

New Deal for Communities

The National Evaluation

Research Reports

Improving Access to Health Care: Introducing New Services for NDC Residents

Research Report 54

The Neighbourhood Renewal Unit is currently sponsoring the 2002-2005 national evaluation of New Deal for Communities. This evaluation is being undertaken by a consortium of organisations co-ordinated by the Centre for Regional Economic and Social Research at Sheffield Hallam University. The views expressed in this report do not necessarily reflect those of the Neighbourhood Renewal Unit.

Those wishing to know more about the evaluation should consult the evaluation's web site in the first instance
<http://ndcevaluation.adc.shu.ac.uk/ndcevaluation/home.asp>



Sheffield Hallam University

**Improving Access to Health Care:
Introducing New Services for NDC
Residents**

Research Report 54

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Executive Summary

Background

- Improving access to health care and ensuring equity in provision of health services are priorities for many NDC areas and also core aims for local Primary Care Trusts (PCTs)
- Data from the baseline MORI survey and on the number of general practitioners per 1000 population in NDC areas, show a range across the NDC areas in terms of both actual access and perceived ease of access to general practice. Overall provision is poorer in NDC areas than in the country as a whole, and this combines with other factors that make it difficult for individuals to get to the services that are available, resulting in problematic access
- A key feature of the projects described in this report is that they involve training and/or employing local people to provide additional services in communities with no access or limited access to these types of services previously. The involvement of the local PCTs makes it more likely that successful projects will be rolled out to other areas or mainstreamed within NHS provision.

Objectives

- The projects which aim to improve access to innovative health care services appear to have two types of identified 'objectives.' The first group focuses on the general health objectives which were often a feature of the initial NDC delivery plans. These include objectives to reduce premature mortality and to improve health and social care in the neighbourhood
- Although general health objectives may reflect the aspirations of the NDC, they are more difficult to quantify and are not practical objectives that can be used to measure success particularly in the time frame of this evaluation. Therefore project specific objectives are also needed
- The projects can generally be related back to objectives set in the delivery plans and nationally recognised need.

Partnership

- In most of these projects the key partner agency is the PCT (or other statutory service) which is often also the main driver of the project. Support from both the PCTs and the local health community more widely is essential for initiatives relating to either health service provision or improving access, along with other key partners such as social services where appropriate. As well as the key NHS partners, the projects also have strong links with other community projects within the area - these include those supported by the NDC and other funding bodies
- NDC boundaries are not natural boundaries for the provision of primary care services or community services which are frequently either general practice population based or PCT based. Services are often therefore PCT or practice based with joint or matched funding from the PCT in order to ensure NDC resources are not solely funding a much wider service provision.

Community consultation and involvement

- Access to health care services was identified as an area of concern in every NDC neighbourhood. Poor access to health care services and health care staff was one of the few health issues which were highlighted in the initial NDC community consultations

- The projects bring novel services into the NDC area but these are generally given credibility by being based on similar successful schemes which have been conducted elsewhere
- Involving the community in these health services projects is easier than is the case for many health theme projects. These projects are very large scale often with their own (or shared) premises and therefore have more visibility in the neighbourhood. The communities are kept informed via theme groups and community newsletters. These projects generally have high budgets and they receive good coverage in both of these methods of dissemination.

Mainstreaming

- The obvious mainstreaming agency for most of these projects is the PCT, who in most cases already has involvement in the project and often some level of control over its development. As such the PCTs see these projects as pilots - as an opportunity to try out ideas which, if successful will potentially result in roll out throughout the PCT population. The projects are generally much more geared towards sustained provision and mainstreaming than other health theme projects.

PCT involvement

- Monitoring and evaluation are still generally low priorities for the NDC projects. The same problems persist in terms of a lack of short term, achievable outcomes. But, there is at least a better understanding of the issues with measuring health change, where PCT staff are involved in managing the evaluation. PCT audit processes mean data collection for the projects with a lot of PCT involvement and direction is more thorough and better planned
- Projects related to health care delivery (compared to the rest of the health theme projects) are longer term, larger and more structured. Budgets are generally relatively large and key local and government priorities provide guidance for the projects. Partnership is much more structured due to PCT (or other statutory service e.g. ambulance service) involvement in many of the projects. This in turn leads to more structured plans for evaluation due to the audit requirements of the partner agencies
- Several successful projects have employed experienced health professionals in community settings to work in and with the local community and to train local people to deliver health interventions in a variety of fields. Others involve employing community workers without professional qualifications, such as link workers or patient support workers. These latter projects have generally been more difficult to implement and are still in the piloting or planning stages because the involvement of the health professionals has been key in ensuring local action and leadership
- It was noted in several cases that the NDCs see secondments and joint posts as a strength as the staff are not under the same pressures as those NDC staff who are employed temporarily on short term contracts. Joint posts also feature within other NDC themes. Secondments of NHS employees (and to a lesser extent joint posts), allow the NDCs to recruit experienced NHS professionals who can develop projects within NDC areas
- Employing support workers through the local PCT gives them considerably more professional support, relatively greater job security and access to many other benefits of NHS employment that NDCs, as small, local and time-limited organisations cannot offer e.g. NHS pension arrangements, career development opportunities, workplace crèches etc.

Key messages

- A number of NDC programmes have funded the development of new services that improve access to health care for NDC residents
- Access to health care services is seen as a priority by NDC residents and therefore it is easy to engage them in the issue
- There are a number of areas where local priorities in the NDC communities are matched by NHS policy developments or local PCT priorities and it has been possible to harness local NHS developments to meet NDC objectives
- Objectives relating to general health are often used in combination with more project specific objectives
- Several successful projects have employed experienced health professionals in community settings to work in and with the local community and to train local people to deliver health interventions in a variety of fields
- Evaluation is often guided by the audit requirements of the partner agencies, which questions the control of the mainstream agency over the community led agenda
- Other projects are planned that will involve employing community workers without professional qualifications, such as link workers or patient support workers. These projects have generally been more difficult to implement and are still in the piloting or planning stages
- Support from both PCTs and the local NHS community more widely is essential for initiatives related to health service provision or improving access
- Secondments of NHS employees (and to a lesser extent joint posts), allow the NDCs to recruit experienced NHS professionals who can develop projects within NDC areas. Employing support workers through the local PCT gives them considerably more professional support, relatively greater job security and access to many other benefits of NHS employment that NDCs, as small, local and time-limited organisations cannot offer e.g. NHS pension arrangements, NHS University and career development, workplace crèches etc
- NDC boundaries are not natural boundaries for the provision of primary care services or community services which are frequently either general practice population based or PCT based. Services are often therefore PCT or practice based with joint or matched funding from the PCT in order to ensure NDC resources are not solely funding a much wider service provision.

1. Introduction

Improving access to health care and ensuring equity in provision of NHS services are priorities for many NDC areas and also core aims for local Primary Care Trusts (PCTs).

The wide ranging involvement of local health staff in NDC programmes is reflected in the range of partnerships developed across different sectors, for example in relation to teenage pregnancy prevention, support for teenage parents and drugs prevention and rehabilitation services. These projects have been discussed in previous health theme evaluation reports. (<http://ndcevaluation.adc.shu.ac.uk/ndcevaluation/Reports.asp>)

This report focuses on specific projects that have involved the development of new health care services in NDC areas. The services developed reflect both the priorities of the NDC areas and the priority areas for local PCTs and NHS services. They also reflect the direction of travel outlined in Department of Health policy documents that set out the modernisation agenda (Department of Health, 1997).

2. Background

The “inverse care law” (Tudor Hart, 1971) suggests that the populations most in need of adequate health care may have poorer access for a number of reasons. In particular access to local, easily accessible primary care is often a problem for people living in NDC neighbourhoods. Frequently the GP practices serving the area are located outside the area due to historical problems with crime and violence towards medical staff and the clustering of practices in more affluent areas. In some cases the estates which now house NDC neighbourhoods were built without the inclusion of essential services. The lack of GP provisions results in a lack of other services such as pharmacies, and poor public transport amplifies the problem of access and also means that reaching hospital based services can be challenging for residents without access to a car.

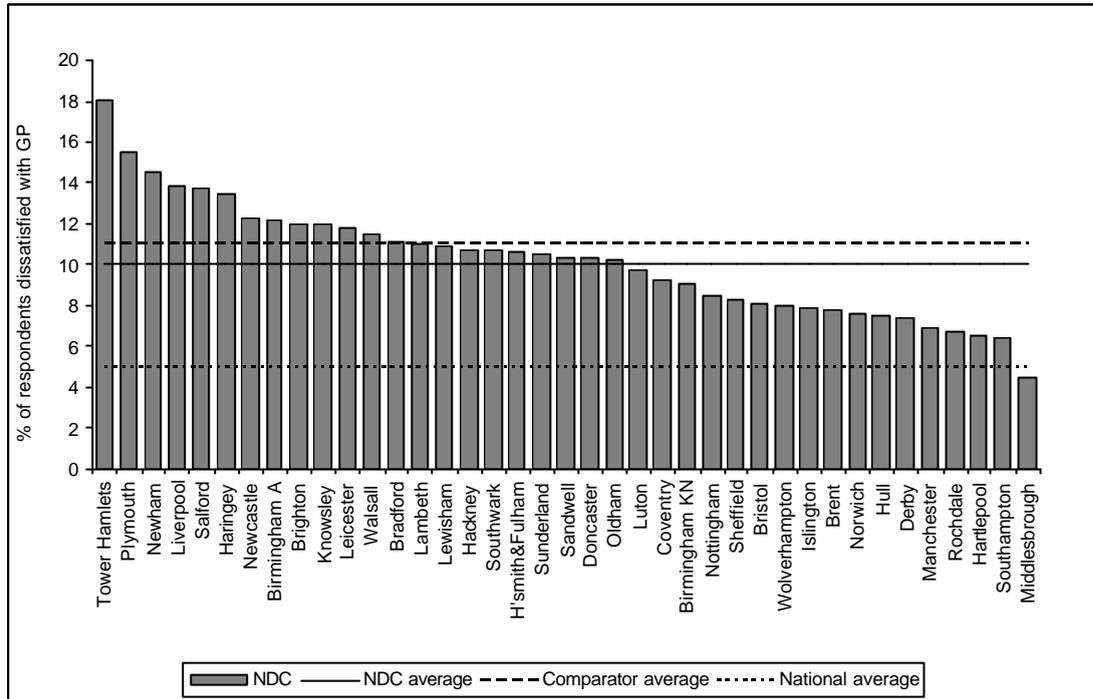
The access to general practice in NDC areas is reflected by data from the baseline MORI survey on dissatisfaction with access to a doctor (Figure 1), and data on the number of residents who had seen their GP in the last month (Figure 2). This data shows a range across the NDC areas in terms of both actual access and perceived ease of access. Overall provision is poorer in NDC areas than in the country as a whole and this will combine with other factors that make it difficult for individuals to get to the services that are available, to ensure access is more problematic.

NDC programmes have looked at developing traditional primary care provision within NDC areas but they have also identified other innovative and imaginative ways of improving health care provision within NDC communities themselves. This report focuses on five of these projects in the fields of: diabetes services, haemoglobinopathy services, services for older people, paramedic and first responders, and pharmacy services. The first three involve recruiting local support workers to support specific patient or community groups. The latter two have involved seconding into the NDC experienced NHS professionals who have the capacity to train and support local people, in one project as volunteer First Responders and in the other as NHS-trained pharmacy technicians.

A key feature of these projects is that they involve training and/or employing local people to provide additional services in communities which had no access or limited access to these types of services previously. The involvement of the local PCTs makes

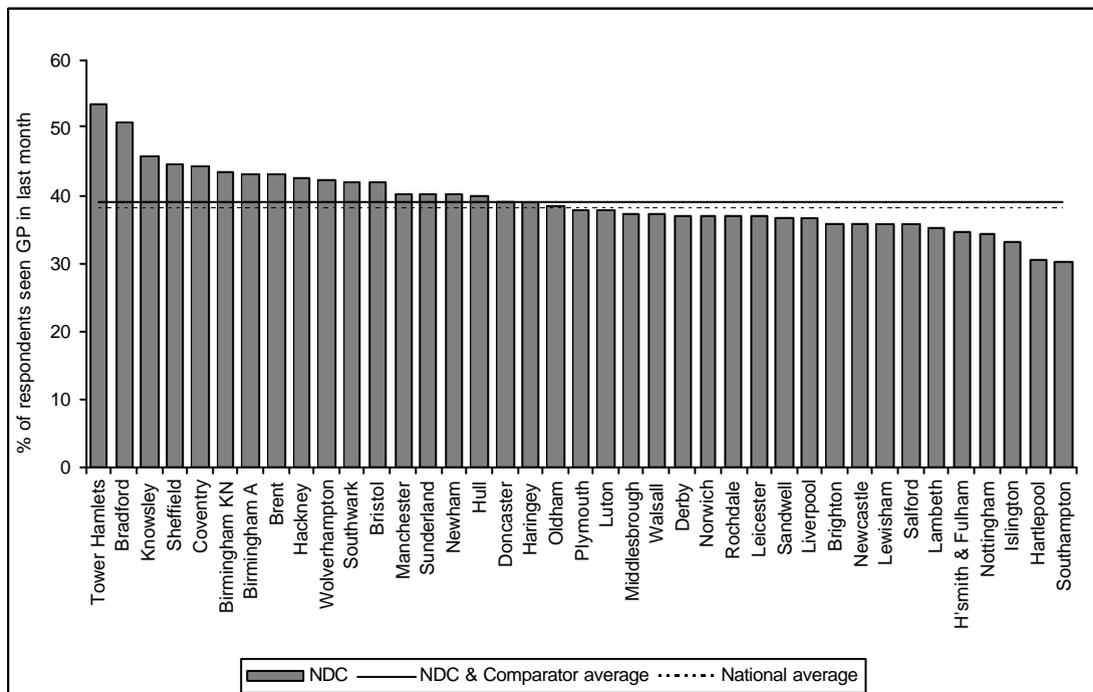
it more likely that successful projects will be rolled out to other areas or mainstreamed within NHS provision.

Figure 1: Proportion of households dissatisfied with their access to a doctor by NDC



Source: MORI/NOP Household Survey 2002

Figure 2: Proportion of NDC residents who have seen their GP in past month by NDC area



Source: MORI/NOP Household Survey 2002

3. Research Approach

Information for this report on access to novel health care services has been collected from four main types of sources. An initial review of the current literature and policy documents was followed by a review of NDC documentation such as delivery plans and partnership reports available from the partnerships or from the CRESR web pages. This information was supplemented by direct contact with NDC partnerships (mainly by telephone and email) and through a number of case study visits.

Access to health care services was identified as a theme present in most NDC plans (see Appendix 1). However, it was not possible to make contact with all the partnerships that had identified health care access as a community issue for them, and the information, where available was often limited and outdated. It is therefore important to note that other initiatives may exist or may be under development currently as well as those we have been able to document for this report.

A number of different approaches have been taken to improve access to health care services. In some cases improvement in the provision of mainstream services has occurred such as the development of a mobile unit, or increased provision of a service out of hours. These projects are the subject of a separate health theme evaluation report. This report is based on information from those projects in which the main aim is to introduce a novel health care service into the community which is not normally provided by mainstream service provision. Although some of these services are designed to benefit the health of the whole population, many target specific sections of the community such as the elderly or ethnic minority groups, who have differing health care needs, or specific patient groups such as those with diabetes.

Subsequent to mapping all the ongoing projects addressing access to health care services in NDC areas, we have selected, visited and studied in depth, five NDC partnerships with innovative health projects. The case studies selected illustrate a variety of chosen approaches and innovative ways of working. They also reflect projects in varying stages of development. In depth interviews were conducted with health theme leads and other relevant staff from both NDC and (where possible) key partner agencies in the five NDC areas. The case study NDCs were Wolverhampton, Hull, Salford, Middlesbrough and Sandwell. The areas for intervention included provision of support workers for integrated diabetes care, social care workers for the elderly, a Sickle Cell and Thalassaemia self help group, a community paramedic and first responders team, and a community pharmacy and medication review pilot. A brief description of selected relevant key features of each NDC area and the specific projects each NDC area are undertaking with respect to health care access are presented in the boxes below.

4. Objectives

The projects which aim to improve access to innovative health care services appear to have two types of identified “objectives.” The first group focuses on the general health objectives which were often a feature of the initial NDC delivery plans. These include objectives to reduce premature mortality and to improve health and social care in the neighbourhood. They are generally broad sweeping and long term objectives designed to incorporate the residents’ concerns over health care provision at a time when individual projects had not been developed and also to acknowledge that any measurable changes in health would be over the long term. Although they may reflect the aspirations of the NDC, they are more difficult to quantify and are not practical

objectives that can be used to measure success particularly in the time frame of this evaluation. Therefore project specific objectives are also needed.

Examples of general health care related objectives:

Wolverhampton

Delivery plan objectives:

- reducing the risk of heart disease, stroke, diabetes and other ill health through community led action for healthy living including improved nutrition, running well-men programmes, smoking cessation and increasing physical activity

Middlesbrough

Community strategy objectives:

- improve health and care so that our citizens live long, healthy and independent lives
- enabling older people to maintain their independence

Delivery plan objectives:

- improve the quality of life of older people
- reduce emergency hospital admissions and re-admissions

Sandwell

Project objectives:

- increased self esteem, confidence and social skills for members
- empowering local people to maintain better health

The second set of objectives have been developed for the specific project and as such vary widely. Examples of project specific health care objectives:

Wolverhampton

ABCD special diabetic team aim to:

- enable the maximum number of people to learn more about diabetes mellitus and how certain lifestyle changes would help them
- increase knowledge for those living with the disease or at risk of developing the disease and will target Asian and African Caribbean communities where there is a significantly higher incidence of the disease
- undertake a baseline assessment of need and identify best practice and current provision of diabetic care in the area

In **Sandwell** the project objectives will include:

- increased information for clients
- improved awareness of sickle cell and thalassaemia by local professionals and GP practices
- targeted work with local ethnic minority communities
- increased opportunities for public and patient involvement in local service delivery

Salford pharmacy milestones:

- a project manager will be appointed who will liaise extensively with all key stakeholders
- the project manager will ensure time scales for implementation are followed and that full development of the Local Pharmaceutical Services (LPS) proceeds in adherence to the formal submission of details approved by the Department of Health
- audits will be fully monitored and evaluated by the LPS provider as well as other relevant parties

Hull project aims:

- raise the awareness of all members of the community on how to deal with a life-threatening emergency
- train members of the community and the local workforce in first responder schemes. Members of first responder schemes will be trained in how to deal with life threatening emergencies including the use of a defibrillator machine
- co-ordinate first responder schemes
- attend life threatening emergencies within eight minutes
- improve survival rates from cardiac arrest and provide a seamless pathway from emergency situation to successful outcome
- contribute to the creation of an environment in which excellence in clinical care can flourish
- link the community with Tees East and North Yorkshire Ambulance Service (TENYAS) Patient Advice Liaison Service
- provide careers information and opportunities for local people to explore careers with the Ambulance Service

In **Middlesbrough** the health and social care workers will increase access to health and care services in a preventative, pro-active way. The primary target population is older people aged over 75 in the West Middlesbrough area who have not been seen by a primary care team and are not in receipt of social services.

In some cases the projects are routinely collecting data which allows progress towards these objectives to be monitored. For example, in Hull, an increase in the number of life threatening emergencies responded to within eight minutes has already been recorded. In other cases due to the wording of the objectives they are very difficult to quantify and measure. Where objectives have specific end points such as appointment of staff or completion of a local evaluation they can be clearly shown to have been achieved. Other objectives such as increasing life expectancy or improving local knowledge are not quantified and may prove difficult to achieve to a significant degree within the time scales of the project. However, all projects are collecting monitoring data, although this may be simply in terms of number of contacts.

5. Process Issues

5.1. Partnership Working

In most of these projects the key partner agency is the PCT (or other statutory services) which is often also the main driver of the project. Support from both the PCTs and the local health community more widely is essential for initiatives relating to health service provision or improving access, along with other key partners such as social services where appropriate.

Other external partners include:

- SHIFT - Salford Health Improvement for Tomorrow - providing buildings
- TENYAS (Ambulance Service) - Hull
- Fire Service (providing accommodation) - Hull

For some projects both accommodation and staff are provided by the local PCT. For example, in Wolverhampton, accommodation is provided by two local GP practices with support, including staff time, for the project from a further three practices.

As well as the key NHS partners the projects also have strong links with other community projects within the area - these include those supported by the NDC and other funding bodies.

Community project links external to the NDC include:

- expert patient programmes and carers projects (Salford and Sandwell)
- Sure Start (Sandwell)
- PALS (Patient Advice and Liaison Service) (Sandwell)
- HAZ (Health Action Zone) (Hull)
- black and ethnic minority groups (Sandwell)
- OSCAR (Sickle Cell Anaemia and Thalassaemia charity) (Sandwell)

Voluntary organisation partners are also involved, such as Diabetes UK (Wolverhampton) and WAITS - Women Acting in Today's Society (Sandwell). These organisations contribute knowledge of the local area or the specific intervention although no additional funding resources are generally provided in these cases.

NDC boundaries are not natural boundaries for the provision of primary care services or community services which are frequently either general practice population based or Primary Care Trust-based. Services are often therefore PCT or practice based with joint or matched funding from the PCT in order to ensure NDC resources are not solely funding a much wider service provision.

5.2. Resident Consultation

Access to health care services was identified as an area of concern in every NDC neighbourhood. Poor access to health care services was one of the few health issues which were highlighted in the initial NDC community consultations. In one case an NDC health theme lead highlighted why this may be the case. When consulted about their health concerns for the area it was noted that most residents thought of health care and the health of the population rather than their own health and wellbeing. It was thought that this is because the residents are more likely to highlight issues which they do not

consider to be something they themselves can alter, such as access to GPs or hospital, rather than issues which it may be argued, are their own responsibility such as diet or smoking. There was also a lack of realisation within the community, at least in the early stages, that lifestyle factors could be considered as health issues.

“It’s always difficult with the health as you say, because as with any consultation, with the initial consultation, they did not raise health at all, other than that there were no health facilities on the estate that is the only thing that ever was raised.”
(NDC worker, Hull)

The normal method for resident consultation for the specific projects discussed here appears to be a presentation to the health theme group where residents are allowed to ask questions and give their opinions on the proposed project. In some cases wider consultations were undertaken throughout the community. Some NDCs stated that they were moving towards a commissioning model where tenders would be invited to run a particular project (as opposed to groups requesting NDC funding as has previously been the case). Although this may do more to address the health needs of the community it will be vital to ensure that resident opinion continues to have an input into the selection of both project areas and individual tenders.

In Wolverhampton, the Bridge Project developed through public consultation and demand for improving access to diabetes care. Wolverhampton Diabetes Health Services, Diabetes UK and the University of Wolverhampton initiated an exploratory pilot project to identify any determining factors in accessing diabetes healthcare for the community. In addition a number of community consultations were commissioned by Wolverhampton BME Consortium to produce a portrait of the position of the BME community with regards to the provision of health services and to identify key issues for the BME community in Wolverhampton (July 2001).

5.3. Community Involvement

Involving the community in these health services projects is easier than is the case for many health theme projects. These projects are very large scale often with their own (or shared) premises and therefore have more visibility in the neighbourhood. The communities are kept informed via theme groups and community newsletters. These projects generally have relatively high budgets and they receive good coverage in both of these methods of dissemination.

In Wolverhampton, members of the community participate in the support groups in a community setting and these groups will help to shape future service delivery. Service users are represented on the Wolverhampton Diabetes Advisory Group and the Project Steering Committee. Work is also being done with Wolverhampton Action 4 Diabetes Service Users support group. The whole community are kept informed of the monitoring process using established graphical representations of progress - this helps to overcome the problems with language barriers in the area which restricts the appropriateness of English language newsletters for a large percentage of the population. Update presentations are also made to the health theme group to keep them informed of project progress.

In Salford, members of CHAP (Community Health Action Partnership) were involved in identifying gaps in service provision. This information was utilised by the PCT in preparation for the Local Pharmacy Services (LPS) bid which was submitted to the Department of Health.

The LPS provider developed the tender for bid provision to incorporate the PCT requirements and their own knowledge of the needs of the community through their

involvement with the initial NDC bid submission. When the LPS is running at full capacity, three pharmacy technicians will be employed. Training will be provided for at least one of the candidates (NVQ level 3). The post will be advertised locally, giving the potential for someone from within the local community to receive vocational training and be directly involved with running the project. The success of the project relies on community involvement in terms of patients within the community agreeing to be referred to the medicine management programme and also in accessing the other services offered. Awareness of the LPS is being increased through local support groups.

In Middlesbrough, the need for increased support for older residents was identified during the consultation and development of the West Middlesbrough Neighbourhood Trust (WMNT) Delivery Plan 2003-2006. Information collected via community outreach workers, residents on the health theme sub-group and voluntary organisations identified a need for this project. The Middlesbrough wide Older People's Partnership Board were part of the consultation process. The health and social care sub group have been involved in every phase of the development of this project. This group includes resident members who have provided feedback from the community on the project and also advise on the detailed content of the project. The running of the project and the delivery will be reported via the health and care theme group which has resident members.

In Sandwell, local residents have been members of the original pilot and also part of a group to develop this new project application, notably at a review and planning day held in January 2004. Members explored the need to retain and develop the project and confirmed the early benefits of the first year of the self help group. Several members of the self-help group took part in the PCT's Expert Patient training course in September 2004.

5.4. Mainstreaming

The obvious mainstreaming agency for most of these projects is the PCT who in the majority of cases already have involvement in the project and often some level of control over its development. As such the PCTs see these projects as pilots - as an opportunity to try out ideas which, if successful will potentially result in roll out throughout the PCT population. This contrasts with other NDC health theme projects (drugs, teenage pregnancy, healthy living), in which, although some of the main aims are health related, local health services are only one of a number of statutory organisational partners and there is greater potential for alternative mainstreaming agencies such as charities and voluntary organisations to take on the running of projects which do not meet PCT criteria.

In each case these projects relate directly to a statutory service provider either the PCT or in the case of the community paramedic in Hull, the ambulance services. Therefore there is a clear path to mainstreaming for each of them. However, in some cases, the projects will not be supported at the same level as is being provided through NDC. For example, the Community Paramedics position in Hull will not be mainstreamed although there will be continued support for the first responders. However, from the experience of similar projects throughout the country, loss of the paramedic has resulted in loss of momentum for the first responders scheme and ultimately, due to decreasing recruitment, some projects have ended. The scheme will now be reviewed at the end of three years with a view to possible extension, but a different funding source will need to be identified.

"I think the success at the moment is the fact that [the paramedic] is actually here, and there to support [the first responders], and it keeps that momentum doesn't it? The only danger is when [he] isn't here; it isn't going to be as focused." (NDC worker, Hull)

In Wolverhampton, after one year a review and evaluation will define what is needed in the next two years. Some of the services may be continued via the PCT or local GP practices if they are successful. Alternative funding will be sought if necessary at a later date.

"It is envisaged that the success of the Bridge project will ensure funding from the neighbourhood renewal programme as well as becoming an integral part of the diabetes service. The process of integrating this service into the NHS will commence during the three year period of the Bridge project and at the end it is envisaged that the NHS would run this service along with support from other initiatives." (NDC worker, Wolverhampton)

In Middlesbrough, there will be need to continue the project activities after the proposed end. The Health and Care Team was established in 2003 and jointly funded through Neighbourhood Renewal Fund (NRF) resources and Public Service Agreement Funding. Following the initial pilot additional NRF resources have been secured until March 2006 enabling the project to expand to cover all NRF priority wards and neighbourhoods. The implementation of the team is a joint intervention between Middlesbrough Social Services and Middlesbrough PCT with the funding through a joint budget arrangement. The project is currently being reviewed by both partner organisations with a view to making recommendations for mainstreaming the work beyond March 2006. It is intended that an additional worker secured through WMNT resources would automatically be factored into this process.

Where the projects already form part of the PCT strategy (irrespective of the main funding source), mainstreaming is a more straight forward process:

The LPS in Salford is a new form of pharmaceutical contract funded by the PCT following Department of Health (DOH) procedures. It will be fully audited and evaluated by the PCT. It is therefore envisaged that, assuming all evaluations are successful, after the pilot stage the project will be maintained by continued DOH funding. The project will be incorporated into the new Community Health Centre which is being developed in the area as part of the Salford LIFT programme.

There is a similar feeling in Sandwell where the NDC is not seen as an 'add on' by the PCT, and the work is seen locally as an integral part of the plans to improve services. The PCT will consider mainstreaming of the project after successful evaluation. Successful projects are used by the PCT as examples of good practice to influence local service development.

6. Monitoring and Evaluation

Monitoring and evaluation are still generally low priorities for the NDC projects. The same problems persist in terms of a lack of short term, achievable outcomes. But there is at least a better understanding of the issues with measuring health change where PCT staff are involved in managing the evaluation. PCT audit processes mean data collection for the projects with a lot of PCT involvement and direction is more thorough and better planned.

In Wolverhampton the output measures being collected are:

- number of diabetics attending training or advice sessions
- number of people attending training or advice sessions
- number of support group members
- number of sessions for carers, schools, community groups etc

Wolverhampton have a monitoring team within the NDC and have received training from regional NDC evaluators based in Birmingham which has improved the prioritising of data collection and analysis. Monitoring occurs on a quarterly basis for each project and targets are set for each project (although at the time of our visit the targets for the diabetes project were still being developed). Diabetes project targets will include improved access to services including support for partners, parents etc.

The Middlesbrough project has a strong PCT leadership and as a result its outcome measures directly reflect the priorities of the PCT. The health and social care workers will continue to promote, deliver and further develop the promotion of healthy lifestyle opportunities and help to address health inequalities. They will identify health needs through community involvement and increase the proportion of people who say their health has been good or fairly good in the last year to the national average.

The main responsibility for auditing this project will rest with Middlesbrough social services. The project will also be required to report on performance and quality to other partners including Middlesbrough PCT and the West Midlands Neighbourhood Trust health and care theme group. In this case all the monitoring is done by the partner agencies and there is no in house support from the NDC centrally. Although all NDC projects in Middlesbrough undertake their own evaluation there is a realisation that this is generally limited to monitoring. It is easier for the PCT to evaluate schemes that are part of city-wide initiatives.

The paramedic project in Hull is expected to see an increased survival rate for heart attack victims and other life threatening medical emergencies. The monitoring of the project is undertaken by Hull City Vision with whom there is a service level agreement. Monitoring occurs on a quarterly basis. The Community Paramedic is responsible for maintaining records and collection of monitoring data including:

- how many people have been trained as first responders
- how many people can use a defibrillator
- the impact on the ambulance service
- feedback from everyone attending Heart Start courses

There is also a requirement within the NDC to conduct internal evaluation; a consultancy firm were also commissioned to evaluate all the NDC projects in Hull. The project has received a lot of positive press coverage, which is regarded as good for NDC and the ambulance service by all those involved.

7. What works and lessons

7.1. Specific findings

Projects (compared to the rest of health theme) are longer term, larger and more structured. Budgets are generally relatively large and key local and government priorities provide guidance for the projects. Partnership is much more structured due to PCT (or other statutory service e.g. ambulance service) involvement in many of the projects. This in turn leads to more structured plans for evaluation due to the audit requirements of the partner agencies.

There is an obvious mainstream agency and the projects are geared towards that (mostly the PCT) from the onset. The projects are generally much more geared towards sustained provision and mainstreaming than other health theme projects. The projects can generally be related back to objectives set in the delivery plans and nationally recognised need.

Access to health services and health care staff was one of the few health issues which was cited as an area for improvement in most of the initial NDC community consultations. The projects bring novel services into the NDC area but these are generally given credibility by being based on similar successful schemes which have been conducted elsewhere.

Several successful projects have employed experienced health professionals in community settings to work in and with the local community and to train local people to deliver health interventions in a variety of fields. Other projects are planned that will involve employing community workers without professional qualifications, such as link workers or patient support workers. These projects have generally been more difficult to implement and are still in the piloting or planning stages because the involvement of the health professionals has been key in ensuring local action and leadership.

It was noted in several cases that the NDCs see secondments and joint posts as a strength as the staff are not under the same pressures as those NDC staff who are employed temporarily on short term contracts. Joint posts also feature within other NDC themes. Secondments of NHS employees (and to a lesser extent joint posts) allow the NDCs to recruit experienced NHS professionals who can develop projects within NDC areas. Employing support workers through the local PCT gives them considerably more professional support, relatively greater job security and access to many other benefits of NHS employment that NDCs, as small, local and time-limited organisations cannot offer e.g. NHS pension arrangements, career development, workplace crèches.

7.2. Barriers

NDC boundaries are not natural boundaries for the provision of primary care services or community services which are frequently either general practice population based or PCT based. Services are often therefore PCT or practice based with joint or matched funding from the PCT in order to ensure NDC resources are not solely funding a much wider service provision. There was also concern that in these projects the NDCs were allowing the agenda of the mainstream agency to guide the project rather than the community (and NDC) agenda. The involvement of the mainstream agencies on such a large scale can sometimes distort the communities perception of a project:

"...sometimes it's not always clear to them where is the West Middlesbrough money going...sometimes I think because the PCT's involved they don't see the association... they think it's the PCT delivering it not the neighbourhood trust."
(NDC worker, Middlesbrough)

The key points which were considered to be important lessons to be learned from the first failed diabetes project in Wolverhampton were to think things through thoroughly from the beginning and iron out issues as they arise.

In Wolverhampton several rounds of appraisal are now undertaken before a project is sent to the board for approval. This includes thoroughly developing the aims and objectives of the project and ensuring milestones are achievable within the scope and time scale of the project.

Many of the measures of success in improved health are long term and will not be demonstrated within the duration of the NDC programme. This makes evaluating at a more strategic level rather than measuring activity (e.g. numbers of people accessing a service) very difficult. At the other end of the scale there's very little understanding within the NDC about PCT resources and what can be delivered:

"I mean we can't commission in isolation otherwise West Middlesbrough would just get cut off. So what we are trying to do is commission services that provide some additionality and provides maybe innovation but is actually a coherent part of the Middlesbrough wide strategy." (PCT worker, Middlesbrough)

8. Conclusions

Support from both PCTs and the local NHS community more widely is essential for initiatives related to health service provision or improving access.

Secondments of NHS employees allow the NDCs to recruit experienced NHS professionals who can develop projects within NDC areas.

NDC boundaries are not natural boundaries for the provision of primary care services or community services, which are frequently either general practice population based or Primary Care Trust based.

9. References

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Appendix 1: Health care initiatives across all NDC areas

NDC	Projects
Leicester	Integrated health and social care centre
Brighton	GP PMS pilot - involving residents, new GP premises
Coventry	Nurse led clinic
Derby	Long term PCT secondment to NDC
Hull	Community Paramedic
Islington	Increasing range of health services, community based medicines management
Clapham Park	Improving health facilities
Norwich	Health first - welfare access
Liverpool Kensington	PCT dedicated worker, improving NHS access
Middlesbrough	Health and Social Care Workers
Newcastle	Skills for people with learning disabilities accessing health care
Rochdale	Improved access to community health services
Salford	Community Pharmacy, reducing inpatient waiting lists and times
Sandwell	Sickle Cell Self Help Group, Enhancing Nursing Services project
Sheffield	Women's screening project
Southampton	Family support, disability access
Tower Hamlets	Bengali advocate worker to promote breast screening, community diabetes nurse
Walsall	Access to primary care
Wolverhampton	Diabetic services

Appendix 2: Case Studies

Wolverhampton Bridge Project

Wolverhampton NDC is close to the average NDC score in terms of both satisfaction with access to a doctor and the number of GPs per 10,000 population.

The need for extra diabetic services was identified by the health and social care baseline study conducted to provide a portrait of the health needs of the community. Diabetes UK has recognised that diabetes in the community is of epidemic proportions due to the high BME population and increasing obesity.

The original plan had been to work with a city-wide private and public sector partnership to use NDC funds to employ a lay person who possessed local language and cultural knowledge as well as community development, administrative and clerical skills. They would have been employed to support the diabetes health care professionals to promote diabetes and health through local statutory and voluntary organisations including various religious and cultural groups. The “integrated diabetes support worker” would also work with the healthy living co-ordinator, food advisors and the health and care theme group to develop patient centred, integrated diabetes care that has respect for privacy, dignity, religious and cultural beliefs in the area.

However the development of this project was held up by concerns about the ability to keep a trained individual within the NDC project and a lack of secondary care support. A new project has therefore been developed which will instead be based on a partnership with the PCT and will involve employing two support workers and NHS professionals (for example chiropodists, dieticians) on a sessional basis. They will be based in a GP surgery but provide outreach services to other GPs in the area. The service is funded for three years using NDC funding and matched funding from the PCT and is also supported financially by Diabetes UK.

Salford Community Pharmacy Project

At the time of delivery plan writing there were no health facilities within Charlestown and Lower Kersal and few other local services and, although a number of services were located within the city-region, there was a question as to how accessible these are to particularly disadvantaged groups.

Within the NDC area of Lower Kersal and Charlestown there is a recognised need to improve accessibility to primary health services. The standard mortality rate (SMR) is twice the national average with chronic disease management highlighted as a key area for improvement. 46% of households do not have a car, local public transport is limited and over 36% of households have a household member with a long term health problem or disability which affects their daily activities. Whilst 18 GPs provide medical services to the area only two part time GPs are currently located within the area.

Community health centre with dispensing pharmacy and pharmacist.

Lower Kersal and Charlestown Well Being Centre opened at the beginning of July 2003 and is now providing advice and support to many local residents. Two trained pharmacy technicians work with the pharmacist to help patients manage their medicines. The service includes a medication review, advice on medicines and a dispensing service for repeat prescriptions. For clients who are housebound the service can visit them in their home. The dispensing service involves ordering and collecting repeat prescriptions from the GP surgery and home delivery if required. The centre also provides information on lifestyle management and health.

This service provides medicine reviews monthly for local residents. People are often confused about their medication and may be taking large numbers of pills without adequate understanding of their regime. The pharmacist reviews the medication they have in their possession, and removes any excess they may have ordered on repeat prescription unnecessarily, incurring unnecessary NHS costs. The centre has also become a social centre and the pharmacist feels this has the potential to impact on mental health and could potentially reduce prescriptions for anti-depressants because people have somewhere they can go and talk to someone about their life.

Patients are identified and referred to the medicine management programme by GPs, specialist nurse professionals, hospital discharge pharmacists, and key voluntary group and social services personnel following set protocols. Information dissemination is co-ordinated by Salford PCT prescribing personnel. Minor ailment provision is co-ordinated with GP practices and PCT prescribing advisors. All residents have been informed of the service through local dissemination of information flyers and regular reports and updates in the NDC monthly newsletter send to all households.

In Salford the pharmacy project shares the same premises as the NDC expert patients programme and carer's project. All three health programmes are closely integrated with strong professional liaison between all key workers.

Sandwell - Sickle Cell Self Help Group

At the time of delivery plan writing Sandwell had better health service provision than many NDC neighbourhoods but there were still concerns regarding access especially for minority groups.

Sickle Cell disease is an inherited blood disorder which affects the red blood cells. The condition predominantly affects people of African, African-Caribbean, Asian and Mediterranean origin. Beta Thalassaemia Major is a serious inherited anaemia. Children with Thalassaemia Major cannot make enough haemoglobin, hence bone marrow cannot produce enough red blood cells and the red blood cells that are produced are nearly empty.

OSCAR Co. Ltd is a community based voluntary organisation that was founded in 1988 and has its centre in the Greets Green NDC area. It represents all black and ethnic minority families, working mainly with individuals and carers affected by Sickle Cell or Thalassaemia.

The Level Advance Sickle Cell Self Help Group was established as a pilot project in 2002 and has received one year's funding from the Greets Green Partnership. External evaluation commissioned by the NDC in 2003, showed that the pilot self help group had supported clients and their carers to access support, advice and information to help them cope better with their condition. The pilot project has also enabled members to reduce their isolation, to build their confidence and to start to influence agencies and professionals regarding the needs of those suffering from these chronic diseases.

Although the funding ceased in 2003, the enthusiasm of the self help group and fundraising by individual members has enabled the group to continue to meet on a less regular basis. However, without external funding for the self help group it will be difficult to build on the early success. The sickle cell-self help group has completed its initial phase and has just submitted a project outline for new NDC funding. The project outline was endorsed by the Greets Green NDC partnership in May 2004 and the group is working on its full project application form to be submitted to the Greets Green Partnership in 2005. The project is in an interim phase at present and the outcome will not be clear until later in the year.

The planned project will include the following:

- a part time support worker will be appointed, plus administrative time to manage the project on a day to day basis and to run the fortnightly self help group
- the support worker will develop health promotion and training opportunities about Sickle Cell and Thalassaemia for local GP practices and health professionals
- the support worker will engage with providers to seek changes in local service delivery to meet members' needs
- to build capacity, group members will have the opportunity for personal training in life skills, IT, and communication skills, mentorship and to link to the training offered through the NHS expert patients programme
- an informal telephone support network will be established by members of the group

Hull Community Paramedic and First Responder scheme

There is a high incidence of ischaemic heart disease on the Preston Road estate and the rate is the highest it has been in the last three years. 36% of households have someone with a long term limiting illness, 24% of households have someone who is registered disabled, 29% of households have two or more people who are aged 60 or over. The survival rate of heart attack victims is about 4% of those having a cardiac arrest on the street. Research has shown that if a cardiac arrest victim is defibrillated immediately, their chance of survival increases to 85%. The odds decrease 5% for every minute that passes without treatment.

Local people feel vulnerable as a result of the distance between their home and local hospital emergency services. The nearest A&E is four miles away. The provision of facilities on the estate increases the sense of wellbeing reducing anxiety and stress for the sick and for their carers. Early treatment can speed recovery and improve the level and rate of recovery which in turn leads to reduced costs to the health service and to the community in general.

The community paramedic recruited as a secondee from the local ambulance service works with all forms of community groups in order to train and organise members of the community into first responder schemes as well as to raise the awareness of the general population in how best to use the emergency services. The paramedic and vehicle add to the availability of expert emergency response in the area. The Ambulance Service manage the scheme and ensure appropriate clinical standards are met.

The primary benefit is a community which is better prepared to deal with a wide range of medical emergency situations. The paramedic is based on the estate and links with all local groups and employers offering awareness raising opportunities for people who live and work on the estate. Links with schools raise awareness of emergency response issues and inform young people of ambulance service careers.

From December 2003 to November 2004, the scheme was utilised by the ambulance control 76 times. 50% of the calls were from outside the NDC area so there was collaboration with other communities to provide the service. There are 21 trained responders with one or two on duty at any one time giving 24 hour cover.

A further ten people are currently going through training. This includes some from outside the NDC who see the potential benefits of having a first responder scheme in their community in the future.

Middlesbrough Health and Social Care Workers

In the baseline survey respondents were more satisfied with the use of, and access to, health facilities than is the case across the NDC Programme; 89% are satisfied with their local hospital compared with 79% across all NDCs.

However, the needs of older people has been a long standing issue which has been identified in Middlesbrough. A health and social care worker was appointed originally in East Middlesbrough to address Standard 8 of the NSF (the development of the single assessment process). They have piloted an electronic version of the assessment called Easy Care. The health and social care workers are essentially health care assistants who work with the GP practices to identify the over 75s and then go out and do the assessments. They have expanded to include other projects to include addressing fuel poverty and housing issues.

The project is a PCT partnership project which looked at the single assessment review and expanded on the range of questions and it is locally perceived to be really successful. The project has got through to the national final of the NHS health and social care awards. The PCT and social services are already looking to mainstream the work beyond 2006 - which is the current life span of the project.

An additional worker has been recruited to work for the West Middlesbrough (NDC) community but who will also be part of the team with the other support workers.

The project has links to the community caretakers' scheme and the NDC befriending scheme. It will also link with health promotion work carried out in West Middlesbrough.