



# West Dunbartonshire Healthy Living Initiative

## Final Report from the Board

*“While hindsight is a wonderful thing, the Board hopes that this report of their experiences will help other community board members in the future.” – the WDHLI Board*

This report can also be downloaded from [www.askclyde.co.uk/downloads](http://www.askclyde.co.uk/downloads)





# West Dunbartonshire Healthy Living Initiative

## Final Report from the Board

Summary .....	4
Introduction .....	6
The Project.....	7
Origin .....	7
Key Stakeholders .....	7
Governance.....	8
Activities & Staff .....	8
Outputs & Outcomes .....	10
Stress Management Services.....	10
The Lay Community Health Workers & the Health Development Team .....	10
WDHLI Overall .....	11
Lessons & Observations .....	12
Monitoring & Evaluation.....	12
Lay Community Health Workers .....	13
Management & Leadership.....	13
Common Themes .....	14
Closure .....	16
The Bigger Picture .....	16
Working for Sustainability .....	16
Reality Hits.....	17
Closure with Dignity .....	17
Statement from the WDHLI Board.....	19
Appendices & References.....	20
Summary of key observations.....	21

The report has been commissioned by the Board of the WDHLI and produced by K&D Partnership,  
(contact - [kanddairlie@btinternet.com](mailto:kanddairlie@btinternet.com))

## Summary

---

This report was compiled at the request of the WDHLI Board after the decision to close the project was made in July 2007.

### The Project

The report starts with an outline of the origins of the project as the largest in the New Opportunity Funds Healthy Living Programme in Scotland, with a budget of £2.3 million over 5 years. Designed to meet the health needs identified across 16 pockets of severe deprivation in West Dunbartonshire, the original project business plan was compiled by West Dunbartonshire SIP staff, with input from a range of health and public sector bodies. Local representation in the governance of the project was weak in the early stages, but strengthened as the project developed.

The structure of the project, as set out in the business plan, involved two key strands of delivery - Development of the Lay Community Health Worker scheme and Stress Management Services. From local consultation and needs analysis, five key issues were identified:-

- Food & Food Poverty
- Children and Youth Activity
- Community Based Family Support Services
- SIP-wide Stress Management Service
- Community Capacity Building

The recruitment and development of the project followed this business plan, with two main delivery teams – the Stress Management Team and the Health Development Team – supported by an administrative team. Throughout the five years of the project, the staff structure and the five key issues remained unchanged.

### Lessons and Observations

From the interviews and material gathered at the end of the project, several key learning points emerged which the WDHLI Board is keen to share with other community board members.

- **Monitoring & Evaluation** – In the main, the project was reactive to the demands of external bodies (funders in particular) in the information they collected and the reports they collated. These demands varied regularly and were perceived as distractions from the real work, of little benefit to the clients and users of the project. However, as the period of secure funding came to an end, it became obvious that there was no body of evidence to demonstrate the effect of the project, or to support its continuation. Both staff and Board would like to emphasise the need for a workable and relevant monitoring and evaluation system, which meets the needs of the project as well as funding and partner bodies.
- **Lay Community Health Workers (LCHWs)** – While the project's LCHWs themselves were an essential part of the staff team, there was a lack of clarity about the long-term role of the LCHW posts. If the LCHW posts were created mainly to give local people an opportunity to enter the community health field, then the expected outcome would be that the first recruits would move on to other employment and allow new recruits to join the project. However, if the LCHWs were employed to provide local knowledge and a bridge between the health professionals and the community, then their role as on-going local liaison is important throughout the life of the project. Even at the very end of the WDHLI project, conflicting information was still circulating about the

LCHW posts, and this lack of clarity had affected some aspects of the staff and project's work. If this model is used elsewhere, there needs to be greater clarity in the length of the LCHW appointment and the expectations of the posts.

- **Management & Leadership** - Strong management and leadership was missing for a large part of the project's life. Weakness in management can lead to a lack of overall vision, no common focus, overly rigid organisation structure, poor team support and staff development. In the particular instance of WDHLI, the lack of a common vision led to the project's activities being almost entirely reactive to external forces – community groups and individuals on one hand, and the stakeholder and partnership organisations on the other.

While the above issues were specific to WDHLI, they reflect the hurdles experienced by other Healthy Living projects, as described in the Scottish Evaluation of the Healthy Living Centre Programme,<sup>1</sup> including:-

- The capacity of community management committees/boards of directors to take on and direct these large, complex, strategic projects.
- The necessity of building a profile among both the local community and the strategic decision makers, in addition to the problem of monitoring and evaluating impact across a range of communities, issues, and activities – many without hard, numerical outputs.
- The key role of the manager in both the internal development and culture of the organisations, and in the external negotiation and partnership building, which are both essential to the sustainability of the project.
- The shifting external environment of health and regeneration bodies, which the project had to understand, adapt to and function within.

## Closure

Towards the end of 2006 and the beginning of 2007, the WDHLI, along with the other Healthy Living projects in Scotland which were facing major changes in funding, started to look into the options for the long-term future of the project. However, they identified major gaps in the resources they needed, in particular:-

- Lack of evidence of outputs and outcomes.
- Lack of profile with the public and with key partners.
- Lack of resources, staff resources being the major gap.

The collective effect of these gaps made the continuation of the WDHLI, in any form, impossible.

When the Board took the decision to close the project, reluctantly and with a heavy heart, they made every effort to follow, and if possible exceed, best practice. The final part of this report outlines the steps they took during the period of closure.

---

<sup>1</sup> The Scottish Evaluation of the Healthy Living Centre Programme in Scotland, October 2007 (carried out by Research Unit in Health, Behaviour & Change, University of Edinburgh)

## Introduction

---

The WDHLI closed on 31 October 2007 and the Board will be dissolved at their EGM in 2008.

This report looks at how the project was originally set up and makes some observations on how the project worked in practice. It includes lessons learned by the staff and Board which they would like to pass on to other projects. The report also notes the WDHLI's position within the wider context of other Healthy Living projects across Scotland and the current struggle for sustainability.

The Board made the decision to close the project reluctantly, and this report lays out some of the reasoning behind that decision. The Board also wanted to record the 'closure with dignity' strategy which they adopted, and the effect this had on the final stages of the project.

### Methodology

The source material for this report included:-

- A review of a proportion of material generated by the project, including the original business plan for the first funding application, reports, publicity, returns to funders, etc.
- Interviews with staff and board members. The closure process encouraged reflection, which was generously and honestly shared during interviews.
- Desk based research using the reports and materials generated by the organisations involved in supporting and evaluating Healthy Living projects.

It is worth noting what this report does not attempt to address. This report is not:-

- An evaluation. The WDHLI is part of the wider Evaluation of the Healthy Living Centre programme in Scotland; Report of Phase 2, October 2007, produced by Research Unit in Health, Behaviour & Change, University of Edinburgh.
- Comprehensive. There has been neither the time nor the source materials to provide a comprehensive history of all the activities of the project during its five year life-span.
- An assessment of how the project performed or what effect it had on local people.

The Board has been involved and fully consulted on the final content of this report.

## The Project

---

### Origin

The New Opportunities Fund (NOF), a branch of Lottery funding established in 1999, was focussed on three strands - Education, Health and the Environment. This was a large UK wide programme, aiming to fund initiatives which would make a real impact in areas of deprivation. To tackle the Health strand, NOF called for applications for a new kind of project, community focussed but supported and match-funded by statutory providers and regeneration initiatives. The application process involved building partnerships between health providers, local authorities and regeneration organisations as well as bringing local people into the management process. £34.5m was allocated to Scotland for the Healthy Living Centres Programme.

The original business plan which was submitted to the NOF Healthy Living Centre Programme was drawn up by the West Dunbartonshire Social Inclusion Partnership (SIP). An Advisory Group of key partners and a Steering Committee of community representatives was involved in developing the bid. Local consultation was done through questionnaires, street interviews and public meetings. The health statistics for the area were also used to identify the key priorities.

West Dunbartonshire was one of the ‘archipelago SIPs’ – 16 pockets of severe deprivation across the local authority area. This was the key factor in deciding against a building-based Healthy Living Centre. It was decided instead to work as a Healthy Living Initiative delivering services from existing premises across the region.

Total funding of £932,622 over 5 years from NOF was awarded in March 2002.

Match funding was provided by

ERDF grant Urban II.....	£359,618.00 .....	from 2002/07
West Dunbartonshire Council.....	£100,000.00 .....	from 2002/07
Greater Glasgow Health Board .....	£250,000.00 .....	from 2002/07
NHS Argyll and Clyde .....	£100,000.00 .....	from 2002/07
West Dunbartonshire SIP/CCP.....	£325,000.00 .....	from 2002/08
Additional from Partners (NHS A&C and GG HB).....	£278,387.00 .....	from 2002/05

### Key Stakeholders

The Advisory Group which was set up to develop the original business plan continued to support and advise the fledgling Board once the project started in 2002. The Advisory Group consisted of representatives from:-

- Argyll & Clyde Health Board
- Greater Glasgow Health Board
- West Dunbartonshire Council
- West Dunbartonshire Social Inclusion Partnership
- Clydebank Local Health Care Co-operative
- Lomond Local Health Care Co-operative.

In the early stages of the project, while the Board was developing their skills and confidence, the Advisory Group was closely involved and highly influential. This was particularly true during the recruitment of key staff, a daunting operation even for experienced community-based committees.

## Changes in Stakeholders

With the sole exception of West Dunbartonshire Council, none of the Advisory Group bodies existed in the same form when the project closed in 2007.

- The two health boards were amalgamated into NHS Greater Glasgow & Clyde with 11 Community Health Partnership areas, of which one is the West Dunbartonshire Community Health Partnership. Set up in April 2006, they have now produced their Development Plan for 2007-2010.
- The Social Inclusion Partnerships (SIPs) are no longer operational, and the Community Planning Partnerships (CPPs) now work across a broader range of areas, still with the community regeneration remit but in partnership with the full range of service providers for the area.
- The local health care co-operatives were assimilated into the new community health partnerships.

Boundaries, organisational structures and key personnel have all changed, as has the relationship with the WDHLI. Only West Dunbartonshire CPP was attending Board meetings and providing support in the final stages of the project.

## Governance

The Steering Committee, recruited for the development of the original business plan, became the Board of Directors when the organisation became a company limited by guarantee in 2002. A skills audit was done in the early stages and training provided. There has been other capacity building support throughout the life of the project from various voluntary and health sector support organisations.

Initially, the Board was highly reliant on direction and support from the Advisory Group as this was a large project, with one of the largest NOF awards in Scotland. Concerns about the capacity of community-based groups to take on the management of large projects is a common theme across the Healthy Living projects. The Scottish Evaluation of the Healthy Living Centre Programme<sup>2</sup> states that managerial roles for local people had “mixed levels of success” (further observations about this specific issue can be found on page 10 of this report).

This pressure is born out by the experience of the WDHLI Board. Throughout the five years of the project, there have been regular changes in the make-up and culture of the Board. The working relationship between key staff members, stakeholders and the Board has ebbed and flowed. There have been times when communication did break down and the elusive quality of trust was lost.

However, by 2007, when difficult decisions had to be made about the future of the project, there was a strong Board with the skills, experience and confidence to make these decisions and to carry out the work involved. The key Board members were tireless and meticulous in their attention to due diligence.

## Activities & Staff

Two key strands of activity were prioritised in the original business plan.

- Development of the Lay Community Health Worker Scheme
- Stress Management Services

---

<sup>2</sup> The Scottish Evaluation of the Healthy Living Centre Programme in Scotland, October 2007 (carried out by Research Unit in Health, Behaviour & Change, University of Edinburgh)



In addition to these, the business plan highlighted the following activities, which were identified through the local consultation and needs analysis:-

- Food & Food Poverty
- Children and Youth Activity
- Community Based Family Support Services
- SIP-wide Stress Management Service
- Community Capacity Building

The focus on these key strands influenced the appointment and remit of the staff, the management structure of the organisation, and the operation of the project. Front line staff were recruited to one of two teams:-

- **The Stress Management Team** – which required counselling or other professional qualifications.
- **The Health Development Team** – made up of the Lay Community Health Workers (LCHWs), who were not expected to have any health qualification but were expected to undertake training as part of their appointment. The LCHWs were appointed with a specific remit e.g. Food & Food Poverty, Children & Young People, Vulnerable Families, Mental Health, Stress Management and Community Development. One LCHW was also placed with the Stress Management Team.

Each team had an officer with line-management responsibilities, who were managed in turn by the project manager who was directly responsible to the Board. There was an Administrative Team of four providing the financial recording and reporting, reception and clerical support. In addition, sessional workers were hired for specialist and local services, and volunteers were encouraged to become involved in service delivery in their own areas.

The project staff worked from the administrative base in Dalmuir, but the services were predominantly provided in community premises throughout the West Dunbartonshire area.

At the end of the project, these two key strands of activity and two front-line staff teams were still strongly in evidence – there had been little change or adaptation.

## Outputs & Outcomes

---

### ***Stress Management Services***

The Stress Management Team consisted of a stress management officer, three stress management workers, one community lay health worker and a bank of session workers. The Team provided stress management services to everyone who was referred to them, including those who referred themselves. This generic quality – open to everyone and not targeting a specific group or age or issue or gender - was felt to be unique by both the providers and the users of the service.

As well as self-referrals, referring agencies included GPs, Community Psychiatric Nurses, Carers' Centres, Mental Health projects, Social Work etc. At the peak, the service was receiving 120 referrals a month. While the target was to give all referrals an assessment appointment within two weeks of the first contact, this was not always possible and at times of high pressure on the service, it could take up to six weeks. Each referral received an assessment interview where their needs were identified and appropriate services or treatments were agreed. Around 85% of those attending were provided with counselling services, and 15% were given stress management training, though there was some overlap. These services were provided as close to the clients home as possible, using the range of sessional workers and community premises across West Dunbartonshire.

While one-to-one sessions were the core of the service, the Team also provided workshops and courses including relaxation techniques and the Stress Busters Course. These group activities were particularly useful when there was a growing waiting list, providing options for those who had not yet been assessed.

The complex logistics of running this type of generic service, across this wide geographic area, with session staff and borrowed premises, cannot be underestimated. The Team had to deal with assessing and monitoring sessional staff, identifying and securing appropriate premises, making and tracking appointment keeping, and monitoring progress in the clients. They also had to deal with staff absence (including stress-related sick-leave), central monitoring requirements and a small but time-consuming number of inappropriate referrals.

Despite this, the service has been recognised as unique and important. The client feedback<sup>3</sup> which was collected on the closure of the project (extract from the report – Appendix 1) expresses the anguish that the closure of this service caused for both clients and referring agencies.

*“Without exception all [the clients] felt that not having the WDHLI Stress Management Service available would have a negative impact on them.”*

### ***The Lay Community Health Workers & the Health Development Team***

The development of Lay Community Health Workers (LCHWs) was the method of delivery of the other issues prioritised in the original business plan – Food Poverty, Children & Young People, Supporting Vulnerable Families, etc. The Health Development Team, made up of five LCHWs and a line manager, dealt with these issues, with an additional LCHW as part of the Stress Management Team.

The LCHWs were recruited from those without formal health qualifications, though many recruits had qualifications in other fields. Their training consisted of, in the first instance, the Health Issues in the Community pack, an accredited course run by CHEX for NHS Health Scotland. The pack develops the students' understanding of a community development approach and the social model of health, and how these can be used in addressing health inequalities. Some of the LCHWs undertook further training and courses, leading to university degrees for four staff.

---

3 Collation and Summary of Questionnaires from Clients and Partners of West Dunbartonshire Healthy Living Initiative's Stress Management Services, November 2007, produced by Collaborate Consulting Ltd.

The types of activities which the LCHWs ran was dependent on the specific area for which they had been recruited. For example:-

- Food & Food Poverty - organising and running healthy cooking classes, healthy eating awareness workshops in schools and with the elderly, and fruit barras.
- Children & Young People - emotional literacy workshops and youth drop-in sessions.
- Vulnerable Families - breast-feeding support groups, parenting classes, and dads' groups.

In addition to the issues specified in the original business plan, the Health Development Team demonstrated their community development ethos by working with community groups on specific, self-identified issues. The team's overall aim was to empower the groups and individuals they worked with, increasing their participation in their own treatment and well-being. Some generic community development work was also necessary – e.g. setting up voluntary groups, developing constitutions and applying for funding - due to the lack of this type of resource elsewhere.

## **WDHLI Overall**

These two teams – Health Development and Stress Management – ran in parallel. While there was some joint working at promotional events, there was little cross-over between their two areas of work. The joint administration of the two teams brought them together on an operational level, but there was considerable distance between their methods of working and the issues they were addressing. There is little promotional material that deals with both aspects of the project's services, and it was noted in interviews that even staff social activities tended to reinforce this division.

There was no record or reporting of any efforts to bring the two strands of the WDHLI together, or indeed that this separation caused any problems or needed addressing. The main concern expressed was whether the public recognised WDHLI as a single project, or as two separate services.

There was a relatively low level of staff turnover. Those who worked for both strands of the project, including volunteers, showed a great level of commitment and dedication.

## Lessons & Observations

---

One of the key aims of this report is to pass on the lessons learned from running and closing the WDHLI. During the interviews with staff and Board members and reviewing the project material, there are several key points which emerged – some which resonate with the findings of other evaluations, and some which are particular to this project. Other projects may benefit from these observations.

### *Monitoring & Evaluation*

The WDHLI staff, in interviews at the end of the project, identified two conflicting problems:-

- The perception that they had spent a lot of time monitoring and recording their work.
- A lack of useful information to describe the project's impacts.

All members of staff interviewed mentioned the amount of monitoring that had to be done. This included observations about how the data they had to collect changed regularly; how difficult it was to find time within service delivery to complete reports or get feedback forms filled in; how, when the database had finally been set up, it was even less useful than what had gone before. The funders received the blame for this set of problems, ascribed to the different forms, information and timetables required by the different funders of the project.

Only in the final stages of the project, when all staff were seeking to draw together information to assess what had been done and justify continuation of the services, did realisation dawn that there was little concrete evidence of the numbers the project had dealt with and the effect of their services on communities and individuals. Even for this report, with free access to the administrative base, when everybody was working to clear the premises, it has not been easy to get any statistical information.

Monitoring and evaluation of work based on the social model of health is a difficult task because the outcomes of many activities are not easily quantifiable. It is notoriously difficult to enumerate the distance individuals and groups have travelled, or the ripple effect on families and other services of improving an individual's self-esteem. It was not made easier in this project because the two teams – Stress Management and Health Development - were delivering different services, in different ways, with different outputs and outcomes.

Despite all these difficulties and qualifications, the staff and Board came to realise **the absolute necessity of an effective monitoring and evaluation system**. It was agreed that a good system needs to be:-

- **Developed early**, right at the beginning of the project, which may be counter-intuitive when there is the pressure to 'get things up and running'.
- **Owned** by those implementing it. It should not be seen as an imposition by funders, or other bodies, but something which is vital to the core of the project, helping the service to improve and develop. To generate this ownership, those implementing it need to be involved in designing and finalising the system.
- **Workable** with the service delivery, instead of being seen as an additional and non-essential task. It needs to be embedded in work programmes with sufficient time for recording and reporting built into delivery schedules.

It is the role of management to enable the development of this type of monitoring and evaluation system, and to enforce its implementation.

## **Lay Community Health Workers**

The development of Lay Community Health Workers, identified as a key priority in the original business plan, gave the project many strengths, but there was also a lack of clarity and consistency in the application of the concept. The following observations in no way reflect on the LCHWs employed by the project, who were a vital and essential part of the WDHLI, but on the lack of clarity under which the system operated, some of which had an adverse effect of the LCHWs themselves.

Even during the final interviews, there was contradiction and confusion about the role of the LCHWs. This ranged from the perception that “they have had their opportunity and they should move on and give someone else a chance,” to statements such as “but we’ve trained them up, why should we want to start again with someone new?”

Were they appointed as part of a job creation scheme? Was the aim to give local people an opportunity to enter the community health field, receive initial training and then move on to work elsewhere? If it was this type of post – similar to intermediate labour market models – why were they given the same length of contract as all the other project staff, instead of a target date to be moving back into the labour market? Or were they appointed with the same status as all the other staff members, for the skills and experience they brought to the role of helping individuals and groups to articulate their health needs?

No answer was found to this conflict even in the final days of the project, and it had created some friction at points in the past. The LCHWs had been referred to, in public, as ‘supported employment’, or ‘trainee health workers’, slights to their perceived skill level which still stung. The lack of clarity of their roles spilled over to the health and education professionals with whom they worked, and subsequently to the groups they were supporting.

**If the Lay Community Health Worker model is going to be used in other projects, their role needs to be clearly set out from the beginning.**

**EITHER** the LCHW is taking part in a job creation scheme, gaining work experience in the project so that it is possible to move into the labour market, and the work experience opportunity can then be opened to someone else. (It should be noted that running a consistent service for the public with the fluctuating workforce of a job creation project is next to impossible.)

**OR** the LCHW is recruited to the project as a community liaison worker, valued for the skills and experience that they have when they arrive in post.

The LCHWs’ position in this project fell between these two options, so their position was never clear. This confusion should have been tackled and clarified in the early stages of the project, so that all ambiguities were resolved.

## **Management & Leadership**

Finding solutions to both these previous issues lies in strong management and leadership, which was missing for a large part of the project’s life. Weakness in management can lead to a lack of overall vision, no common focus, overly rigid organisation structure, poor team support and staff development. In the particular instance of WDHLI, the lack of a common vision led to the project’s activities being almost entirely reactive to external forces – community groups and individuals on one hand and the stakeholder and partnership organisations on the other. Without strong management and the proactive development of project goals, WDHLI was at the mercy of external forces.

## Common Themes

The experience of WDHLI reflects many of the issues which were identified in the Scottish Evaluation of the Healthy Living Centre Programme,<sup>4</sup> including:-

- The capacity of community management committees/boards of directors to take on and direct these large, complex, strategic projects.
- The necessity of building a profile among both the local community and the strategic decision makers, in addition to the problem of monitoring and evaluating impact across a range of communities, issues, and activities – many without hard, numerical outputs.
- The key role of the manager in both the internal development and culture of the organisations, and in the external negotiation and partnership building, which are both essential to the sustainability of the project.
- The shifting external environment of health and regeneration bodies, which the project had to understand, adapt to and function within.

Relevant quotes from the evaluation report are included under the appropriate headings below.

### Capacity of community management committees

*“While some communities had members who were more willing to become involved in governance, others still were mistrustful of engagement as a result of the curtailment of previous services in the area. Local history therefore also played a part in how HLCs could be implemented.”*

*“... In some instances throughput of management group members was related to the often onerous nature of the responsibilities involved. Some local people sought to be involved for a limited period of time or at a level that was less demanding of time and responsibility than that on offer. Although skills deficits in management group members were addressed through training, new challenges in overseeing large and complex organisations continued to emerge. Having attracted key members of the community to such positions, their throughput led to a declining number interested in assuming such roles. ...”*

### Building a profile & demonstrating an impact

*“When discussing sustainability with potential funders, stakeholders struggled to demonstrate impact or to establish a profile, particularly when work was delivered in partnership with other organisations. HLCs undertook their own local evaluations, with some seeking retrospectively to apply outcomes measures. Some partners also suggested alternative ways of measuring impact, although few were implemented. Several stakeholders reported how they had sought help from CHPs and CPPs about outcome measures, but had received little guidance. ...”*

*“Attention given to profile raising differed between HLCs, although all acknowledged its importance. For some sites, the main aim in establishing an identity was to appeal to local people, in other sites profile raising was intended to promote effective partnership working, whereas for yet others it became salient when considering sustainability. In all cases it was found that such activity takes time and often money to develop, with staff members in some sites having greater skills and experience relevant to performing such tasks than staff in other sites.”*

---

<sup>4</sup> The Scottish Evaluation of the Healthy Living Centre Programme in Scotland, October 2007 (carried out by Research Unit in Health, Behaviour & Change, University of Edinburgh)

## The importance of the manager.

*“The role of HLC manager was central to each site’s development. The manager was typically responsible for guiding service development, positioning in terms of community involvement and user participation, developing links with partners and for leading strategic consideration of sustainability. However, the managerial role and its functions differed between sites as did the level of managerial resources available for operational oversight and strategic command.”*

*“Among their many responsibilities, managers and management groups were tasked with planning the strategic direction of their HLC. However, differences in capacity, ability, time and access to decision-makers were evident across the HLC sample. The strategic significance of such roles was particularly evident when managers left post and where such roles had not been fully developed (often as a result of lack of capacity). Expectations of managers were considerable and varied, sometimes requiring them to be all things to all people. ...”*

## Partnership working with shifting partners.

*“... Managers in several sites highlighted how they had repeatedly sought an indication of the changes to HLCs and service provision that might need to be undertaken. However, the system-wide changes underway often resulted in a lack of guidance or indeterminate responses from CHP/CPP bodies to HLCs seeking to become sustainable over the longer term.”*

*“HLCs have had to accommodate to multiple changes in partners and partner organisations both when delivering services and when considering strategy, particularly in relation to sustainability. Some sites have had more success in engaging partners because of favourable strategic resource allocation, shared boundaries and ‘fit’ with the strategic interest of partners. Partners that are required for winning bids for funding may have little to offer in terms of practical service delivery, whereas other partners’ influence and inputs may become more important over time.”*



## Closure

---

### *The Bigger Picture*

The New Opportunities Fund (NOF) for Healthy Living projects had been awarded for a maximum of five years. Towards the end of 2006 and throughout 2007, the surviving projects of the 46 originally funded by NOF (now the Big Lottery Fund - BLF) were exploring the potential for their future development, or even existence. The initial investment from the lottery was unlikely to be replicated on the same scale, but expectations for health services in and for the community had been raised during the five years of the initiatives. In most instances, the services provided by the Healthy Living projects were additional to statutory provision and no mainstream funding could be identified to continue the service. However the HLCs and HLIs across the country, which were established and answering local need, were facing a massive gap in their funding.

### *Working for Sustainability*

WDHLI staff and Board had done some initial exploration of options for the long-term future of the project, developing ideas for a second phase. Draft outlines for a social enterprise arm were prepared. Early negotiations were started with the Community Health Partnership towards a possible service level agreement. A successful application was made to the BLF for an Investing in Ideas grant to support the preparation of sustainability plans.

However, there were major gaps which brought these plans to a halt.

- Lack of evidence of outputs and outcomes – from the monitoring and evaluation shortfall previously identified. The external second stage survey of the project's impacts<sup>5</sup> commissioned to support development plans attracted only a small response.
- Lack of profile with the public and with key partners – the reputation of the WDHLI to deliver services and health improvements was severely damaged by the lack of reporting and evidence. The public perception of the two separate strands of the project did not help the overall profile.
- Lack of resources, staff resources in particular. At the critical period, there was a severe lack of senior managerial capacity to carry out the planning, partnership building and development work needed.

On reflection, the accumulation of all these factors made the long-term sustainability of WDHLI problematic and increasingly impossible.

### **Sustainability Factors**

It is useful to use the 'Four Factors for Sustainability' identified by CHEX<sup>6</sup> to clarify the hurdles which WDHLI was facing. Strength in these four factors is common to the Healthy Living projects which have developed their sustainability in the longer-term.

- **Factor 1 - Identifying and nurturing local champions who will promote the project at a higher strategic level.** The WDHLI had no strong relationships to build on due to changes in the Board, absence of project staff, and structural and personnel changes in the local stakeholder organisations.

---

5 "To assess the impact of the West Dunbartonshire Healthy Living Initiative upon its service users - Phase 2; Changes over a 12 month period", produced in October 2007 by Ask Clyde.

6 Healthy Living Centre Support Programme Newsletter, Issue 5



- **Factor 2 – Effective marketing and communication is essential for creating high visibility, locally and strategically.** The WDHLI worked in partnership with community groups and other organisations and there was little ‘branding’ of WDHLI work collectively. The work of the two teams was rarely linked in any promotional material. There was little publicity information produced which promoted the WDHLI as a whole.
- **Factor 3 - Demonstrating impact.** The monitoring and evaluation shortfall in the project made it impossible to provide concrete evidence of the impact of their activities. Several external surveys and assessments had been commissioned over the lifetime of the project, but there was no body of data which could illustrate the effect of WDHLI.
- **Factor 4 - Gaining recognition with partners and the public of the uniqueness of your work and contribution to health improvement.** With a lack of strong relationships with key partners, little evidence of impact and a low-key public profile, the materials needed for gaining wider recognition were not available.

These four factors are intertwined and interdependent. Unfortunately, given the late start of the sustainability planning and the absence of staff, WDHLI could not address the project’s weaknesses in any of these factors.

## **Reality Hits**

During early 2007, the Board became increasingly aware of these hurdles which stood in the way of the sustainability of the project, or even of part of the project. They were also becoming more fully aware of the lack of resources available to tackle these hurdles, including key staff members. There was a period of understandable tension, where loyalty and commitment to the project was pitted against the scale of the problem to be solved. Both individually and as a group, the Board struggled with their commitment to staff and clients and the realities of the barriers they faced.

In May, the Board had a half-day workshop where they explored the two main options thoroughly – developing the sustainability of WDHLI or complete closure of the project. The workload involved in both options was discussed, as well as the potential ramifications of a decision in either direction.

The decision was not taken immediately or lightly, but after reflection and further discussion. At a SGM in July, the decision was made to close the project on 31 October 2007.

## **Closure with Dignity**

Once the decision was taken to close the project, the Board made every effort to follow best practice. They sought out and took advice from OSCR<sup>7</sup>, Companies House and GCVS<sup>8</sup>. The WDHLI’s constitution and articles of association were examined and all criteria were followed. They developed a comprehensive ‘checklist for closure’ for the project (see Appendix 2) which complemented a generic closure checklist prepared by GCVS. The WDHLI check-list covers issues such as:-

- **Staff** - the Board was committed to providing the best option in the circumstances for the staff. Best practice in redundancy was followed at all points. All staff but one moved to other jobs, many within the health sector. The one exception is taking free-lance work with a view to setting up a social enterprise, again in the community health field.
- **Disposal of assets** – the project’s assets were disposed off through West Dunbartonshire CVS, with all furniture and equipment being redistributed to other charities in the area. The project’s computers, after all information had been wiped from the hard drives, were also redistributed to other local charities.

7 Office of the Scottish Charity Regulator

8 Glasgow Council for the Voluntary Sector

- **Clients & public** – all the clients and users of the project were informed of the closure as early as possible. Appropriate alternative services were signposted where this was possible. Work with community groups was wound down and alternative arrangements made with other organisations for on-going support if this was possible. For the Stress Service, a questionnaire was sent out to clients and referring agencies, to collect the reaction of those most directly affected by the closure. The returned questionnaires were collated and an extract of the report<sup>9</sup> is available in Appendix 1.
- **Storage of records** – both funders and regulators required records to be kept for a period, even if this is beyond the life of the organisation. The length of this period was checked with all relevant bodies, the correct records to be stored were identified and arrangements were made for secure storage, and access if necessary. All remaining project paperwork was shredded and binned.
- **Funders and finance** – all funders were made aware of the closure at the earliest opportunity. Arrangements were made for all final reporting and claims to be completed. The Investing in Ideas award was returned. A budget for closure was drawn up and agreed. The finance officer and administrative support have been retained to carry out these pieces of work and to prepare for the final audit of the project.

## The Stress Management Service

There was some potential for a proportion of the Stress Management service to be transferred to another organisation. The service would have undergone some changes – most notably, it could no longer be open to all, but would be provided only for a limited target group. The WDHLI staff, who had first-hand knowledge of the gap this closure would leave, prepared a range of proposals for the transfer of some aspects of the service. However, there was insufficient time and expertise available to iron out the complexities of staff transfers, data exchange and funding, despite the efforts of all involved.

The closure of this service will leave the biggest gap, as demonstrated by the returned questionnaires from service users and partners – see extract in Appendix 1. It is hoped that there is the potential for a similar service to be re-introduced.

## Final Closure.

The three months from the final decision being taken to the actual closure of the project was a period of intense activity. All staff were involved in delivering the closure check-list, and several of the project's volunteers became an essential part of the workforce. Due to staff moving to other jobs, one of the volunteers was recruited to a paid post temporarily. The Board were also closely involved in all aspects of the closure as they were acting as project management due to the continued absence of key staff. The WDHLI project closed as planned, moving out of their premises on 31 October 2007. The finance officer and the administrator are being provided with desk space in the West Dunbartonshire CPP offices, where board meetings also take place.

The Board continue to meet monthly, working towards the final EGM when accounts with funders and creditors will be finalised and the Board will dissolve.

---

<sup>9</sup> Collation and summary of questionnaires from clients and partners of West Dunbartonshire Healthy Living Initiative's Stress Management Services<sup>7</sup> produced in November 2007 by Collaborate Consulting Ltd.

## ***Statement from the WDHLI Board.***

The Board would like to thank those who supported them during the period of closure, including:-

- West Dunbartonshire CPP
- Glasgow Council for Voluntary Services
- West Dunbartonshire CVS

They would also like to thank the staff who stayed and worked hard to the end of the project – the positive attitude they displayed in the final stages of the project were an indicator of how under-utilised they had been in the previous development of the project.

While hindsight is a wonderful thing, the Board hopes that this report of their experiences will help other community board members in the future.

## ***Appendices & References***

**Appendix 1** – Extract from “Collation and summary of questionnaires from clients and partners of West Dunbartonshire Healthy Living Initiative’s Stress Management Services”, produced in November 2007 by Collaborate Consulting Ltd. Full report available to download from

[www.askclyde.co.uk/downloads](http://www.askclyde.co.uk/downloads)

**Appendix 2** - WDHLI Project Closure List

## **References**

Other documents referred to:-

**Evaluation of the Healthy Living Centre programme in Scotland; Report of Phase 2, October 2007**, Produced by Research Unit in Health, Behaviour & Change, University of Edinburgh (Stephen Platt, Kathryn, Backett-Milburn, David Rankin)

Available from NHS Health Scotland website

[www.healthscotland.com/documents/2149.aspx](http://www.healthscotland.com/documents/2149.aspx)

**Healthy Living Centre Support Programme Newsletter – Issue 4 – The Route to Sustainability: Four Factors**. Produced by CHEX. Available from

[www.chex.org.uk/publication/hlc-newsletter/](http://www.chex.org.uk/publication/hlc-newsletter/)

In addition, the CHEX Healthy Living Centre Support programme has additional information available at

[www.chex.org.uk/healthy-living-centres/](http://www.chex.org.uk/healthy-living-centres/)

**To assess the impact of the West Dunbartonshire Healthy Living Initiative upon its service users - Phase 2; Changes over a 12 month period**, produced in October 2007 by Ask Clyde. Available from

[www.askclyde.co.uk/downloads](http://www.askclyde.co.uk/downloads)

# Appendix 1

---

Extract from “**Collation and summary of questionnaires from clients and partners of West Dunbartonshire Healthy Living Initiative’s Stress Management Services**”, produced in November 2007 by Collaborate Consulting Ltd.

## Introduction

Once the decision was made to cease the services of West Dunbartonshire Healthy Living Initiative (WDHLI), the Stress Management Team were keen to record some of the impacts of their work.

They sought to evidence some of the benefits they had delivered and also to provide information about local needs which might inform future service planning.

Questionnaires were distributed to individual clients and partner agencies.

Eighty users returned the forms articulating their views on the services they had received.

Twenty-two agencies which referred clients together with fifteen organisations which identified themselves as working in partnership with WDHLI returned the questionnaires.

Collaborate Consulting Ltd was commissioned to produce a brief analysis of these 117 returned forms.

## Summary of key observations

### Overview

The questionnaires received from clients, referral agencies and partners were all totally positive. Service users commented on the professional and caring approach from WDHLI staff and many of the comments about what clients would have done without the service are indeed heart rending.

Referral agencies are also positive, reporting positive impacts of people referred and a reduction in resources and prescribing as a direct result of the stress management work carried out by the service.

Partners are positive about working alongside WDHLI Stress Management Services and report enhanced outputs and outcomes as a result.

There is real concern about the closure of the service with the majority of service users and referral agencies being uncertain as to where to go for a similar service while staying within their budget constraints.

Everyone wants to see the service continue and all feel that it has positive effects on clients.

*“The most vulnerable clients will be unable to access these services. For many clients it has been a life saving exercise – Many depressed clients have been lifted out of depression through contact with HLI staff. It’s the most valuable service we have had in this local area for years and if it is lost clients and their families will suffer.”*

### Key points

#### Views of clients

80 clients responded to the questionnaire with the majority of them using more than one service offered by WDHLI Stress Management Services.

Without exception all felt that not having the WDHLI Stress Management Service available would have a negative impact on them. Specifically they reported that this would lead to:

- A reduction in their ability to cope
- Increased suicidal tendencies
- Increased stress and anxiety
- No future access to support
- A reduction in their recovery
- A reduction in both mental and physical health and well-being
- Loss of therapeutic benefits for themselves and others

The vast majority of clients did not know where they would go to for support in the future with only a minority identifying other sources of support for themselves. All these people however had reservation about accessing other support in terms of:

- Length of waiting time
- Level of support and sufficiency of appointments
- Returning to medication
- Being unable to pay the cost of private treatment

### Views of referral agencies

WDHLI Stress Management Service received referrals from 37 agencies in the area. There are many reasons for referral to WDHLI with the majority of people having mild to moderate mental health problems where medical intervention is inappropriate or could be helped by additional support. Another reason for referral is linked to client's caring responsibilities, where caring for disabled relatives have left them isolated and stressed.

The 22 referral agencies who responded to the questionnaire identified the following differences that the service had made to their clients:

- Coping mechanisms were learned
- Employability enhanced – earlier return to work or ability to think about looking for work again
- Increased confidence
- Improved mental health and well-being

All 22 respondents identified positive impacts that WDHLI Stress Management Services had on their own service. The biggest by far was the fact that referring people for additional support freed up time and resources:

*“Significantly reduced number of consultations with patients. I think there are long term implications that patients will access these services more readily. Feel has reduced antidepressant probably reduced referrals to psychiatric services.”*

*“Helps if our waiting lists mean an individual has to wait, they can increase the change of relieving a service and make full use of our other supports quicker.”*

The comments relate both to the reduction in human resources required to support patients and the reduction in medication as a result of the support.

13 out of the 22 Referral agencies were unsure where they would refer their clients when WDHLI Stress Management Services ceased to exist. 5 agencies stated that they could perhaps adapt their own services but stated that this would have big resource implications.

Another 4 Referral agencies stated that they would refer to Psychiatric Services and the Primary Care Mental Health Team but that this would also put more strain on resources locally.

### Views of partner agencies

23 organisations work in partnership with WDHLI and many of these also refer clients. Key partnership working involves:

- training in mental health issues
- co-ordination of SMHEA training
- youth counselling
- outreach workshops for clients and staff
- partnering community events
- provision of therapy days

Partners feel that the biggest impact of working in partnership with WDHLI is the increased confidence and reduced stress and anxiety in their clients. Feedback from clients was mentioned by many and was always positive.

It is also clear from the feedback that vulnerable individuals gained a great deal from the experience. For example partnerships with women's groups supporting women who experience domestic abuse or post natal depression was especially valued.

All the partners identified negative impacts on their own service delivery once WDHLI ceased to exist. Many will lose a valued referral source but there will also be big impacts on partner organisations who wish to try to continue to provide an holistic service within their existing resources.

The majority of partners could not identify other organisations / agencies who could support the delivery of work and as one partner put it:

*“It is not about what other organisations/agencies can do, it is about the people currently involved and the positive feedback received from our clients about the people delivering services.”*

## Appendix 2

---

### WDHLI - Notes for closure plan 2<sup>nd</sup> DRAFT.

Taken from the discussion with the Board, 3 July 2007

Amended after meeting with Board & Staff, 24 July 2007.

#### Initial list of actions to be taken.

##### 1. Finance

- a. Clarify budget needed for remainder of wind-down period, including:-
  - i. Redundancy payments.
  - ii. hire of accountant/lawyer – covered mostly with support from GCVS
- b. Identify contingency needed – for activities which might be necessary – still some research needed to find out costs, which may be variable.
- c. Clarify funding position – identify:-
  - i. funding already drawn down
  - ii. funding still to claim
  - iii. funding which will be left unclaimed.
  - iv. funding already received which may need to be returned.
- d. Notify all funders and discuss b & c (above) with them. – Board to draft letter to funders.
- e. Make final claims and return any funds due.
- f. Close bank accounts.

##### 2. Governance – all this section is being supported by through GCVS

- a. Ensure that project wind-up is legal and transparent and that there is no continuing liability for current Board or staff.
  - i. Seek advice from GCVS or other support agency.
  - ii. Identify and appoint support agent - lawyer and/or accountant and/or other organisation - for current period, to allow liaison with current finance manager, and for activities beyond 31/10/07.
- b. Inform Companies' House, ask for guidance for process, and follow.
- c. Inform OSCR, ask for guidance for process, and follow.
- d. Confirm list of work needed after 31/10/07 and cost delivery with support agent. This list could include:-
  - i. Final accounts – prepare and sign off
  - ii. Final reports to funders
  - iii. Final claims
  - iv. Pay any outstanding bills
  - v. Submit final reports to OSCR and Companies House.

##### 3. Goods & Services

- a. Lease of premises – suggest that lawyer is main agent in negotiations re lease and any work to be done. Agree Board's position, consult with lawyer that it is a valid position, then leave it to them.



- i. Notify landlord of intention to quit.
  - ii. Clarify with landlord any works needed to premises before vacating.
  - iii. Cost these works and add to 1.a.
  - iv. Arrange for works to be carried out
- b. Other service contracts - Identify and give notice on any other contracts which WDHLI is a signatory for – photocopier etc. Identified the need to use up existing stationary and order no more. Also looking at promotion contract with taxis – contact and ask for information to be removed after 31 October
- c. Record Storage
  - i. Check funding agreements for responsibility to store records – of project, of clients, financial etc. (e.g. Urban II records need to be stored till 31/12/2012, accounts to be kept for 7 years)
  - ii. Identify appropriate agency to take on storage of records.
  - iii. Cost storage for period needed, and include in 1.a. Also make arrangements for what will happen with the records at the end of the storage period. Will access be needed? Who?
  - iv. Arrange and label records for storage.
  - v. Arrange for secure disposal of any records which will not be stored.
- d. Disposal of assets – computers, furniture, monies etc.
  - i. Check Memorandum and Articles for guidance on disposal of assets.
  - ii. Check any funding criteria on disposal of assets.
  - iii. Make inventory and circulate to appropriate charities, with dates for when equipment or furniture can be picked up. May also want to leave time for circulating to voluntary and community organisation too, after charities have had first refusal.
  - iv. Ensure all project information is wiped from computers, or hard drive removed and destroyed.
  - v. Dependent on the above, arrange for the dispersal of any assets – community groups, other projects, etc.
  - vi. Arrange for secure disposal of any equipment not dispersed.

#### 4. Staff/volunteers

- a. Get advice from GCVS on redundancy procedure and notice required.
- b. Clarify position re recruitment with other health projects which may be looking to start new services in area. Settle this issue as early as possible, as it may affect staff, equipment and, possibly, lease.
- c. Carry out consultation with staff, individually and collectively – as outlined in guidelines from GCVS.
- d. Consult with Volunteer Co-ordinator for strategy for volunteers. This should happen as soon as possible, as volunteers may be able to provide essential help with all these tasks.
- e. Provide detailed information to staff about the redundancy process and the requirements for redundancy entitlements.
- f. Issue redundancy notices – (35 or 90 days before 31/10/07? – clarify length of notice which all staff are entitled to)
- g. Prepare general references for staff – Line managers prepare references for rest of staff, Board prepares those for line managers.
- h. Support staff in seeking employment – including time off for interviews, where appropriate.

## 5. Clients & Public

- a. Signpost other services available in the area through individual consultations and through printed handouts.
- b. Wind-up current clients, especially as staff numbers may diminish in the coming months.
- c. Provide information about why the project is shutting down – through press releases and handouts.

## 6. Links & Connections

- a. Consult with funders of Y2Y to transfer project to another management organisation. Undertake transfer.
- b. Consult with funders of Healthy Haldane to transfer financial management to another organisation. Undertake transfer.
- c. Check that financial transfer with both Y2Y and Healthy Haldane is tidy – no loose ends or money owing on either side.
- d. Identify full list of partners that WDHLI are currently working with. Circulate list for all staff to add to. Communicate with all partners about closure.

## 7. Reports

- a. Annual Monitoring Report to the Lottery – due October 2007.
- b. Quarterly report & claim for Urban II funds (may also need final report after 31/10/07).
- c. Final Exit Report on project. The audience for the report can include; internal audience, other HLIs, funders, partners, local community, policy makers, research bodies. Report could include; background to project, achievements and successes, qualitative and quantitative monitoring information, lessons for future action. Information and articles could be collected from; clients, partners, staff, Board, funders.
- d. Submit next return to Companies House (8/11/07).
- e. Submit final accounts to Companies House (31/3/08).

THIS LIST TO BE DISCUSSED AND EXPANDED BY BOARD AND STAFF