their needs successfully and taking ownership of the results.

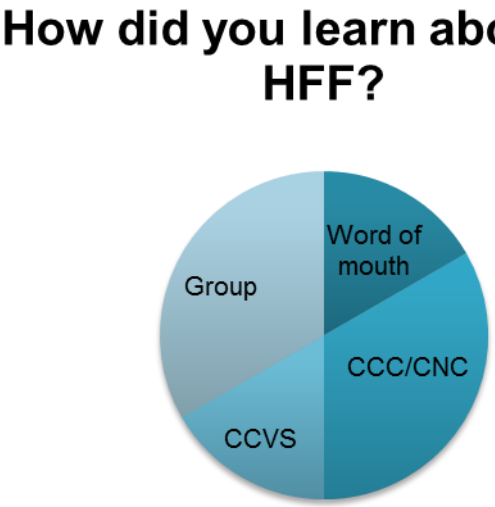


Figure 6. How committee members learnt about the HFF.

5.2. Focus groups

- Around thirty people participated in four focus groups in Wisbech and March.
- The main motivations to get involved in HFF-supported groups were interests or personal experiences (group leaders) and to increase their social circle (participants).
- Health benefits mentioned included both physical (e.g. keeping fit through playing sports) and mental (e.g. emotional support from the group).
- An improved sense of community was recognised by many attendees with a particular sense of reward felt when giving back to the community.
- Feedback on the questionnaire suggested it is currently too generic and needs more open questions, tailored to the different characteristics of the groups.

We organised and ran four focus groups across Fenland. Two in Wisbech on Thursday 4th of July 2019, facilitated by Brigitte McCormack, and two in March on Saturday 6th of July 2019, facilitated by Kelly Gilders. Both facilitators work for Everyone Health and have experience working with communities in Fenland. The facilitator topic guide is attached in Appendix 7.3. Here, we report the key points from discussions concerning the motivation of individuals to participate in HFF-supported activities, the health and community benefits perceived and the feedback on the questionnaire.

5.2.1. Participants

Four focus groups were attended by around thirty individuals, both group leaders/committee members and participants involved in a range of activities supported by the HFF. Some individuals did not complete a questionnaire but did attend the focus group. Most of this set of participants were from the migrant community who may not have sufficient skills in written English or did not feel confident enough to complete the questionnaire. To enable the views and experiences of non-English speakers to be gathered, we suggest that questionnaires are translated into other languages or a translator is present when filling in the questionnaires. The full list of the groups who participated in this pilot evaluation is shown in Appendix 7.4.

5.2.2. Motivation

The motivation for participating in HFF-supported activities differs between group leaders/committee members and participants. Group leaders tend to set up the groups based on personal interest or experiences that they want to share with

other people in the community. Participants are attracted by the social side of the activity, in addition to their personal interests.

Group leaders start groups to channel their interests. Love for a particular sport (such as netball, football, archery or goalball) was channelled into an outcome that could benefit the community. In some cases, the focus was on teaching young people (such as the Manea Strikers Youth Football Club), while in other cases, the focus was creating an environment where everyone of all abilities could enjoy it (such as a walking netball club).

Personal experiences, however, are equally important to starting a new activity. The triggers, in this case, included reasons such as being part of the migrant community or having overcome physical or mental health issues and wanting to help others in the same situation.

Participants often attend a group to improve their social life. Many of the focus group attendees were retired people, dealing with bereavement, solitude or illness, and took part in activities to help their mental wellbeing. As revealed from the questionnaire, they often learnt about the group from the local newspaper or from friends and decided to go along to enjoy the activity and more importantly be part of a community. A common theme established in the discussions is the difficulty in going to a group where all other participants are unknown, therefore often they were helped immensely by going there with a “buddy”.

However, health benefits were mentioned when asked about motivation. Playing a sport to improve health and singing in a choir to help with breathing difficulties were mentioned as reasons for joining a group.

The biggest hindrance to participation is transportation. Difficulties in moving around Fenland are the biggest barrier to the initiative. Moving around Fenland itself is a challenge due to a lack of public transport. Therefore, travelling to the meeting location for a specific time can be difficult, and the needs of caretakers who may need to travel long distances must also be considered. In fact, disabled people have an additional difficulty in participating in activities due to the need for another person to enable them to attend activities, with carers often working set shifts which may be incompatible with the times of the activities.

5.2.3. Health benefits

Unlike in responses to the questionnaire, health benefits from participating in HFF-supported activities are more readily perceived and reported during conversations. Benefits explicitly mentioned include both physical and mental health issues. Concerning physical health benefits, there was a consensus that sports including table tennis, netball, football and goalball increase levels of physical activity. It was appreciated by all focus group attendees that the different skill levels provided by sports clubs enabled a greater diversity of people to participate. Other physical health benefits recognised were improvements in breathing and lung capacity associated with singing, and raised awareness about healthy behaviours

(such as drinking more water or eating healthy snacks) acquired during group sessions.

In agreement with responses from the questionnaire, benefits to mental health and social life remain the most recognised aspects of HFF-supported activities. Being able to take part in a group, getting out on a regular basis and socialising with people are key reasons for improvement in participants' general wellbeing and mental health. "It's like being in a support group, without being in a support group" is how one attendee described being part of their group. Attendees to the focus groups gave value to the fact that many people within the groups shared similar experiences, for example being a widower, enabling people to support each other. Another important aspect of improving mental health touched on in the focus groups is that the activities helped participants in dealing with the anxiety and stress of their daily life.

Finally, participants were also aware and appreciative of the new skills learnt from the groups. Skills gained directly from the activities included singing, playing a sport or learning photography while wider skills included improved memory or management skills.

5.2.4. Community benefits

Participating in activities increases the sense of belonging to the community. To understand more about the improvements in sense of community as suggested from the questionnaire data, we asked focus group attendees about their sense of community as a result of being involved in a HFF-supported activity. Attendees described the fact that the groups allow people of different ages to come together for shared experiences through activities like table tennis, netball or singing.

Value is also given to the educational and social benefits for young people. Many participants described being worried about their children or grandchildren. One attendee suggested young people in Fenland to be in a "lose-lose situation" as they are isolated when at home or may get involved in antisocial behaviour when out of the house. It was proposed that HFF-supported group activities improve their skills, and improve their sense of belonging to the community. An example of how a group in Wisbech tried to improve this sense of community is the initiative "pack a bag", where young participants prepared bags of items to distribute to homeless people in the area.

A second major source of concern regarding young people in Fenland is access to sport for those who are home-schooled. Attendees were appreciative that groups supported by the HFF help keep children active, particularly if they are home-schooled.

The sense of giving back to the community also came out in the focus groups. Many groups take part in charity events, collecting funds for local initiatives (such as fixing the roof of the church or singing in care homes) and feel a sense of reward in helping their community in such a way.

Finally, group leaders were proud of the visibility of certain groups in their area. Group leaders discussed how the popularity of certain activities means they are well recognised in the community and people ask them for information about services in the area, allowing them to work as a hub and enabling a particular sense of reward by giving back to the community.

5.2.5. Feedback on the questionnaire

Many focus group attendees would have preferred more open questions in the questionnaire. A general consensus suggested the need for less structured questions and more space to express personal views and comments. Attendees enjoyed telling their experiences and opinions in the focus group setting and would have preferred a questionnaire more in line with the conversations developed in that context.

Suggestions were put forward on how to improve the current limitations to the questionnaire. In particular, separating physical and mental health improvements was recommended; more child-friendly questions were considered necessary for groups with young people; different sections to the questionnaires depending on the activity were suggested to take into account the variety of activities supported by the HFF; more specific questions should be asked, as many stated the present format is too generic. It was also noted that many participants still have health concerns despite being part of the group so it is important to consider this context when evaluating improvements in health.

Overall, it was considered most suited for participants and older people. Committee members felt that their experiences in setting up the groups were not considered. Groups aimed at younger people would also not suit this type of evaluation.

Most participants would be willing to take part in one-to-one interviews. Attendees appeared to greatly enjoy their involvement in HFF-supported activities and being able to share their experiences and views as part of a focus group. When asked if they would be willing to participate in one-to-one interviews as part of the evaluation process most attendees said they would be and suggested that other members of their group not in attendance would be too. Many attendees expressed a strong interest in following the outcomes of the evaluation, potentially reflecting their appreciation of the HFF initiative.

5.3. Lessons learnt from pilot evaluation

The pilot evaluation enabled us to explore which evaluation techniques would work best for the group leaders/committee members and participants involved in HFF-supported activities. We were also able to gather some preliminary data on whether the desired outcomes of the HFF were being achieved. Our key take home messages from this pilot evaluation are:

1) From questionnaire responses and focus group discussions, there does appear to be improvements in physical and mental health and a stronger sense of community as a result of HFF-supported activities suggesting that the desired outcomes of the HFF are being met, at least in this small sample of individuals.
2) Concerning the impact that participating in HFF-supported activities has on services, we asked in the questionnaire about access to support services and number of visits to the GP, without obtaining constructive responses. However, during the focus groups a strong link between activities and personal health and well-being emerges. Questions about impact on services should be rephrased and potentially allow a longer answer, to clarify the link between the activities and the use of services.
3) Focus groups and interviews appear to be the preferred method of evaluating the HFF from the perspective of the participants. This method also enables a greater sense of individual experiences to be appreciated and a better understanding of the impact on service usage.
4) The questionnaire should be adapted to provide different sections depending on the type of activity being assessed and be more comprehensive when covering physical and mental health needs.
5) There should be separate questionnaires for group leaders and participants.

6. Conclusion and recommendations

Key recommendations:

- Set reasonable objectives, in terms of number of people reached, health improvements for participants and savings for services
- A mixture of quantitative and qualitative data is required
- Consider outsourcing the evaluation
- Emphasis should be put on focus groups and interviews

This report has outlined the background to the HFF, the challenges associated with evaluating ABCD projects and the techniques used to evaluate similar programmes. A pilot evaluation was also conducted to assess which evaluation techniques would be most appropriate when evaluating the HFF.

Here we outline the most significant conclusions from this research.

Framework of the evaluation

The main questions that need to be addressed during the evaluation of the HFF are:

1) Is the HFF working as expected e.g. the grant application process?
2) Is the HFF reaching the target population?
3) Is the HFF achieving the desired outcomes?

To answer these questions, we recommend that the HFF evaluation follow a similar framework to those described in evaluations of RT and Fit as a Fiddle. This framework should include:

- **Questionnaires:** containing open questions tailored to the type of activity being assessed, with separate questionnaires for group leaders and participants. People from the area, but not involved in HFF-supported activities should be considered. Questionnaires should be translated into other languages when required.
- **Focus groups and interviews:** conducted with group leaders and participants involved in HFF-supported activities and also with the administration team behind the HFF.
- **Case studies:** of individuals and of HFF-supported groups as a whole.
- **Indicative economic value analyses:** with a focus on social value, value of volunteering and, if possible, cost savings made by other service providers.

Evaluation team

Due to the small nature of the HFF administration team it is unlikely that there will be sufficient resources ‘in-house’ to complete a thorough evaluation of the HFF.

Furthermore, to obtain the best and most objective results, it is good practice to have a separate team performing the evaluation to the team running the project. In addition to keeping the workload manageable for the personnel, this will avoid conflicts of interest between the administration team and the evaluation of the initiative. Therefore, we recommend that this evaluation is outsourced to an external organisation such as Associate Development Solutions Ltd or Ecorys to ensure a comprehensive and unbiased evaluation. Based on the feedback obtained from the questionnaire and focus groups, a company which focuses on case studies and alternative evaluation methods may be the best approach for the HFF evaluation.

Main recommendations for the evaluation of the HFF

- **Set reasonable outcomes for the area of the initiative.** Two main aspects to take into account from evaluations of similar initiatives are:
    - rural projects can rarely achieve the number of beneficiaries or cost effectiveness that similar projects in urban areas can, and
    - the time needed for these initiatives to show results in terms of changes to service use is greater in rural areas.

  This, for example, could influence the number of people expected to take part in HFF-supported initiatives or the savings expected by other service providers, such as GP surgeries. This should be considered when starting the evaluation through the setting of reasonable expected outcomes from the outset, such as the number of individuals reached, health improvements to individuals and identification of community assets.

- **Identify barriers to the initiative.** Major barriers to the ability of individuals to participate in activities supported by the HFF still remain. The major barriers we identified through discussions in the focus groups and with individuals working in Fenland include both physical aspects (i.e., transportation) and attitude aspects (i.e., reluctance to enter in a group where they do not know anyone). It is certainly a challenge to address all of these barriers, as they are influenced by a wide range of policies and organisations. Some communities within Fenland remain ‘difficult to reach’ such as the migrant communities and transient population. We recommend that a section on the ability for the HFF to engage with these populations at present and in the future is included in the evaluation.

- **Changes to the distribution and content of the questionnaire.** We recommend the questionnaire is distributed to all participants to ensure the highest number of respondents possible as, based on the evaluation of Fit as a Fiddle, it is likely that only a small proportion of people will actually complete them. In section 5, we explained the rationale behind our questionnaire and the feedback we received from focus group attendees. This feedback should be used to improve the information gained from the questionnaire, such as adding more open questions and leaving more space for comments. To encourage people to think more about their health a question stating ‘What does healthy mean to you?’ could be included. We recommend that the

wellbeing scale should remain but that the questionnaire be kept as brief as possible to encourage responses. We also recommend a more thorough monitoring of the newly supported groups, with a questionnaire distributed at the beginning, middle and end of the activity to track the progress in health and wellbeing of the participants. It may also be beneficial to distribute a questionnaire 6 months after the end of the funding period to assess the sustainability of the projects. Language barriers for migrant communities may be overcome through the use of translated questionnaires or the presence of translators.

- **Consider all the different stakeholders.** It is also important to encompass as many different viewpoints as possible. Due to time constraints it was not possible to conduct questionnaires, interviews or focus groups with the administration team or stakeholders involved in the HFF. Based on published literature and case studies, we recommend conducting interviews or focus groups with staff from the CCC, CNC, CCF and any partner organisations as part of the evaluation. This would enable perspectives on the administration processes of the HFF and strategic value to other organisations to be evaluated. Furthermore, emphasis should be put on focus groups conducted in different areas of Fenland and with more groups to ensure the richness and diversity of groups supported by the HFF is highlighted as much as possible. We also recommend that an effort is made to conduct questionnaires, focus groups and/or one-to-one interviews with people in Fenland not involved in the HFF or taking part in supported activities, to assess any differences in terms of health and wellbeing. It would also be beneficial to understand if other people are aware of the HFF, the groups or activities supported and to find out what, if anything, is preventing them from taking part.

- **Conduct one-to-one interviews with participants and group leaders.** These interviews could be conducted to follow up on specific points emerging from the focus groups, such as the health benefits. One important point which emerged from the pilot study is that the health benefits associated with the activities are not always realised when completing a questionnaire, but the awareness of health benefits emerges more clearly during a conversion. As said previously, a question focussing on people's own perceptions of their health and what healthy means in general may enable a more thorough evaluation of changes to health and health-related behaviour.

- **Consider the possibility of including an economic evaluation.** While a pilot economic value analysis was beyond the remit of this project, we suggest that a comprehensive evaluation could include an assessment of the social value gained by the actions of the HFF. A guide to Social Return on Investment has been published by the Cabinet Office and would be a good basis for an assessment of social value[22]. There could also be an investigation into local service use for example changes to the number of GP

[22] Nicholls, J. *et al.* 2012. A guide to Social Return on Investment.

visits by individuals and the community as a whole. While it may be difficult to link any observed changes directly to the HFF, it may give an indication of the health status of the whole population in a particular region, which would be valuable to an evaluation of health and wellbeing initiatives.

Our preliminary data suggests that the desired outcomes of the HFF are being realised. However, there are many further aspects of the HFF that need to be measured, such as changes to local service use, for a comprehensive evaluation to be achieved. This report has outlined the key challenges to consider during an evaluation and suggested an appropriate evaluation method for the HFF.

Acknowledgements

We would like to express our sincere gratitude to CUSPE and Cambridgeshire County Council for promoting and facilitating this project. We would especially like to thank Val Thomas, Joachim Dias and Alan Scott for their valuable advice and guidance during the course of the project. We are also thankful to the members of the Care Network Cambridgeshire team, particularly Julie Jeffryes, who provided us with an in depth understanding of the Healthy Fenland Fund and were instrumental in setting up the focus groups. We would like to thank Ian Manning, Woody Allen, Ivan Annibal, David Bailey, Brigitte McCormack, Kelly Gilders, Alice Westlake and the countless other individuals who have supported us and offered advice during this project. Finally, we would like to thank the focus group participants, without whom the key findings of this project would not have been realised.

7. Appendices

7.1. Questionnaire

Healthy Fenland Fund Group Leader/Participant Questionnaire

Name of group:

Role:
♦Group leader ♦Group participant

Age:
♦ less than 18 ♦18-30 ♦31-50 ♦51-70 ♦more than 71

Gender:
♦Male ♦Female ♦Prefer not to say

Ethnicity (please circle):
Asian / Asian British ♦ Asian / Bangladeshi ♦ Asian/Pakistani ♦ Asian / Indian ♦ Asian / Chinese British ♦Asian / Other Chinese ♦ Asian / Other Asian ♦ Black / Black British ♦ Black / Caribbean ♦ Black / African ♦ Black / Other Black ♦ White / White British ♦ White/Lithuanian ♦ White/Polish ♦ White/Russian ♦ White / Other White ♦ Mixed ♦ Prefer not to say

How long have you been involved in this group:
♦less than 1 month ♦1-3 months ♦3-6 months

♦more than 6 months ♦ more than 1 year

Since getting involved in this group:
Please circle the most appropriate statement

I feel optimistic about the future*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I feel useful*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I feel more relaxed*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I am better at dealing with problems*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I think more clearly*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I am more interested in other people*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I am able to make decisions about my health*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I feel better about myself
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I feel more confident
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I have more energy
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I am more active
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I am more aware of my physical and mental health needs
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree
If so, are you doing anything differently which will benefit your health e.g. changed diet, reduced smoking, increased walking?

I have gained new skills
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree
If yes, could you name them e.g. speaking with others, leading groups?

I feel more connected with my community
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I can identify concerns within the community and consider solutions
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I have found it easier to access support services
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

The number of times I visit my GP has decreased
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

How did you hear about this activity/group? What motivated you to take part?

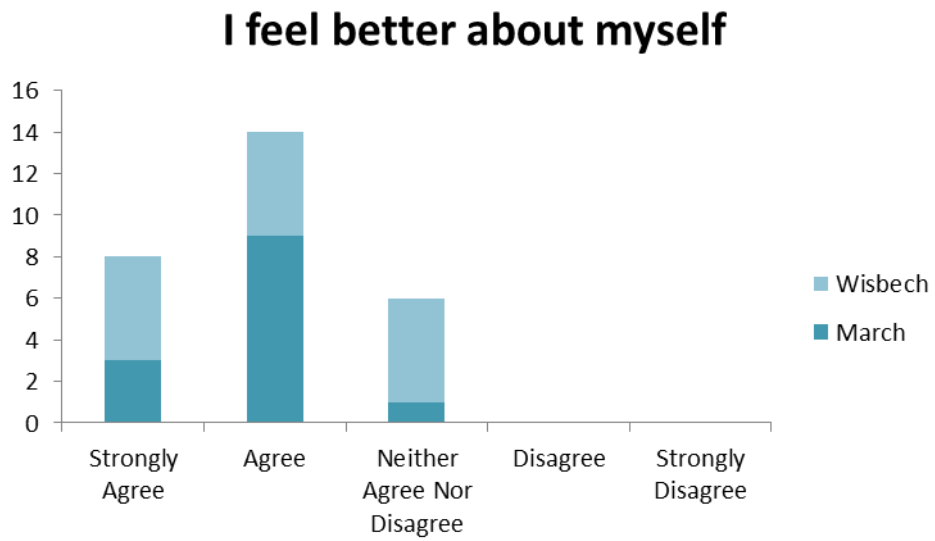
How did you hear about the Healthy Fenland Fund?

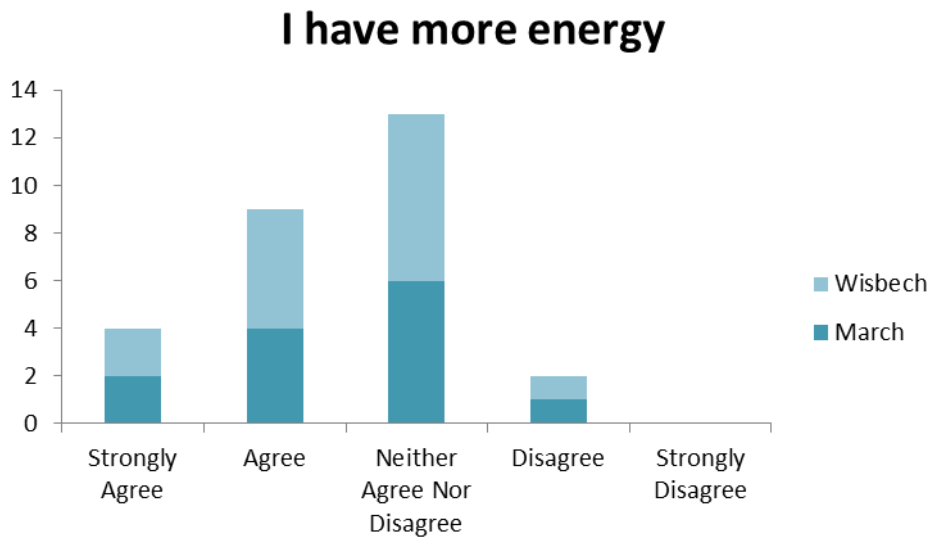
Are any other family members involved in this activity or any activity supported by the Healthy Fenland Fund?

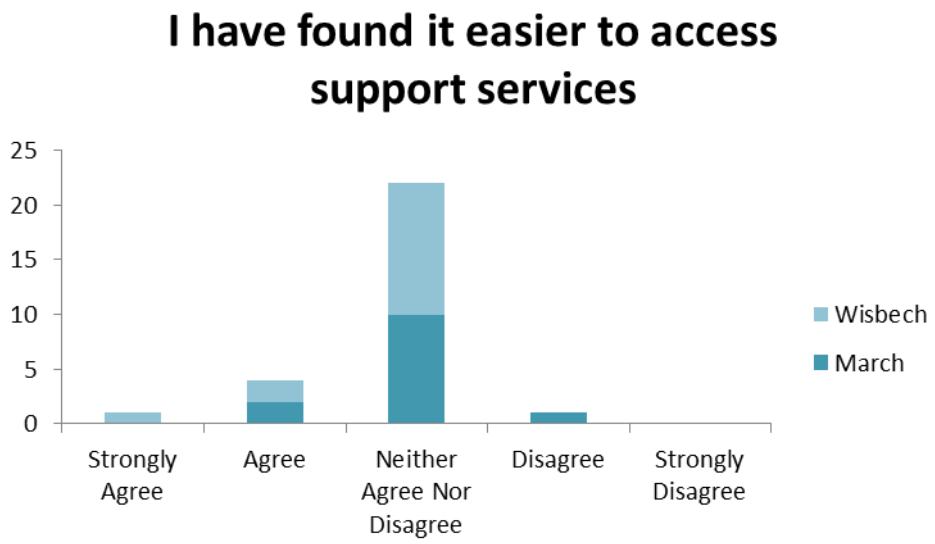
*Statements marked by an asterisk are based on the Short Warwick-Edinburgh Mental Wellbeing Scale

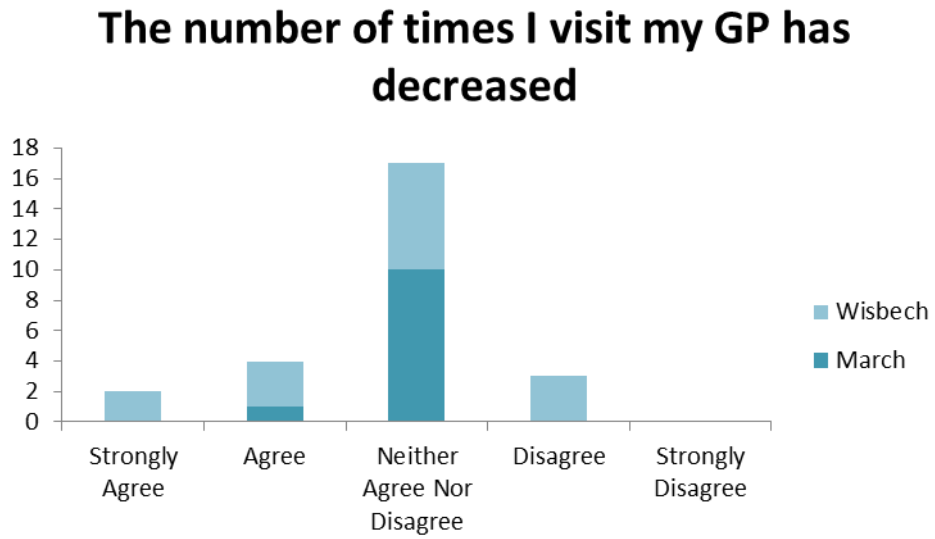
7.2. Supplementary results from HFF questionnaire analysis

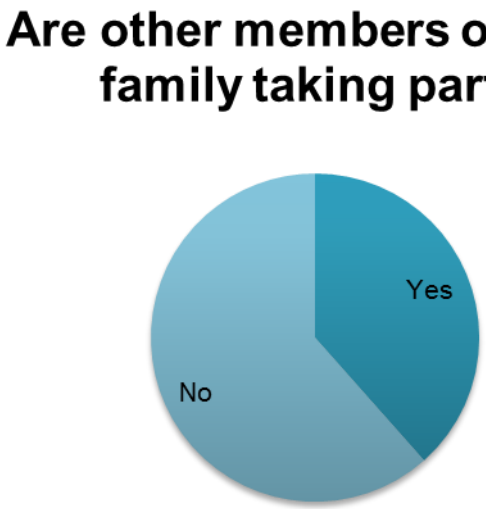
In these plots we report the results to the other questions in the questionnaire.






I have found it easier to access support services
25
20
15
10
5
0
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree
Wisbech
March


The number of times I visit my GP has decreased
18
16
14
12
10
8
6
4
2
0
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree
Wisbech
March


Are other members of your family taking part?
Yes
No

7.3. Focus Group Topic Guide for Facilitators

Aims of the focus groups:

- To assess whether we are able to evaluate through the focus groups if the desired outcomes of the HFF are being met
- To determine which evaluation methods would work best for the participants and project leaders
- To get feedback on the questionnaire

Desired outcomes of the HFF:

- To build strong and resilient communities that are able to identify their own needs and make decisions to address their needs
- Improve mental and physical health and wellbeing

Focus group discussion points:

1. **Ice breaker** (5 mins)
   - Find out who everyone is including name, group they are part of and the best thing about being involved

2. **Motivation** (15 mins)
   - Why did you choose to take part in this activity?
   - What do you want to get out of this activity?
   - Would you have taken part if there wasn't funding?
   - For project leaders: Would you have been able to start this group without the support of the HFF grant and team?

3. **Health behaviours** (10 mins)
   - Has your attitude towards your health changed?
   - Have you changed your lifestyle in any way because of this e.g. diet, activity?

4. **Community** (15 mins)
   - Do you have a stronger sense of community?
   - Has your social life changed?
   - Do view your community/neighbours in a different way?
   - Are you more actively involved in your community e.g. community groups?

5. **Questionnaire** (15 mins)
   - What do you think of the questionnaire? E.g. was it easy or difficult to complete, too long or short.
   - Was there enough space to express your views? Would you prefer more or less open questions?
   - Do you think the questionnaire fully captured your experiences of the HFF?
   - Would you be willing to fill out a questionnaire like this once the funding for your group has ended?

- Are there any other questions you would like to be asked?
- Would you be willing to take part in one-to-one interviews?
- Would the other participants in your group be as willing to take part?

7.4. Groups with committee members and/or participants at the focus groups

Group Name	Activity	Number of participants	Notes
Black panthers	Fun activities for children (including family theatre-with 20 children and 10 mums), arts, drama science.	Attended by a growing number of people (organised a small event for Halloween, a bigger event for Christmas and very successful event for Pancake Day)	The group is now self-sufficient with the money earned selling tickets for events used to buy new equipment.
Click therapy	Teaches people about photography, helping them gain confidence and manage anxiety	Did not specify	Benefits on people with limited social interaction are tangible and rapid
Fen Tigers Goalball club	Goalball (sport for visually impaired and blind people)	Did not specify	Funds from HFF were used to buy essential equipment to play the sport
First Manea Rainbows	Activity group for young girls	23 children between 5 and 7 years old	Funds from HFF were used to buy equipment and secure the venue
Manea Strikers Youth Football Club	Children football teams (ages between 7 and 15)	Did not specify	Funds from HFF were used to increase the number of teams
March can't sing choir	Choir, singing along a karaoke	Around 50 people attend each session, from a pool of around 70, aged between 35 and 80	They perform at charity events and in care homes
Rima's ladies and families	Art clubs in foreign languages	50-60 participants, mainly young people	Many people take part in special events throughout the year (e.g., 200 attendees at the Christmas event)
Whittlesey sports association	Raises awareness of sporting opportunities in town and collates	Did not specify	Organised a fun day, which included 14 sport events and

	details of existing groups		involved between 200 and 400 people
Whittlesey table tennis club	Table tennis	74 people between 7 and 90 years old	4 sessions a week
Whittlesey warriors netball club	Netball	Did not specify	Funds from the HFF help set up a walking netball club
Wisbech PHAB club	Various activities for disabled people	Did not specify	
Wisbech Warblers Group	Singing group	12-15 core members	Perform at various events in the community.
Youths of Fenland	Young people (divided in two groups according to age - 8-13 and 13-18) come together for a range of activities, including crafts and intergenerational events	Did not specify	“Pack a bag” is an example of the activities organised and involved packing bags with food for homeless people in the area.