Item 6 – Annex 1

Washington Area Committee SIB applications

Applications for Washington Healthy Lifestyles Project

Washington Healthy Communities
Project Brief

CALL FOR PROJECTS

Washington Area Committee would like to invite Washington based Voluntary and Community Sector (VCS) groups, to submit a full application that will deliver a project to address health inequalities in our most deprived neighbourhoods.

Washington Area Committee wishes to see proposals which address the Health and Well Being priority and in particular delivering support and services for over 50's and embedding joint working to address the health needs of the aging population. Applications will be considered from VCS groups who have a management committee, constitution and bank account with dual signatories. VCS groups must adhere to accounting requirements in accordance with the Companies Act. **Partnerships and collaboration is encouraged.**

Introduction and Background

- The Area Committee has delivered a range of initiatives under their 'Health and Well Being' priority and their Adult social care priority. This includes
    - Washington Way to Well Being (Physical Hub, Charter Mark & Go Washington Small Grants scheme)
    - The Washington Way
    - Addressing social isolation of older people
    - Projects to improve health through activities and accessing green spaces
    - Home from Hospital
    - Time to Care
- It is intended this project will build on and consider previous Area Committee investment but focusing on a specific age group and targeting a number of long term illnesses and health inequalities suffered by the community.
- Whilst this will be a targeted approach, Area Committee is keen to see a collaborative approach from local VCS organisations.

Expected Outcomes

This proposal will:

- Address health inequalities of people aged over 50 years, in our most deprived neighbourhoods with a focus on Washington North but with a view to relevant services and support into other Wards, based on need.
- Provide a community led personalised approach to encourage people to live healthier lifestyles. This could include 1:1 health planning/interventions and engagement, and identification of relevant pathways and progression routes
- Identify partners and build and secure relevant partnerships and joint working protocols for those services and activities identified
- Identify and confirm robust referral systems for all activities and services
- Identify how relevant health messages, education and awareness raising to support the initiative will be implemented

- Identify how opportunities for outreach will be developed in other Centres
- Identify how activity and services can be sustained post SIB funding
- Identify the mechanism for a mid-term evaluation to provide evidence of effectiveness and assessment of impact.

Budget:
The total budget available for this targeted Call for Projects is **£100,000** to deliver a 2 year project**.** The application will be subject to formal assessment and scoring. A collaborative proposal is encouraged. All applications will be assessed and weighted accordingly with regards to partnership working, co-ordination with other services and initiatives, and the range of activities delivered.

December Area Committee approved £100,000 for this call and agreed a 'targeted' approach, inviting Washington Millennium Centre to submit a full application under SIB protocols and procedures

Application No.1.

Name of Project	Washington Healthy Lifestyles
Lead Organisation	Washington Millennium Centre

Total cost of Project	**Total Match Funding**	**Total SIB requested**
£107,000	£10,000	£97,000
Project Duration	**Start Date**	**End Date**
2 years	April 2017	March 2019

The Project
This project has presented robust evidence re health indices, deprivation statistics etc. to show that parts of Washington are worse than the Sunderland average. For Washington North – 35% pensioners live alone, binge drinking & obesity in adults. Income deprivation is high. Long term illnesses are significantly higher compared to Sunderland average. CHD & respiratory disease are main issue with higher levels of emergency hospital admissions. More cancer than Sunderland average and some of the long term conditions and illnesses reflect previous industries.

Whilst Washington North Ward will be the key target area, the project is aware that there are other pockets of deprivation in other wards within Washington and those residents will have needs similar to those of the North Ward. The project through the outreach work will attemp to target and engage these residents and it is not the projects intention to turn any Washington resident away. The health checks will be offered in various venues across the town and appropriate advice, support and signposting will be undertaken.Washington Millennium Centre proposes to address a range of health issues and support residents to improve their health and wellbeing through making positive lifestyle changes, including increasing physical activity, healthy eating, reducing alcohol intake and stopping smoking through advice, information and support. Regular physical activity can help maintain cognitive function, reduces risk of cardiovascular and other diseases, helps maintain the ability to carry out daily living activities, reduces the risk of falls, improves mood and can improve self-esteem.

The project will deliver via a community led personalised approach to encourage and support people to live healthier lifestyles by working with local groups, GP's, setting up health checks

(Health MOT) at the centre and other local venues, engaging with people to start a discussion, and offering advice and support where required or sign up to the project. There are two distinct and different strands of delivery to the project and each has equal weighting. One strand is about helping people manage their health issues.

The project's role will be to provide support at a community level through exercise referral. We expect more people to self-refer rather than be referred from their GP or the Move to Improve Programme. This is based on two key facts, the way we will promote the project and the impact we expect the healthy lifestyle strand will have along with the number of people we get coming into the centre to talk about health issues. We currently send more residents to their GP practice to get their screening PAR Q signed off saying they are fit to exercise than we get residents saying their GP has sent them to do the exercise referral programme. Based on experience we believe the split will be 60-40 or 70-30 in favour of self-referral. A 'referral pathway' is attached to show how the project will link to other services and specialist provision. The GP is the professional who is at the heart of the referral process. They are the gatekeepers to specialist services as only they can do the referral and they will have to sign off the Par Q to say the participant is ok to take part in activities the project will deliver as part of the Exercise On Referral (EOR) strand. The current arrangement with the local practices will continue and be developed once we have briefed them more fully in April if the project is approved for funding which is what they have advised.

Project staff (2 x part time qualified EOR staff {Level 3}) as well as fitness instructors and other specialists will be used to deliver activities. A 12 week physical activity programme designed specifically for those who are 50 years+ and are inactive and have a health need will include 1:1 gym sessions, Easyline, Low intensity/impact circuits, Pilates, Move to improve, and health walks. This offer will be regularly reviewed to ensure it is meeting the needs of the participants. It is hoped to expand the offer to encourage self-help groups or establish disease specific groups which will form part of the sustainability plan to continue the work beyond the initial 2 years. Individuals may be referred to the programme by their GP, Practice Nurse or other healthcare professional if they believe that a programme of physical activity would be of benefit to the individual. This may be identified either at a regular appointment or via the NHS Health Check which is aimed at people aged 40 – 74 years. Alternatively, a self-referral process will be in place to allowing the individual to complete the referral form and take it to their GP or other healthcare professional for sign off.

On completion of the 12 week physical activity programme, individuals will be provided with the opportunity to continue to be physically active and/or continue other lifestyle improvements. Options will include:

- Mainstream activities within Washington Millennium Centre
- Sunderland Walking for Health programme
- MIND Washington activities as set out on the Wellbeing site
- Other physical activity opportunities within the local community via Wellbeing.org

The first 12 weeks will be at no cost to the participant and to encourage and support them to continue with the activities and lifestyle changes they will be offered the opportunity to continue to be part of the project at a reduced cost, 50% when compared with the regular centre charges.

The project will track participation and monitor the impact the scheme is having. Any gains that are made i.e. reducing medication or no longer needing it will be recorded. GPs will make these decisions with the patient, not the centre staff. This strand offers patients an exit route from Move

to Improve or from a specialist service, so extends the period of support someone will have to help them get better or improve their health. Those who wish to will also have the opportunity to continue after the 12 weeks at a subsidised rate and that subsidy is the in kind contribution the centre will make to the project. This means some patients will have an opportunity to be supported by a range of teams for up to 36 weeks plus.Most activity will take place at the Millennium Centre, though as we develop work in other pockets of high need we will try to deliver an offer local to them and will need to hire venues for example churches, CAs. However because the ward stats do not identify those pockets we will be dependent on information from ward councillors and council officers to confirm which areas hit the project outcomes.

In addition counselling services will be brought in as appropriate via Washington MIND to help participants address mental health barriers that prevent them making informed lifestyle choices. Experience tells us that until other issues that impact on mental health are addressed and unhealthy coping strategies are challenged, the person will be unable to find the motivation or understanding, to make the necessary behaviour change to manage their health risks. Washington Mind advise us that these people will need on average 6 sessions to help them move on, make a commitment to set goals and work to achieve them.

People who need this support will be identified when they do the health screening and Washington Mind have advised to expect 40% of people referred will require some element of support and counseling and may also benefit from other wider wellbeing activities in a safe, familiar environment. Progress will be tracked by Mind during this phase of support and intervention. An example of this is a bereavement can trigger mental health issues that can then lead to excessive drinking or binge eating to, these people need support to help them to help themselves. Sessions can be delivered at both the Life House or at the Millennium Centre. Standardised evaluation tools will be used to establish pre and post outcomes and build an evidence base.

An additional service is to trial telephone support as well as using messages to keep people motivated. We propose to equip the project with the necessary software to record and track user's activities, how often the access the programme, how the project has interacted with them, and what support has been given. One option is to utilise the NHS Florence service – negotiation will commence if the proposal is approved. The project is also exploring using Text Magic as a way of targeting individuals to offer encouragement and motivation and looking at other ICT programmes to support the offer. These measures will form the report each participant will get and this will be the qualitative evidence we need to take a funding bid forward and to report to area committee on. It will inform the year one review as well.

The second strand is health promotion and education - prevention and giving people advice and information which helps them live healthier lifestyles. This part of the project will be much harder to show impact - we have said how we will attempt to track these participants through recording data when we do the health MOTs. The health MOTs allow us to discuss lifestyle issues and offer advice and give them the opportunity to have the tests redone. MOTs will be repeated at 12 and 26 weeks so any lifestyle changes or improvements can be recorded. If any contra-indicators come out of the health check they will be advised to go and see their practice nurse or GP, e.g. high blood pressure. The staff deployed on the project are fully trained and will follow the REP's guidelines, which is very clear about what they are qualified to do. The delivery of the health education messages will be done in various ways:

- A signposting service to direct residents to the most appropriate services to meet their needs ie Stop Smoking, weight management, alcohol support etc. This will be achieved through use of the Live Life Well service and wellbeinginfo.org operated by Washington

MIND, reducing duplication and making good use of a resource that is already recognised as good practise.

- Web pages will promote the project and regular health improvement information and project information will be uploaded.
- Health promotion messages, talks/workshops will be promoted and delivered within Washington Millennium Centre, addressing healthy lifestyle topics including the benefits of physical activity, healthy eating, smoking cessation, alcohol etc. and rolled out to other venues and groups.
- Set up a Facebook page for the project and use that. Experience has shown that is an effective tool with some.
- For others we will get pop up screens printed with health messages that can be put out in various centres.
- Leaflets and posters
- Give local groups and clubs an offer of staff attending their sessions or meetings to give talks on healthy living and undertake health MOT's.
- Utilise the Wellbeing.org website to give advice, steer people to activities posted on their by other groups and to promote the project and how people can self refer.

Centres in the North we hope to use include Albany, Sulgrave, Donwell and the local churches and groups in our centre and some of the others we mention have said they would welcome us to do that. During the life of the project we will work to build relationships with other groups that we know are based in Washington and who's users fall into the over 50 category like the WI, Age UK groups that Hazel supports and some of the U3A groups, some of whom we already have contact with. We will also talk to some commercial/community businesses about putting up displays, pull up message boards and giving talks in other areas of Washington once the work in the North Ward is up and running. In addition Washington Mind have a number of groups who use the Life House as a venue and we will have the opportunity to offer them access to the project and to benefit from it. We will provide regular updates on the work as it develops and the number of groups we work with increases.

Partnership

The proposal supports Area Committee priorities re collaboration, supporting older people, addressing social isolation and tackling health inequalities. The proposal undertakes to link into current initiatives to ensure joint working, value for money and to ensure no duplication of provision. The project will both compliment and support the work of the **Sunderland Move to Improve (MTI) programme.** This project will signpost participants to MTI for those that are in need of additional support for specific long term conditions that are over and above what the project team can support. Alternatively, this project will provide exit route options for individuals graduating from the Move to Improve programme, so supporting the programme in Washington and offering residents additional support for a further 12 or 24 weeks.

The Millennium Centre has a track record of working in partnership and not duplicating the work of others. **Washington Mind** will deliver elements of the project when councelling or psychological support is need to help people make progress to improve their health and wellbeing. We have links with **Slimming World** and other services which are delivered by external partners on site and some of the council led services as listed below. The centre has worked with the **GP surgeries** in previous years when the centre delivered exercise referral and smoking cecassation in partnership with the council. Other partneships include **Active Sunderland Walking for Health programme** who will provide Volunteer Walk Leaders (VWLs) for initial delivery of health walks from WMC and VWL training for volunteers identified by WMC/Mind in order to ensure sustainability of the activity.

The walks will be promoted by Active Sunderland, WMC and the Wellbeing website. **Victoria Road Heath Centre (Concord Medical Practice, Dr Bhatt and Dr Benn, Dr Stephenson and Partners, Dr Thomas) –** GPs and Practice Nurses will be kept informed of the project and encouraged to refer patients to WMC for healthy lifestyle advise and physical activity as they have done previously with EOR. Local GP practices advised they were happy to work with us and refer patients to us and those links to the practices at Victoria Health Centre are still in place. We will grow those links through the project by meeting on a regular basis with health professionals to ensure we are up to date with health issues and challenges and we are sharing the impact of the project. **Local Pharmacies (Arndale House, Victoria Road and Heworth Road) –**pharmacist will be informed of the project and encouraged to refer patients to WMC for healthy lifestyle advise and physical activity.

The offer will not duplicate the council offer and will focus on education and Tier 1 support exercise referral. Higher need individuals will be signposted to either the council project or specialist services provided by the hospital or CCG as it would be the GP who would be the lead to refer into these specialist services. Staff working on the project will develop these link further and keep updated on provision through the Health Forum. During the life of the project we envisage more partnership working to be developed and will report on this in the quarterly returns.

Detailed research and consultation carried out with Centre user groups identifed local provision is important, Washington North has a good transport hub, older residents prefer the informal atmosphere of a local centre to commercial gyms and centres.

Outputs of the Project

Description	**Number**
No. programmes tackling health	1
No. beneficiaries (200 MOTs 100 EOR)	300

Key Milestones and objectives for the Project

GP Practice/Pharmacy visits complete	April 2017
Monitoring systems in place	April 2017
Project Promotion underway	April 2017
Physical Activity Programme live	April 2017
Signposting services live	April 2017
Telephone service live	June 2017
50 users participating	April 2018
100 MOTs undertaken	April 2018
Year 1 mid term evaluation	May 2018
100 EOR participants and 200 MOTs	March 2019

Funding

Item	**Total Cost**	**SIB**
Staffing costs (on costs @ 20% included) 1 x 10 hours @ £19.20 = £20,000 1 x 15 hours @ £12.00 = £19,000 1 x 5 hours @ £9.60 = £5,000	£44,000	£44,000
Facility hire, room use, classes, venues, 1:1	£ 6,000	£ 3,000
Monthly gym passes 100 x 3 months @ £20 per month	£ 6,000	£ 5,000

Fitness instructor sessions @ £25 per hour	£ 5,200	£ 5,200
Travel and mileage	£ 1,000	£ 1,000
Equipment (health and general)	£ 5,000	£ 5,000
ICT equipment and software	£ 3,000	£ 3,000
Telephones	£ 800	£ 800
Supplies and services	£ 3,000	£ 3,000
Management Fee (WMC) @ 7%	£ 7,000	£ 7,000
Washington MIND counselling services £35 per session (6 session per client)	£15,000	£15,000
Wellbeing.org – platform and support	£ 2,000	£ 2,000
Weeks 13 – 24:Project access to facility use	£ 5,000	£0
Staff training budget	£ 1,000	£0
Health Promotion material	£ 3,000	£ 3,000
TOTAL	**£107,000**	**£97,000**

Sustainability
The centre will use this project to collect data and experiences to enable it to bid for long term funding to deliver a healthy living project which will continue this work over a 3 to 5 year period. Whilst at the same time, the centre will look at how it can embed elements of the project into its daily offer to the community.

Health Statistics: As mentioned North Ward stand outs and is much worse than other wards - unfortunately health stats for the other wards do not identify deprivation or challenges where the health of residents is worse than that of the average resident in Sunderland. The last health initiative that targeted the North Ward was healthy living centres and since then there has been no targeting of the area to address the health inequalities and issues of residents. The health stats we mention in the bid highlight how big the challenge is in the North ward, how they are worse than the Sunderland average and it is the only one of the five wards in Washington that is in this position. So the need is there - the need to challenge lifestyles issues is reinforced by the stats and the concern has to be that no improvements will be seen and the health of residents in the ward may deteriorate if nothing is done. We know from various health reports going back to Wanless, there is no magic wand that will solve these inequalities but doing nothing is not an option and Wanless identified in the early 2000's that prevention was key to delivering change and was a cost effective approach. That then led to the white paper, the choosing health consultation and some of the changes in approach to health inequalities over the last 10 years.

This is why we are committed to using this project as a pilot to facilitate a funding bid to one of the larger funds as that might be the best way to sustain the work in the longer term and have the biggest impact. We will continue with the MOT's on site and will continue to support residents through exercise referral after the life of the project but some elements will need to have a charge attached to it. We will discuss what other elements of the project could be embedded in the centre offer once we have feedback from staff and participants on this project and we have undertaken the year 1 review.

Additional information

- Why will this approach work? Why aren't others already established able to deliver these outcomes?
    - Following the changes that were made to the old citywide EOR programme when the new contracts went out to tender, the focus switched to support reducing the pressure on hospitals and specialist services. People who would have previously benefitted from the scheme no longer can, so there is a gap and some people's needs are not being met. This means their health issues are at risk of deteriorating and then the strain on the health service, which is well documented, becomes greater.
    - Local provision is preferred
- The statistics for the North Ward show that with unplanned admissions and visits to A&E being greater than the Sunderland average and worse than the national average, failure to be pro-active will only compound these problems and pressures and we know these people then find their way into the Adult Services system and become a pressure on the local authority.

This application has been submitted through Area Committee's Call for Project and using the formal SIB governance protocols and guidance, the application has been assessed and the Panel score is 133 out of 200

This application:

1. **Evidences a good track record of successful delivery and experience**
    - This application evidences previous experience of similar projects, the organisation is based in the area and all beneficiaries will be from Washington.
    - Project Management and monitoring systems robust and clearly explained with examples given. Work monitored against planning, electronic financial systems, regular updates and reporting mechanisms identified. Experience of managing and monitoring other SIB projects.
    - Milestones realistic.
    - **There is reference to purchasing IT equipment/package where users of the service can track their progress. There are already tools out there that people can sign up to and track progress against targets (LLW and Change 4 Life do something similar) which should be explored before final design of project is agreed.**
    - **Risks and potential issues not identified in relation to this particular application. No reference to risk of lack of referrals.**
    - Requires some flexibility to be able to respond to demand as the project is developed.
    - Sustainability addressed – intends to data gather in order to provide evidence of need and apply for longer term funding. Mid-term evaluation identified although how and who needs confirming.
2. **Evidences it meets at least one of the key priorities of the Washington and co-ordinates with a range of activities and projects:**
    - This proposal meets three of the Area Committee priorities - health and well-being, adult social care and VCS collaborative working,
    - The project is clear that it will deliver more healthy lifestyles and support older and socially isolated individuals to become more active using a two strand approach.

- It is co-ordinated with and works in partnership with SCC Move to Improve Initiative, GPs, and other health partners such as Washington MIND. **However some key health providers delivering similar activities in the area (health plans and MOTs) are not identified as partners.**
- The proposal mentions signposting to the Live Life Well Service following initial 1:1 work and completion of the EOR programmes. **The Live Life Well service, commissioned by Sunderland City Council is available in all areas and provides much of the service described in the project brief e.g. health promotion, 1-2-1 support, health MOTs, stop smoking services, weight management etc. free of charge. This should be delivered as standard, with the WMC project picking up additionality, gaps etc. utilising a partnership approach and protocol. From the information provided it is not clear that the WMC engage or work in partnership with services already provided via LLW.**

3. **This proposal has evidenced good partnership working and is committed to further developing local inclusion and collaboration.**
   - Focuses on delivering two strands – exercise on referral/health MOTs and checks, and delivering healthy lifestyle messages. It identifies working in partnership with Washington MIND, GPs, pharmacies, MTI, will target local residents with long term health needs, will provide outreach work throughout the area and will look to be flexible re demand and targeting.
   - **It does not identify how it will engage a wider audience and in particular evidence that relevant partners such as Live Life Well have been engaged. This needs to be explored further.**
   - **The application provides limited information and evidence of how beneficiaries will be reached. The application is weak in terms of 'reaching in' to the community. By the very nature of those not active, they are hard to engage therefore some reference to methods for engagement are required to strengthen the bid**

4. **This proposal meets the project outcomes as detailed in the published Project Brief:-**
   - **a.** Address health inequalities of people aged over 50 years, in our most deprived neighbourhoods with a focus on Washington North but with a view to relevant services and support into other Wards, based on need. **Meets.**
   - **b.** Provide a community led personalised approach to encourage people to live healthier lifestyles. This could include 1:1 health planning/interventions and engagement, and identification of relevant pathways and progression routes. **Meets**
   - **c.** Identify partners and build and secure relevant partnerships and joint working protocols for those services and activities identified. **Partially Meets- need to further engage LLW and CIT**
   - **d.** Identify and confirm robust referral systems for all activities and services. **Partially meets - needs to engage with relevant health providers and other VCS organisations. Whilst the proposal identifies how the referrals will come from the health checks etc. it does not identify how those participants will be recruited or how the opportunities will be promoted**
   - **e.** Identify how relevant health messages, education and awareness raising to support the initiative will be implemented. **Meets**
   - **f.** Identify how opportunities for outreach will be developed in other Centres. **Partially meets but accepted this element will develop as the project proceeds and need and demand is identified**

g. Identify how activity and services can be sustained post SIB funding. **Meets**

h. Identify the mechanism for a mid-term evaluation to provide evidence of effectiveness and assessment of impact. **Partially meets. The proposal indicates a mid-term evaluation but does not describe methodology or who will carry out this 'review'. The applicant has identified data gathering using both qualitative and quantitative data, as well as user satisfaction surveys.**

Consultation comments and queries

To note – the organisation's responses to be considered in the context of early discussions at People Board and requests from Members for the applicant to include additional and expanded activity even though the lead did not have access to evidence to identify similar need in wards other than Washington North. Members asked searching questions and requested that the original project proposal be added to and not just focus on the North Ward (the evidence that was available at the time). It is recognised that some of the successes will be difficult to measure as it is likely to be years before the benefits can be seen. Following a discussion with partners and the Chair of the WMC Trust the application sets out to accommodate the Member's requests although the project proposal will need some flexibility to respond as it develops.

Queries

1. Are we being asked to fund an enhanced exercise on referral (EOR) scheme - the enhancement being the delivery of healthy life style messages?
Response: In order to address health inequalities in the North Ward – 2 strands are required. One will be to encourage people to make lifestyle changes - this is where the success really comes from and where the savings to health budgets will be achieved. The EOR strand is addressing the "current" need and pressures that various diseases are having both on residents and the health budgets/adult care budgets. Both strands are equally important and both will deliver benefits to the individuals and various budgets. As mentioned during 'pre discussions at People Board, we will never be able to full express what the savings are in real terms, but we will measure where we can i.e. prescription changes and reductions in medication. In addition, by doing the outreach work we are meeting the request from Members to widen the reach beyond the North Ward. Whilst there is some evidence that health messages do work, we have stressed the importance of the health checks as this facilitates a 1 to 1 discussion which is much more meaningful and focuses on the individual. We also refer to Wanless and the various tools we plan to use, which are mentioned in the bid.

2. It seems that the majority of candidates to take advantage of the scheme will be self-referrers rather than from doctors on an exercise on prescription system. The latter scheme did appear to exist according to Sunderland Exercise Referral Programme. Is the latter still in place or has it folded due to withdrawal of funding?
Response: Changes were introduced around 2 or 3 years ago when the CCG put out the new tender and exercise referral as it was, ceased and the new contract which the Council won, resulted in the setting up of the current Move To Improve scheme – a partner included in this proposal. The Washington Healthy Lifestyle proposal/activities is not currently available and has not been for some time, We have shown how this scheme will support the Move to Improve work and how we will be an exit route for some of their participants. This is why, along with the health checks we will undertake, we expect more people to self-refer rather

than being referred by the GP. We have only included those figures because we were requested to and therefore have made the best judgement call we can, based on what we know. As discussed at the People Board only once the project is up and running will we know which pathway suits participants best. Perhaps the important point to note is that there are two pathways, which Members had identified as being important when it was discussed at the People Board meeting.

3. If it is still in place could the Millennium Centre be included or used and the appropriate funding obtained from CCG?
Response: This is not an option as far as I understand the contract sits with the Council. The contract offer is different to the one the Millennium Centre is proposing as explained in the previous answer.

4. What is the current cost of EOR to an individual in other parts of the City?
Response: The EOR scheme as it was is no longer running and the Move to Improve scheme is different. When EOR was previously delivered at the Centre, the centre never charged for the use of facilities and had 2 EOR staff on site delivering on average 2 days a week. All participants came via the GP. We don't believe a like for like comparison can therefore be achieved. To ensure value for money we have explained that is the reason why the hours of staff deployed on the project, have been annualised and the project will only invoice for activities that are delivered. This also gives some of the flexibility we refer to as it means the delivery will be demand led, which is another way of ensuring value for money.

5. What is the current base line of referrals to the gym?
Response: As the Centre has not offered this service for several years the is no meaningful base line - as discussed at the People Board meeting when we explained our rationale and evidence to support need. The Centre sends on average 1 to 2 people per week to see their GP to request they sign off that they are fit to exercise, because they have presented with a medical condition when they have wanted to join the gym or take part in the easyline classes. This was also some of the evidence upon which we made our estimate when we were asked how many would self-refer.

6. What the target number of people for the enhanced healthy lifestyle messages is?
Response: Detailed on the outputs section of the application – we expect to achieve 100 EOR and 200 Health MOTs. We see the health checks as the mechanism to deliver healthy lifestyle messages – therefore the target number for enhanced healthy lifestyle messages is 200. Not included in this figure is how many people may attend outreach work, talks or presentations as it is difficult to estimate. From previous experience having conversations on a 1 to 1 basis does make a difference.

7. How will the messages delivered be different from those currently which could be provided by Health Champions?
Response: would question how effective Health Champions has been in Washington and how active some of them are now as many were trained from workplace organisations. Health Champions is a very different project to this proposal - they were given very basic training and their role was to signpost not to give "health advice" as this project will. The 2 key staff are trained and qualified to give out the information and know their own boundaries and when they will signpost or refer people on. They will as has been mentioned be undertaking health checks with individuals (Health MOT's) and discussing lifestyle issues be offering advice appropriately.

OFFICER RECOMMENDATION:

Approve subject to the following terms and conditions:

- **Confirmation of partnership working arrangements with key health providers already delivering in the area – Live Life Well – and other local organisations working with older people, in order to avoid duplication re health promotion and health messages. This will allow more resources to be targeted to delivering activity.**
- **Develop a more 'inclusive and joined up' referral method which will include the partners to bring in added value**
- **Utilisation of current online resources and websites, ICT tools and equipment – LLW, SCC Community Directory, Change for Life. This will allow more resources to be targeted re delivering activities and expanding the services into other neighbourhoods**
- **SCC Public Health colleagues should also be contacted to see if any of the public health promotion information currently held can be better utilised.**