Community Health Synchronisation Project (CoH-Sync) Evaluation Report

March 2022

CoH-Sync has been supported by the EU's INTERREG VA Programme, managed by the Special EU Programmes Body (SEUPB).

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1 Acknowledgements

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1.2 Contributors from CoH-Sync

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- Sadie Bergin, Programme Manager, CAWT Cross Border Health and Social Care
- Dr. Janet Swinburne PhD, Project Officer - CAWT EU INTERREG VA CoH-Sync Project
- Zoe Moore, Project Administrator, CAWT EU INTERREG VA, VA CoH-Sync Project

Their assistance with the provision of key information, guidance and constructive feedback has been invaluable in helping us write this report.

Furthermore, special thanks to the representatives of the CoH-Sync Hubs who kindly helped us write the case studies that gave us insights on how the project operated and was received by participants and communities at local level:

- Siobhan Coyle, Hub 1 – Donegal Local Development – Letterkenny & North Donegal - Republic of Ireland and Hub 2 – Donegal Local Development – Ballyshannon & South Donegal - Republic of Ireland
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Finally, many thanks to the members of CoH-Sync Project Board, for the helpful feedback on the draft version of this report and to all the members of the CoH-Sync Project Team for their work on the records and data collection that helped us present the project outputs. Their names have been added to section 11.4 of this report.

Disclaimer by the EU funders:

"The views and opinions expressed in this report do not necessarily reflect those of the European Commission or the Special EU Programmes Body (SEUPB)."

2 Foreword

Arguably the most impactful public health programmes are those which combine centrally held expertise and resources with community-level knowledge and relationships. The CoH-Sync project aimed to do just that – the central team guided the overall structure of the programme based on the latest evidence and provided the resources, core materials and tools for the project, while empowering organisations and individuals to respond with sensitivity and flexibility based on deep understandings of their communities.

The results of this approach are clear to see in that, even amidst the COVID-19 pandemic, the CoH-Sync project helped people see a significant improvement in their emotional wellbeing; and even under strict lockdowns, people's physical activity and diets both saw marked improvements. Under such circumstances, many projects would have come to a sudden halt. It is testament to the support from the central team and the commitment of the Hubs and Community Health Facilitators involved that the CoH-Sync programme both continued to operate and achieved impressive outcomes for beneficiaries, project staff, institutions, and communities.

The pandemic itself has shown the importance of preventative action when it comes to our health, of reducing our risk factors wherever possible, and of addressing health inequalities. We hope that all of those involved in the CoH-Sync project, and those inspired by its example, will use this report to maintain and build on its positive legacy.

Kiran Kenth
Director of National and Regional Programmes
Royal Society for Public Health

3 Executive Summary

Introduced in 2018, the Community Health Synchronisation project (CoH-Sync) aimed to improve health outcomes and reduce health inequalities experienced by communities located in some of the most deprived areas of the border region between Northern Ireland, the Republic of Ireland and Scotland.

Informed by evidence of the impact of key risks factors on the development of long-term conditions and chronic diseases, the project offered participants tailored place-based support to improve their physical activity levels, nutrition, tobacco and alcohol consumption, mental health, and health literacy.

This offer was provided by eight Hubs led by locally-based organisations with established connections with communities and local health systems. They delivered the project through a peer support model which included: a pre-assessment, developing a personal health and wellbeing plan (or plans), follow-up support (for 6 to 12 weeks), and a post-intervention assessment. In additions, Hubs offered classes, group activities, signposting and direct referrals to other services and/or opportunities.

This report brings together quantitative and qualitative data from the project with the aim of evaluating its outputs and their impact in the health and wellbeing of its participants. The key findings include:

- CoH-Sync was successful at reaching and engaging around 12,000 participants in areas of high deprivation (the bottom two quintiles on quantitative scales of overall deprivation).
- One of the appeals to participants of the CoH-Sync project was the diversity it offered in terms of the areas they could focus on, the activities, services, and support they could access.
- Data recorded in the Data Collection and Reporting Service (DCRS) shows that participants saw a marked improvement in their mental wellbeing, their diets and their physical activity levels.
- The efforts that Hubs employed to make participants feel welcomed and supported was clearly evident, many reported how that had influenced their involvement and their behaviour change.
- The COVID-19 pandemic led to a considerable growth in the demand for emotional well-being support. This was manifested in the increase in the number of participants whose health and wellbeing plans focused on improving their mental health.
- COVID-19 also posed operational challenges for the project in terms of recruiting new participants and continuing to engage and support those who had developed Health and Wellbeing Plans in the face of new priorities and pressures and Government restrictions. Nevertheless, the teams involved in CoH-Sync were able to successfully pivot to supporting the local emergency response. Their practical support – such as organising food deliveries, collecting prescriptions, providing information and signposting to further supported – benefited just over 1,500 individuals.
- CoH-Sync enabled a network of Hubs to develop local and cross-border partnerships and collaborations to best provide integrated health and wellbeing support. Through training, experience, new evidence-based approaches and systems, CoH-Sync also developed the knowledge and capabilities of those working in the Hubs to provide person-centred support. As a result, the capacity of those organisations and local health systems has been enriched, enabling them to build on their learnings from CoH-Sync as they develop and deliver new interventions for their communities.

4 Introduction

4.1 About this Report

This report has been prepared in collaboration by teams from the Royal Society for Public Health (RSPH) and NHS Midlands and Lancashire CSU (MLCSU). RSPH, which led the qualitative analysis of the project, is an independent charity dedicated to improving and protecting the public's health. MLCSU, a clinical support organisation within the NHS, provided the presentation and analysis of the quantitative data.

This report brings together quantitative and qualitative data from the project to evaluate its outputs and their impact in the health and wellbeing of its participants. We hope the insights and findings from this evaluation can fruitfully shape the offer, delivery, and operations of similar health improvement projects in the future.

4.2 About CoH-Sync

The Community Health Synchronisation project (CoH-Sync) operated from January 2018 to September 2021 with the aim of implementing a cross-border, collaborative, community-based approach to promoting healthier lifestyles, targeting key risk factors associated with long-term conditions. It was developed by the Co-operation and Working Together (CAWT) cross-border health partnership via a consortium of organisations:

- Western Health and Social Care Trust (Northern Ireland)
- Health Service Executive (Republic of Ireland)
- Public Health Agency (Northern Ireland)
- Southern Health and Social Care Trust (Northern Ireland)
- NHS Dumfries and Galloway (Scotland)
- Health and Social Care Board (Republic of Ireland)

The funding for the project was provided by the EU INTERREG VA programme, managed by the Special EU Programmes Body, and match-funded by the Government of Ireland and the Northern Ireland Executive. INTERREG is a component of the European Regional Development Fund (ERDF), which aims to strengthen economic, social and territorial cohesion in the European Union by correcting imbalances between its regions. As such, the project area comprised of localities with high levels of deprivation and rurality on the borders between Northern Ireland and the Republic of Ireland and incorporated two areas of South-West Scotland.

The CoH-Sync project was developed with the following key objectives:

- To support co-operation between regional health organisations and local health providers
- To encourage cross-border integration
- To engage with underserved communities and areas of higher deprivation
- To target those with the greatest health needs, specifically in the areas of diet, physical activity, smoking, alcohol and mental wellbeing.

Figure 1: CoH-Sync target areas

4.2.1 Project Approach

The CoH-Sync project approach was based on the premise that, to have real impact on the health and wellbeing of individuals and communities, there must be cooperation between health services, local councils, the community and voluntary sector, and other stakeholders.

Health and Wellbeing Community Hubs led by local organisations were established and operated a network of support in eight areas on the borders between the Republic of Ireland and Northern Ireland and in South-West Scotland. These areas were selected based on their relatively high levels of multiple deprivation, and broad population-level data was collected to inform the overall assessment of need.

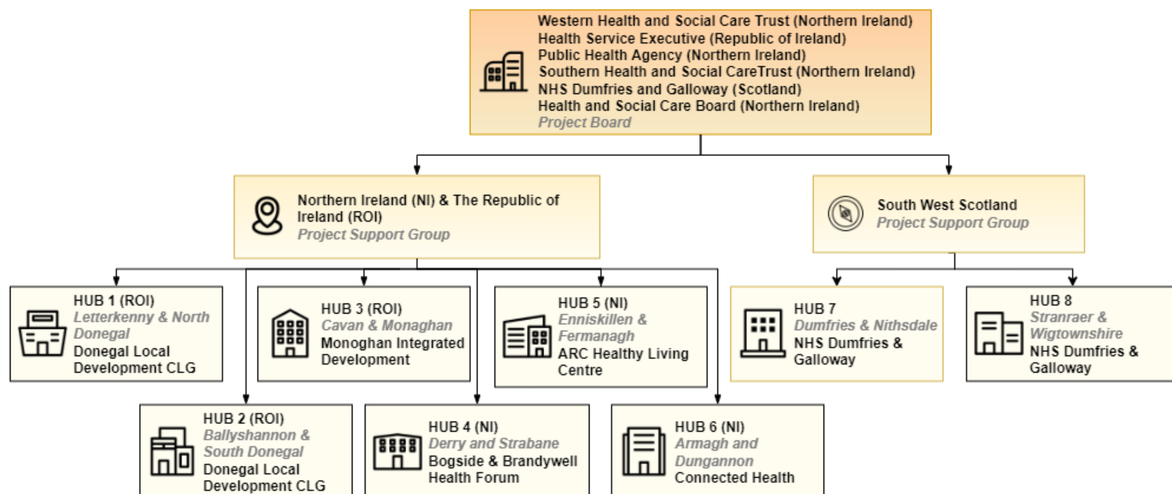


Figure 2 – CoH-Sync Project organisational structure

The purpose of the CoH-Sync project was to improve the health and wellbeing of adults, by helping them develop their own health and wellbeing plans, and make better use of local services, training opportunities and group activities[1].

Informed by evidence of the impact of key risks factors on the development of long-term conditions, the project designed a package of support to enable participants to improve their physical activity levels, nutrition, tobacco and alcohol consumption, mental health, and health literacy.

Figure 3 – Thematic areas of the CoH-Sync project

By being rooted in local communities, working with, and through, existing local organisations and initiatives, it was anticipated that the project would strengthen the capacity in those communities for improving health and wellbeing.

Building on the experience of health trainer services across several areas in the UK, the project developed a peer support model as a key mechanism to assist people to make good health choices. Local individuals were recruited to become Community Health Facilitators (CHFs) – they were tasked with helping participants develop individual health and wellbeing plans, and to take action based on their personal health priorities.

CHFs were trained using a bespoke Level 3 Certificate in Community Health Promotion, developed by North West Regional College, a further education and higher education college in the north-west region of Northern Ireland. The programme involved 180 hours of learning and covered the following units:

- **Unit 1:** The roles and responsibilities of the Health Promotion Champion
- **Unit 2:** Understanding the five key areas of health improvement (reducing alcohol consumption, reducing tobacco consumption, increasing physical activity, normal weight ranges, improving mental health and resilience)
- **Unit 3:** Promoting health literacy (in the five key areas)
- **Unit 4:** Communication and relationship-building within communities
- **Unit 5:** Enabling and supporting individuals to create health and well-being plans
- **Unit 6:** Supporting individuals to meet their health promotion goals

In addition, further training was delivered to staff in each of the Hubs, based on identified training needs linked to the project's objectives. The training offered included:

- Making Every Contact Count training by the Health Service Executive – this sought to enable learners to integrate health promotion information in their routine conversations with

[1] A number of under-18 participants also benefited from the CoH-Sync project during its first year whose data is included in this report.

clients and service-users, to empower and support them to make healthier choices and thereby achieve positive health outcomes.

- Accredited Chi Me training– this enabled participants to deliver simple and easy-to-follow sessions which promote good posture, strength and balance through slow, controlled movements.
- Accredited Chair Based Activity training– this enabled participants to plan and prepare chair-based activity sessions for individuals who want to increase their physical activity.
- Motivational Techniques training by Dumfries and Galloway Health and Social Care – this aimed to develop participants' abilities to have conversations that support participants change their behaviours and health-related beliefs.
- Looking After Your Mental Health training by the Western Health and Social Care Trust – this focused on the promotion and use of the '5 steps to wellbeing' as outlined by the New Economics Foundation: Connect, Be Active, Take Notice, Keep Learning, Give

The project offer to participants

The 12,000 participants (1,500 per hub) were offered a programme of support coordinated by their CHFs which would last between 6 and 12 weeks. This involved a series of sessions for: pre-assessment, developing a personal health and wellbeing plan (or plans), follow-up support, and post assessment. CHFs also offered information, signposting and referrals to relevant groups and activities which would complement participants' efforts to reach their health goals.

In addition to the 1:1 support and personal plans, the Hubs ran a programme of activities to help participants achieve their personal goals. These included, for example, cookery classes, befriending groups, and walking groups.

The design of the assessment and monitoring forms utilised as part of the health and wellbeing plans was informed by a number of validated questions and tools, including:

- Questions from the European Health Literacy Survey Questionnaire (HLS-EU-Q47), Health Survey Ireland 2016, Scottish Health Survey 2016 and Health Survey Northern Ireland 2017/18.
- The Friendship Scale (Hawthorne), the New General Self-Efficacy Scale (G Chen)
- Warwick–Edinburgh Mental Wellbeing Scale (R. T. al).

It is important to highlight that the standardisation of the health and wellbeing plans and data collection system was a process that, given funding and timescales constraints, had to take place in parallel to the delivery of CoH-Sync. Standardisation was achieved in the Hubs in the Republic of Ireland and Northern Ireland, but in Scotland, the Hubs had to retain their local data collection tools and health and wellbeing plans to align with local strategic goals. This challenge provided an opportunity for a participatory development process: personnel from all Hubs and members of the public (past participants and volunteers) were consulted in the design process and then tested the draft forms and plans. Feedback was collated and analysed to guide the final version of these documents. A sample of these materials can be seen in the appendices (section 11.2).

Engagement strategy

The project's engagement strategy built on the Hubs' existing relationships with local organisations and communities. Their reach encompassed providers across the local health system, including

acute hospitals, chronic conditions networks and services, GP practices, third sector organisations, public health and community-based statutory services. This enabled publicity about the project, as well as signposting and referrals to it, to reach a large number of individuals in the target areas.

Quality assurance for the project

To ensure consistent high quality in the delivery of CoH-Sync, the Project Board and central Project Management developed mechanisms to guide and support the Hubs' operations, including the Project Board Directive, quarterly reviews, and training on core project processes and procedures.

The Project Board Directive was a document with the essential elements of the 1:1 offer provided to project participants and the requirements for reporting, including:

a) All participants should complete a pre-questionnaire, post-questionnaire, an action plan with a SMART goal, or goals, and associated interventions for at least one thematic area.

b) Hubs had to provide a minimum of four 'CHF to participant' contacts during a period of between 6 to 12 weeks (or more if required).

c) In most cases, at least two of the contacts had to be face-to-face.

d) Details of all CHF contacts with participants had to be recorded on the Hub's data collection system

e) All goals had to be reviewed and progress recorded using the Hub's data collection system

f) All interventions had to be clearly recorded on the action plan and reviewed with the participant to confirm attendance/completion/other.

g) The provision of information (e.g. leaflet, website, apps) alone could not be counted as an intervention

In addition, quarterly reviews were carried out onsite by a CoH-Sync Project Worker from the central team. These meetings involved discussing operational and contextual issues, monitoring the quality of delivery and data collection, and if necessary, jointly identifying actions for improvement. These visits included the following activities:

- Completion of an assurance form – reviewed and signed with the Hub
- Revision of actions agreed from previous visit
- Review of any contextual factors and considerations that had an influence on the project delivery
- 20% Data Quality Check Feedback (using hard copies of plans randomly selected and checked against the DCRS)
- Provision of detailed feedback to the Hub's CHFs on the overall quality of delivery and data recording
- Discussion of cross-border and community-based meetings
- Revision of Equality Monitoring Form and participants' feedback

CoH-Sync during COVID-19 restrictions

During the COVID-19 pandemic and the associated restrictions, CoH-Sync changed its approach to support the immediate needs of the communities which the Hubs were serving. The COVID-19 Participant Support Form 2020 was introduced in May 2020 to assist new participants who could not

engage with a full health and wellbeing plan due to the restrictions and/or their clinical vulnerability. The support offered included: signposting to services, referral pathways, food parcels, organising the collection of prescriptions, and food deliveries. A second version of this form, which asked for more details from the client, was issued in December 2021.

4.2.2 Project Evaluation Methodology

The monitoring and evaluation framework was developed by the CoH-Sync project team and board members based on the logic model below. They worked with individual Hubs to refine the activities, outputs and short, medium and long-term outcomes.

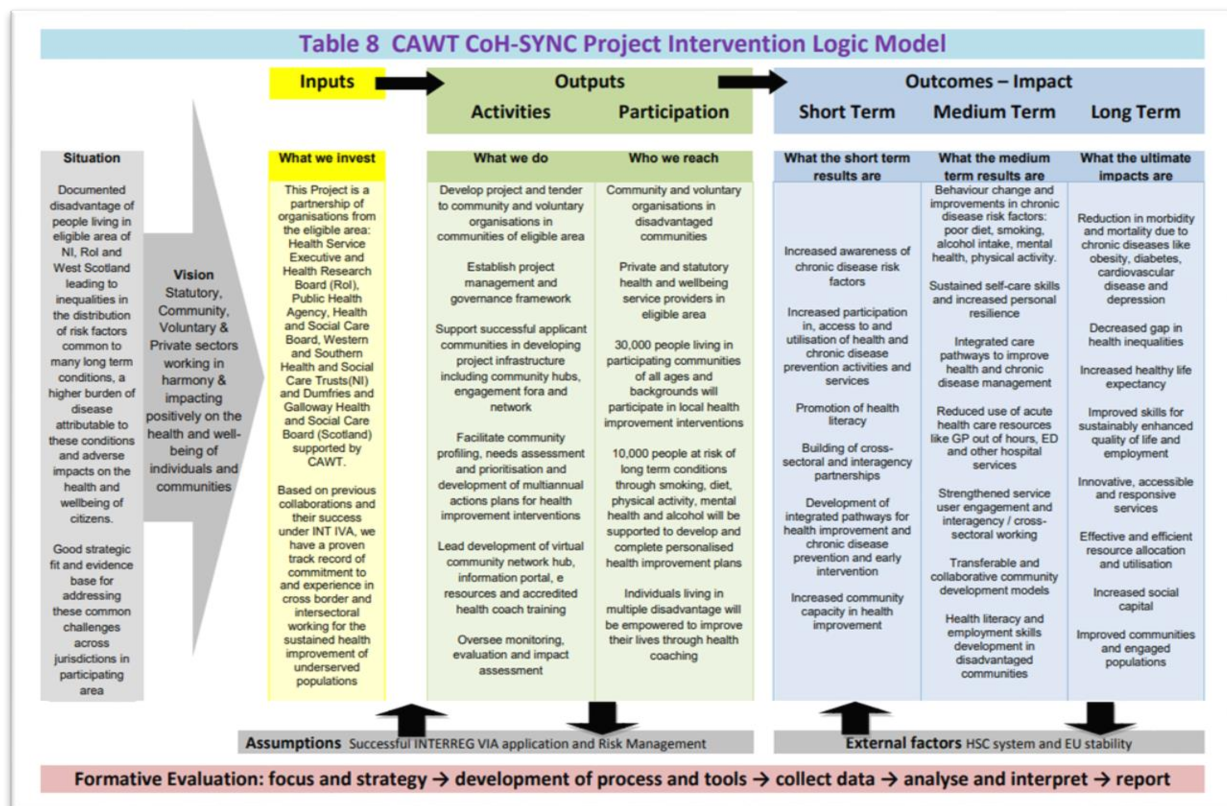


Table 8 CAWT CoH-SYNC Project Intervention Logic Model

		Inputs	Outputs		Outcomes – Impact		
			Activities	Participation	Short Term	Medium Term	Long Term
Situation	Vision	What we invest	What we do	Who we reach	What the short term results are	What the medium term results are	What the ultimate impacts are
Documented disadvantage of people living in eligible area of NI, RoI and West Scotland leading to inequalities in the distribution of risk factors common to many long term conditions, a higher burden of disease attributable to these conditions and adverse impacts on the health and wellbeing of citizens. Good strategic fit and evidence base for addressing these common challenges across jurisdictions in participating area	Statutory, Community, Voluntary & Private sectors working in harmony & impacting positively on the health and well-being of individuals and communities	This Project is a partnership of organisations from the eligible area: Health Service Executive and Health Research Board (RoI), Public Health Agency, Health and Social Care Board, Western and Southern Health and Social Care Trusts(NI) and Dumfries and Galloway Health and Social Care Board (Scotland) supported by CAWT. Based on previous collaborations and their success under INT IVA, we have a proven track record of commitment to and experience in cross border and intersectoral working for the sustained health improvement of underserved populations	Develop project and tender to community and voluntary organisations in communities of eligible area Establish project management and governance framework Support successful applicant communities in developing project infrastructure including community hubs, engagement fora and network Facilitate community profiling, needs assessment and prioritisation and development of multiannual actions plans for health improvement interventions Lead development of virtual community network hub, information portal, e resources and accredited health coach training Oversee monitoring, evaluation and impact assessment	Community and voluntary organisations in disadvantaged communities Private and statutory health and wellbeing service providers in eligible area 30,000 people living in participating communities of all ages and backgrounds will participate in local health improvement interventions 10,000 people at risk of long term conditions through smoking, diet, physical activity, mental health and alcohol will be supported to develop and complete personalised health improvement plans Individuals living in multiple disadvantage will be empowered to improve their lives through health coaching	Increased awareness of chronic disease risk factors Increased participation in, access to and utilisation of health and chronic disease prevention activities and services Promotion of health literacy Building of cross-sectoral and interagency partnerships Development of integrated pathways for health improvement and chronic disease prevention and early intervention Increased community capacity in health improvement	Behaviour change and improvements in chronic disease risk factors: poor diet, smoking, alcohol intake, mental health, physical activity. Sustained self-care skills and increased personal resilience Integrated care pathways to improve health and chronic disease management Reduced use of acute health care resources like GP out of hours, ED and other hospital services Strengthened service user engagement and interagency / cross-sectoral working Transferable and collaborative community development models Health literacy and employment skills development in disadvantaged communities	Reduction in morbidity and mortality due to chronic diseases like obesity, diabetes, cardiovascular disease and depression Decreased gap in health inequalities Increased healthy life expectancy Improved skills for sustainably enhanced quality of life and employment Innovative, accessible and responsive services Effective and efficient resource allocation and utilisation Increased social capital Improved communities and engaged populations

Assumptions Successful INTERREG VIA application and Risk Management

External factors HSC system and EU stability

Formative Evaluation: focus and strategy → development of process and tools → collect data → analyse and interpret → report

Figure 4 – CoH-Sync Intervention Logic Model

The evaluation sought to measure the impact of CoH-Sync on beneficiaries' health and health literacy levels, and on the communities' health infrastructure. Accordingly, the Hubs were asked to systematically record baseline data and post-intervention data on participants' levels of physical activity, health literacy, smoking and alcohol consumption, dietary habits, and mental health – in line with the project's six thematic areas.

In addition, Hubs were encouraged to collate participants' views and experiences about the project through post-intervention questionnaires, testimonials, and case studies. At the end of the project, the Royal Society for Public Health (RSPH) developed case studies for all Hubs to capture their perspectives on what worked well, the impact that CoH-Sync had on participants and localities, and their learnings.

Our evaluation of the effectiveness and impact of the CoH-Sync project inevitably has some limitations, owing to:

- The standardised data collection system provided by DCRS was not introduced until the second year of delivery. Data for the first year from all of the Hubs (and, for the Hubs in Scotland, throughout the project) was submitted in spreadsheets which were imported into DCRS, and thus some like-for-like comparisons (in areas beyond population profiling, throughput analysis and qualitative analysis) were limited by the differences between the datasets.
- The intervention outcomes recorded at the end of participants' involvement with CoH-Sync related to the completion of their Health and Wellbeing Plans as opposed to a metric of success. As such, the analysis of quantitative data provides completion rates and self-reported success rates as proxies for health outcomes.
- During the COVID-19 pandemic, CoH-Sync implemented a Participant Support Form to record the interactions with new participants who were not able to engage with a full Health and Wellbeing Plan. Analysis of the raw data of those forms has not been possible and therefore they are not included in this report.
- There were low sample sizes (significantly below 500 records) for health and wellbeing plans focused on smoking and alcohol, so analysis of that data should be treated as indicative rather than conclusive.

5 Population Profiling

5.1 Participant Distribution

The heat map of participant distribution (Figure 5) shows a broad geographical spread of participants, with strong clusters in border town areas such as Derry, Strabane, Monaghan and Armagh. The strongest clusters in South-West Scotland can be seen the Stranraer and Creebrdge/ Minnigaff areas. This broad spread is representative of the ‘Hub and Spoke’ approach set out in the programme design: the Hub serves as the operational base, located in areas of higher population density and higher deprivation, from which staff could then travel out in order to target more rural areas.

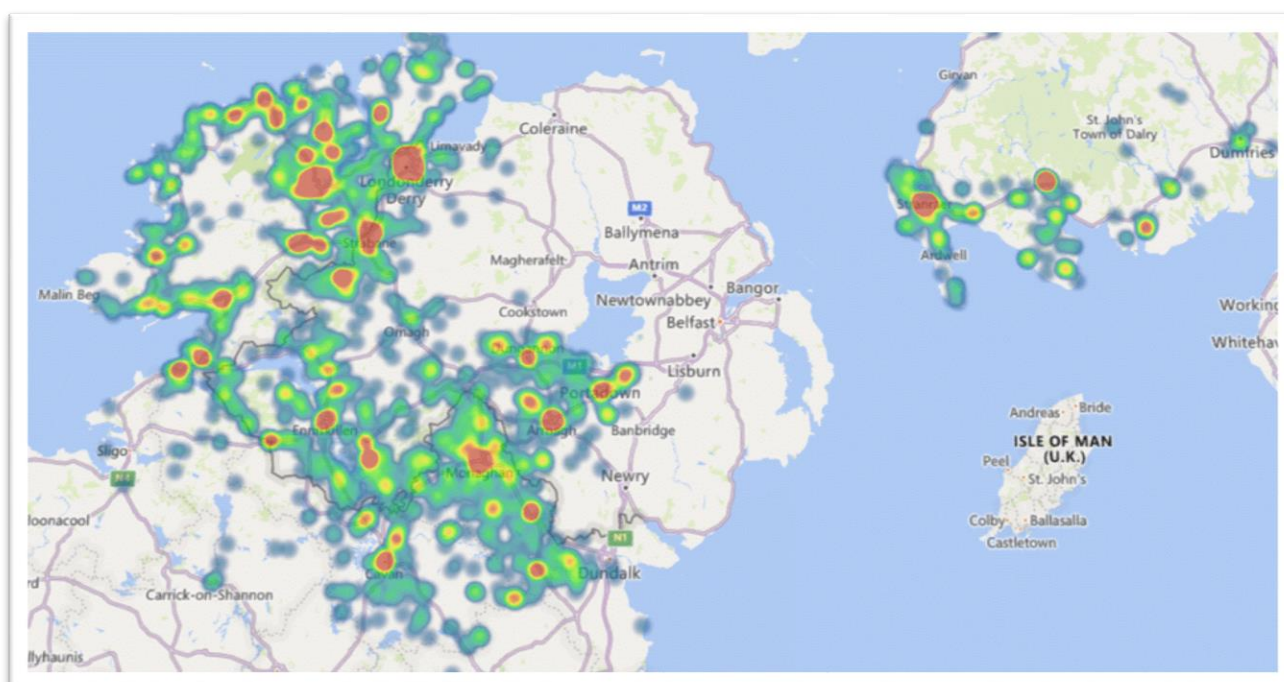


Figure 5 – A heat map of the COHSYNC programme’s participant distribution

5.2 Participant Recruitment Trends

The dates at which participants were recruited, as recorded in the DCRS, is shown in Figure 6. Of over 8,623 records reviewed, the highest number of participants came into the programme at the beginning of the project in Autumn 2018. Project staff accounted for this by citing critical contract deadlines which prompted significant efforts to promote the service and encourage sign-ups. Later into the delivery stage, between 200 and 400 new participants were recruited each month which was in line with the Hubs targets. The low number of interventions recorded in December 2019 resulted from the fact that services were focusing on preparing online course materials. The outbreak of COVID-19 and the first national lockdowns resulted in a slight fall in the number of participants; the funders and project management leads agreed the introduction of COVID-19 interventions (which involved signposting to services, referral pathways, food parcels, organising the collection of prescriptions, and food deliveries) in recognition of the additional pressures caused by the pandemic.

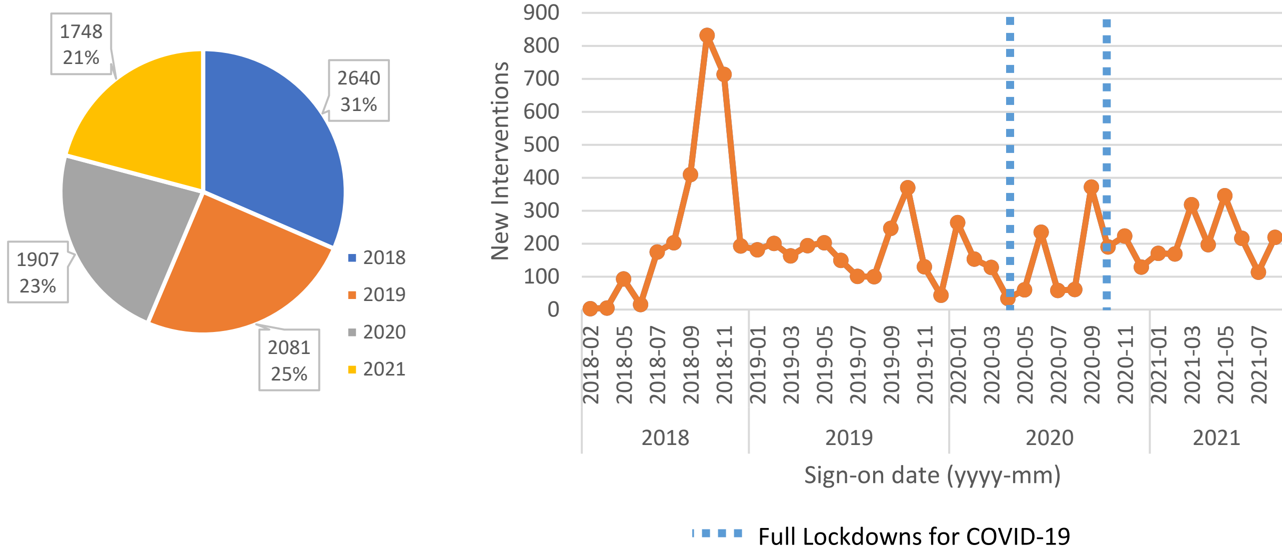


Figure 6 – Total number of participants split by years and new participants by month

5.3 Participant Demographics

The largest demographic groups represented among the beneficiaries of the project, as shown in Figure 7, were female, between the ages of 46 and 55, and residents of the second-most deprived communities.[2] This roughly matches the predominant demographic groupings recorded in DCRS's national public health dataset (Figure 8), though in the national sample, women made up a smaller majority of participants and a larger number came from communities classified as the most deprived quintile.

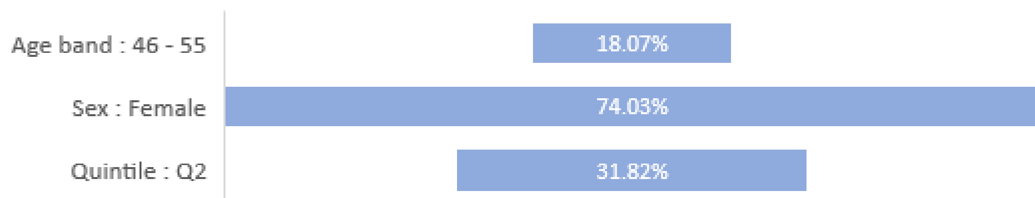


Figure 7 – CoH-Sync Predominant Groupings

Figure 8 – UK Public Health Lifestyle Service Sample Group (source DCRS)

[2] Deprivation figures represent DCRS recorded postcodes matching the ONS index of multiple deprivation, thus this is not representative of participant populations from Scotland, Northern Ireland or the Republic of Ireland.

Compared to the UK population as a whole (Figure 9), women and individuals aged between 46 and 55 were over-represented as participants in the CoH-Sync project.

Age Profile	Male (Count)	Female (Count)	Male (Per cent)	Female (Per cent)
Total	887,323	923,540	51.0	49.0
Aged 0-15	194,392	184,931	21.9	20.0
Aged 16-19	51,876	49,745	5.8	5.4
Aged 20-24	63,913	62,100	7.2	6.7
Aged 25-29	60,795	63,304	6.9	6.9
Aged 30-34	58,210	61,629	6.6	6.7
Aged 35-39	60,160	62,100	6.8	6.7
Aged 40-44	64,530	67,318	7.3	7.3
Aged 45-49	64,967	66,678	7.3	7.2
Aged 50-54	57,860	59,073	6.5	6.4
Aged 55-59	49,802	49,470	5.6	5.4
Aged 60-64	46,180	48,110	5.2	5.2
Aged 65-74	69,076	76,524	7.8	8.3
Aged 75 +	45,562	72,558	5.1	7.9

Figure 9 - ONS general population averages

5.4 Population Profile Analysis

5.4.1 A breakdown of key population profiles

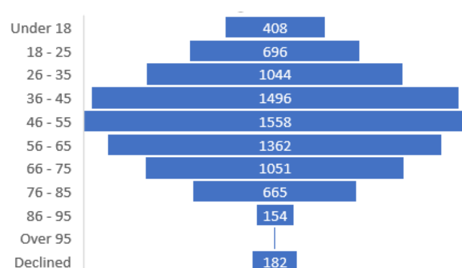


Figure 10 - Age-band spread

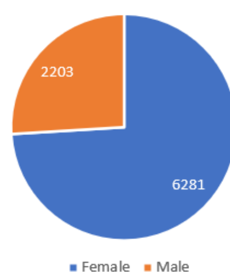


Figure 11 - Gender

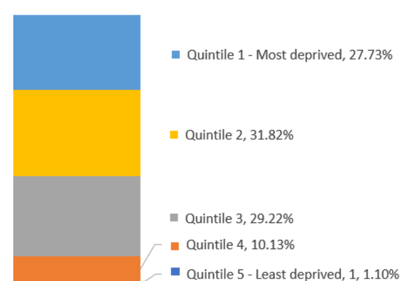


Figure 12 - Deprivation breakdown (UK only)

The population profiles in Figures 10-12 are based on the 8,623 DCRS records reviewed. Given the majority of participants came from the most deprived areas (59.55% for the bottom two quintiles combined) and the weighting towards the middle-of-life age cohorts (including 36-45, 46-55 and 56-65), the CoH-Sync programme succeeded in reaching its target audiences.[3] Although the Republic of Ireland does not have an equivalent to the Index of Multiple Deprivation used in the UK, public health specialists from the Health Service Executive, prior to project helped to identify areas of high deprivation where Community Hubs could be located before the project began.

[3] Deprivation analysis is based upon UK Office of National Statistics postcode data (https://digital.nhs.uk/services/organisation-data-service/file-downloads/office-for-national-statistics-data), these listings are not available for the Republic of Ireland and so deprivation analysis within this report covers just the UK.

5.4.2 Trend Analysis

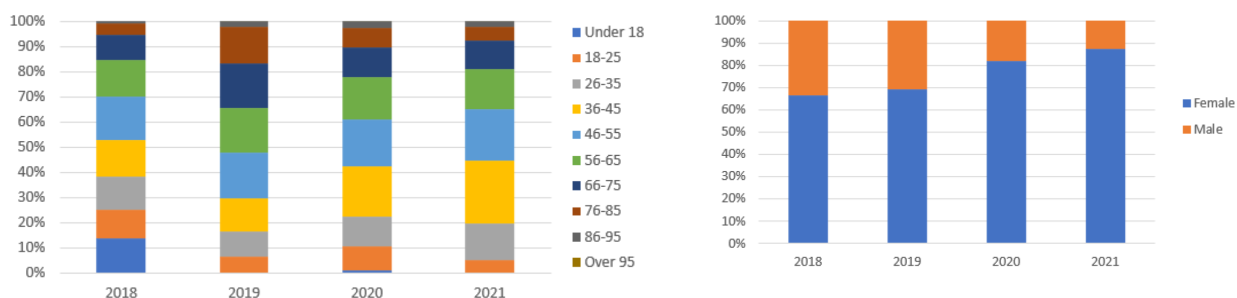


Figure 14 – New sign-on changes in participant age-bands and gender over time

In the first year of the project, under-18s were able to access CoH-Sync's service offer (Figure 14). Building on the success of a previous project that focused on preventing childhood obesity in border areas between Northern Ireland and the Republic of Ireland, uptake among this group was high in 2018 in both countries. But, as the original aim of the CoH-Sync project was to reach adults aged over 18, the Hubs were asked to redirect their efforts to older age cohorts for 2019 and the subsequent years.

CoH-Sync's offer was particularly successful with women, and their uptake significantly increased over the course of the project. This trend applied to each of the Hubs except for the Derry and Strabane hub, where in 2021 there was a 16% drop in female participants (though women still constituted the majority of its beneficiaries). Staff at each of the Hubs and the central project team tried to redress this gender imbalance but found that engaging men from rural backgrounds to be a challenge. One proposed solution for any future iterations of the project was for more male CHFs to be recruited.

5.4.3 Annual Service Uptake

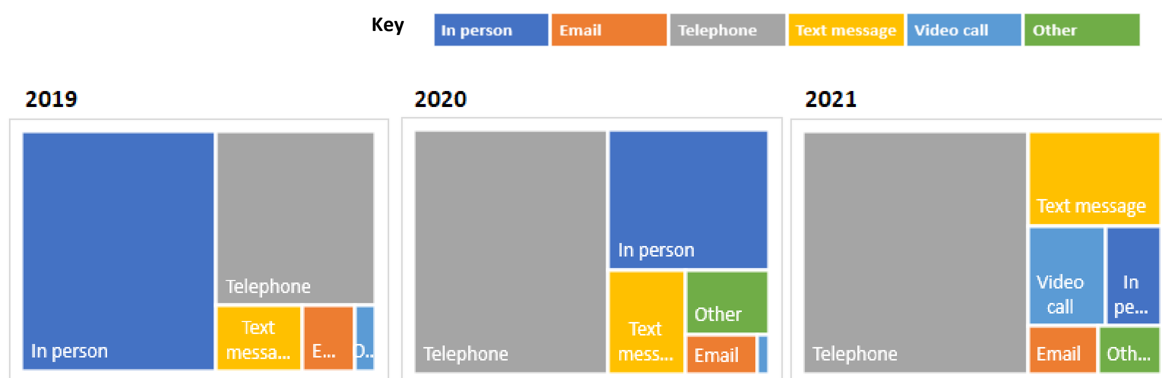


Figure 15 - Proportional representation of participant contact types year by year

Using DCRS data (and therefore not available for 2018), Figure 15 shows a proportional representation of the different contact methods used by CoH-Sync Hub staff used to reach participants. After the outbreak of COVID-19, telephone calls became the most common mode of communication given the lockdown restrictions. Although video calls became more common in 2021, many participants in remote rural areas had no access to wireless internet or digital devices.

Overall, CoH-Sync reached about 12,000 people: 8,376 engaged with the complete project offer by developing health and wellbeing plans, an additional 1,500 were supported through the COVID-19 emergency response, and it is estimated that the Hubs had brief contact with around 2,000 others through the activities they ran and/or information they developed. A breakdown of new participant engagement by each Hub is presented in Figure 16. The Hubs in Derry and Strabane, Enniskillen and Fermanagh, and Armagh and Dungannon were the most successful at engaging new participants even during the year of the most thoroughgoing restrictions for COVID-19, while the Hubs in Donegal and Cavan and Monaghan (Hubs 1, 2 and 3) recovered from the dip in new participant engagement seen in 2020. The Hubs in Scotland (7 and 8) were most affected by the pandemic as a large proportion of their staff are NHS Scotland employees and were thus redeployed to emergency support programmes.

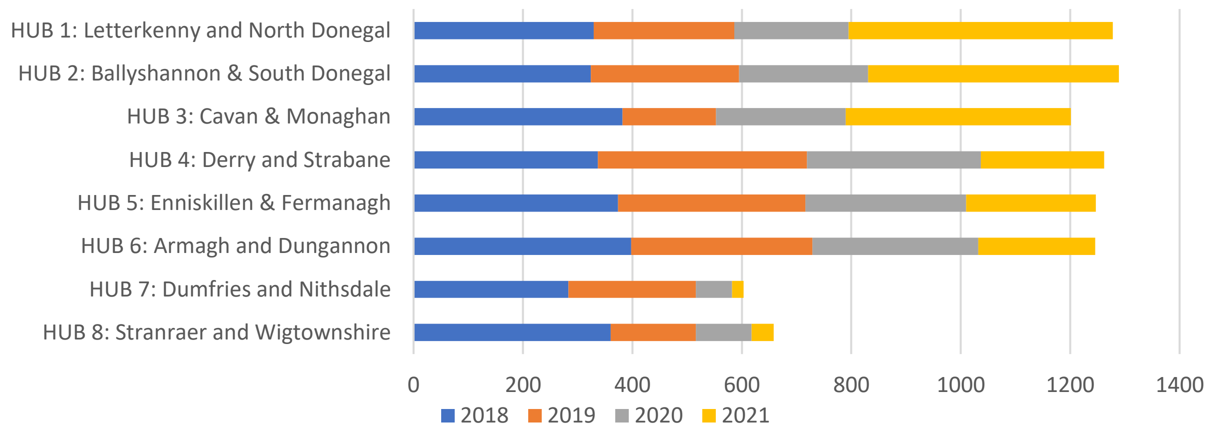


Figure 16 - Participant engagement counts per year by Hub

6 Participant Journeys

6.1 Sources of Uptake & Health & Wellbeing Information

The recruitment strategies used by the Hubs involved engaging with grassroots community initiatives as well as third sector and statutory organisations. Online promotion and word-of-mouth were also key to engaging with individuals, as can be seen in Figure 17, which shows that the majority of participants heard about the project online (45.5%) followed by a recommendation from friends or family (16.9%). Inevitably this result was found to be influenced by the COVID-19 lockdown period. The orange line represents the cumulative percentage of the sources through which participants heard about the project.

Meanwhile we also see in the second Figure 17 chart a breakdown of sources of where participants reported they found their health and wellbeing information from. Over one quarter cited their GP or Healthcare provider, whilst only 10.5% sourced information from local community providers.

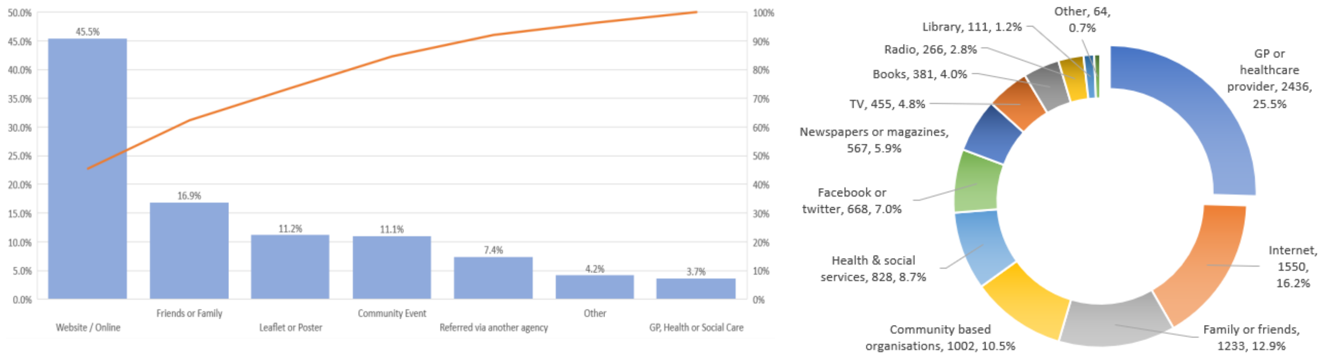


Figure 17 – Participants' source of information about the project (left) & Participants sources of Health and Wellbeing Information (right)

6.2 Intervention Types and Intensity

CoH-Sync was designed to offer participants health improvement support in key thematic areas relating to known risk factors for long-term conditions and chronic diseases: alcohol, smoking, mental health[4], nutrition, and physical activity. Participants were asked to focus their Health and Wellbeing Plans on at least one thematic area.

[4] In this context, mental health refers to the prevention and management of common mental health issues such as anxiety and depression.

6.2.1 Breakdown of Thematic Areas

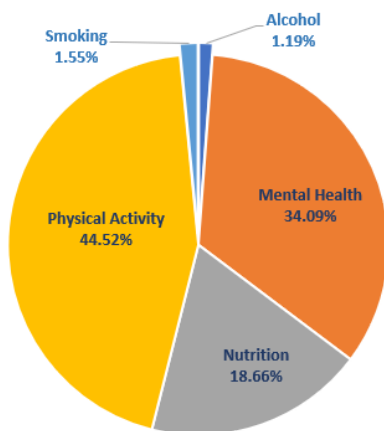


Figure 18 - Primary thematic area breakdown

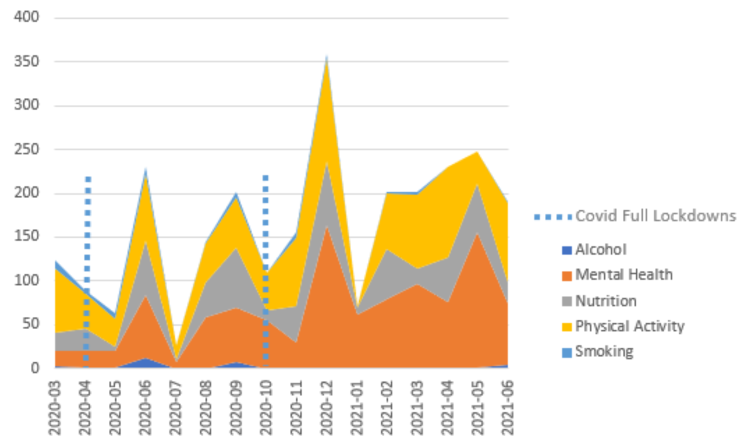


Figure 19 – COVID-19's Impact upon Interventions by Thematic Area

Of a total of 8,352 recorded participant assessments, Figure 18 shows that physical activity and mental health were by far the two most popular thematic areas covered in participants' Health and Wellbeing Plans (chosen by 44.2% and 34.1% of participants respectively). Nutrition was the third most popular area, chosen by nearly one fifth (18.66%) of participants.

By contrast, reducing alcohol consumption and smoking levels featured far less frequently in participants' Health and Wellbeing Plans. One of the reasons for this, posited by staff at the Hubs and the central CoH-Sync project team, was that participants may have had concerns about the level of confidentiality if they sought to address these sensitive issues in a community setting. Personnel from one Hub added that many participants may not have felt confident or psychologically ready to tackle their use of alcohol or smoking habits, especially during the pandemic, which likely reinforced their importance as coping strategies for dealing with stress and anxiety. Nevertheless, during the assessment stage, if a participant described being a regular smoker or drinking moderate-to-high amounts of alcohol, they were offered information on smoking cessation and alcohol harm awareness. It is hoped that those participants will be able to access the appropriate help or make changes to their behaviour outside of the CoH-Sync project.

Over the course of the project, more participants opted to focus on addressing their mental health (Figure 19), likely showing the impact of the pandemic on people's mental wellbeing.

6.2.2 Length & Intensity of Interventions

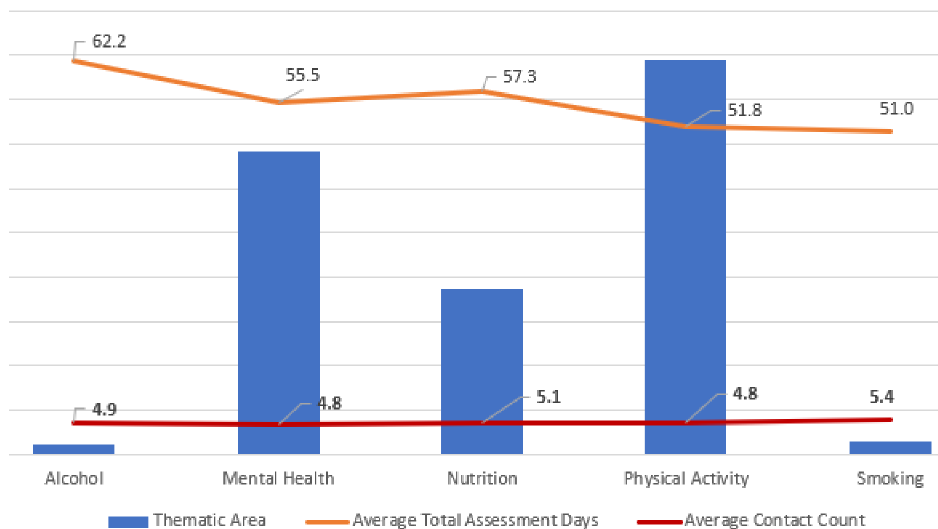


Figure 20 – Average assessment length and number of contacts per thematic area

The average number of days and the average number of one-to-one contacts that took place for each thematic area is shown in Figure 20. Although the variation is not significant, it shows that the most popular thematic area, physical activity, accounted for the second lowest average number of contact counts and assessment days. It can also be seen that the broad target for intervention periods of 6 to 12 weeks (depending on individual participants' needs) set at the beginning of the project was largely met.

6.2.3 Participants Addressing Multiple Thematic Areas

Although participants were encouraged to address more than one thematic area in their health and wellbeing plans, the majority (79.6%) chose to focus on just one (Figure 21). 1 in 5 participants developed plans addressing at least two thematic areas. Staff at the Hubs suggested that participants may have been concerned about their ability to make multiple changes to their lifestyle at once, and therefore they may have benefited from the opportunity to make two or more consecutive health and wellbeing plans.

Where more than one thematic area was included in a participant's plan, Figure 22 shows that the most popular pairing was nutrition and physical activity. Figure 21 and Figure 22 only represent data entered on DCRS.

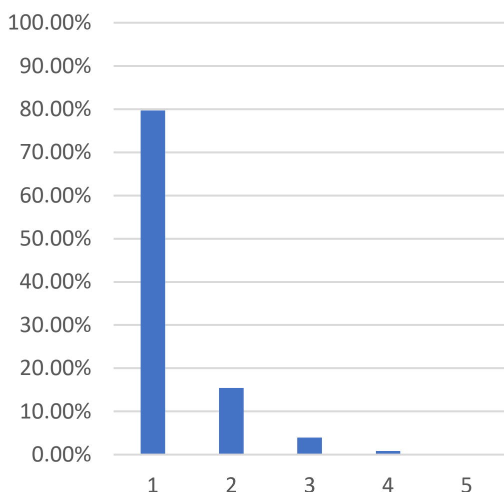


Figure 21 - Instance of multiple thematic areas

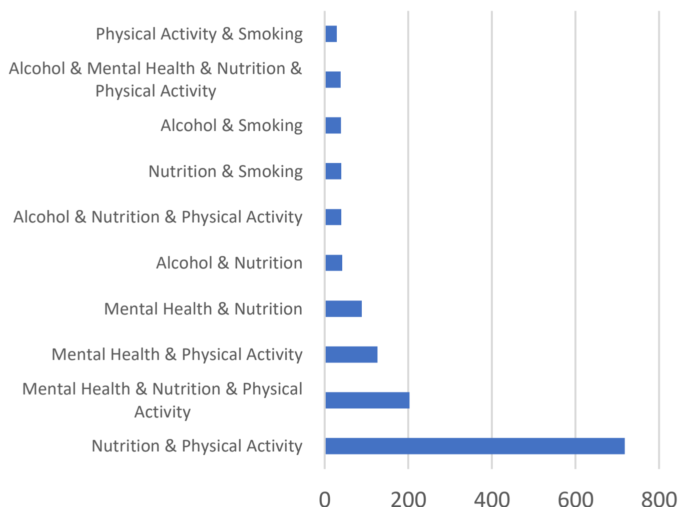


Figure 22 - Most common thematic area pairings

6.3 Types of Smart Goals & Agreed Interventions

Having chosen the thematic area(s) which a participant wanted to address, they then agreed with a Community Health Facilitator one or more SMART goals which set out what they would achieve and by when. Participants could also be referred to another service or initiative outside the CoH-Sync Project to help them improve their health and wellbeing in a particular area. It should be noted that the goal set did not need to be achieved by the time their involvement in the project ended. Most participant did set goals within the timeframe but not all.

6.3.1 A Review of Smart Goal Types

SMART goals are Specific, Measurable, Achievable, Relevant and Time-bound – by defining one's objectives using these criteria, it is easier to ensure that they are attainable in a given time-frame and to assess what progress is being achieved. We now turn to look at the breakdown of SMART goals set for the three most popular thematic areas (chosen by 97.27% of participants combined): physical activity, mental health and nutrition.

6.3.1.1 Physical Activity Smart Goals

The chart in Figure 23 shows the various SMART goals that were set by participants when their plans focused on physical activity. 3,172 participants set one or more SMART goal, which was recorded in DCRS. Half (50.47%) of participants set 'establish an exercise programme' as their goal. Where participants' goals were listed as 'Other', their notes were reviewed, and a breakdown of the themes is presented in the key on the right.

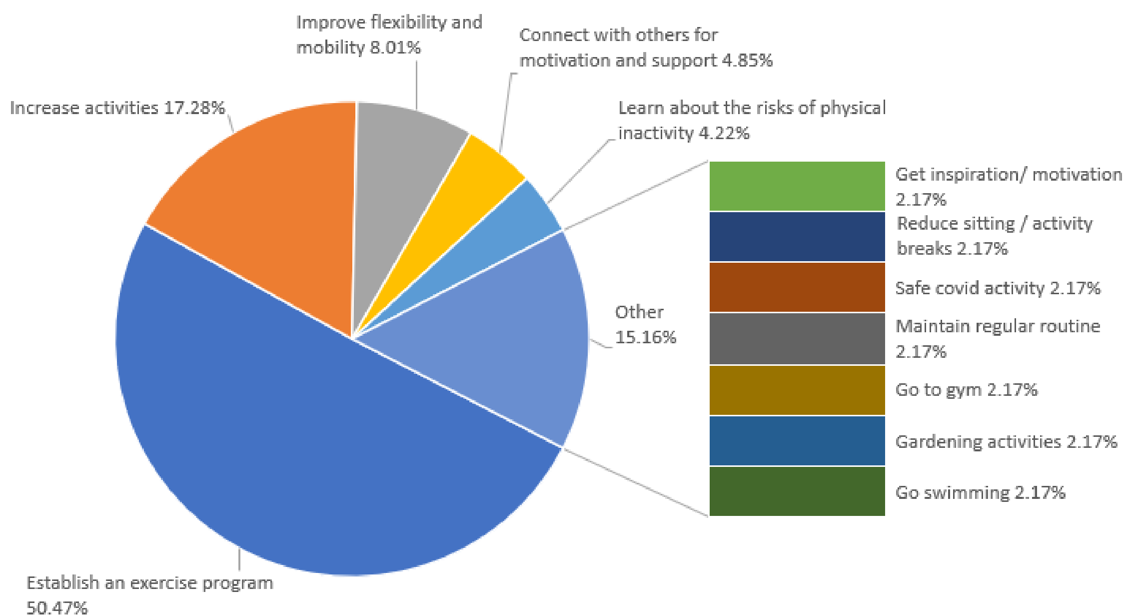


Figure 23 - Physical Activity Smart goals

6.3.1.2 Mental Health Smart goals

There was a greater spread in the SMART goals set by participants seeking to improve their mental health, with 2,570 participants setting one or more goal in DCRS. The most popular goal, chosen by 1 in 5, was to 'improve personal habits'. This goal, when investigated, broke down into a number of subset areas: be more physically active; create 'me time'; get adequate rest; improve self-care; improve sleep habits; improve work/life balance; maintain a healthy diet. Of these, self-care and more 'me time' were the most popular. The key on the right-hand side of the chart below also gives a further breakdown of the themes for the SMART goals categorised as 'Other'.

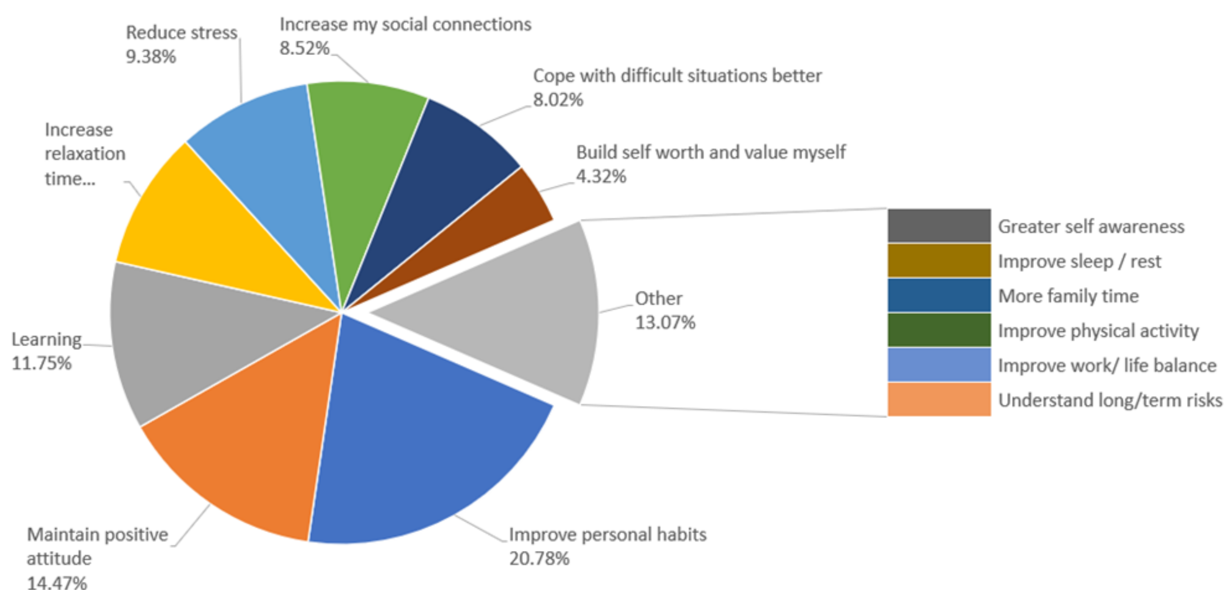


Figure 24 - Mental Health Smart goals

6.3.1.3 Nutrition Smart goals

When participants developed health and wellbeing plans with nutrition as a core focus, there was a reasonably even split between four SMART goals in particular. Learning about nutrition and the risks of not having a balanced diet; eating the recommended portion sizes; making healthier meals at home; and improving the uptake of key nutrients were each selected by between 1 in 4 and 1 in 5 participants. In total 1,365 participants set at least one nutrition goal. Among the SMART goals categorised as 'Other' were similar objectives phrased negatively. In other words, rather than aiming to improve the uptake of key nutrients, they aimed to reduce their intake of salt or sugar.

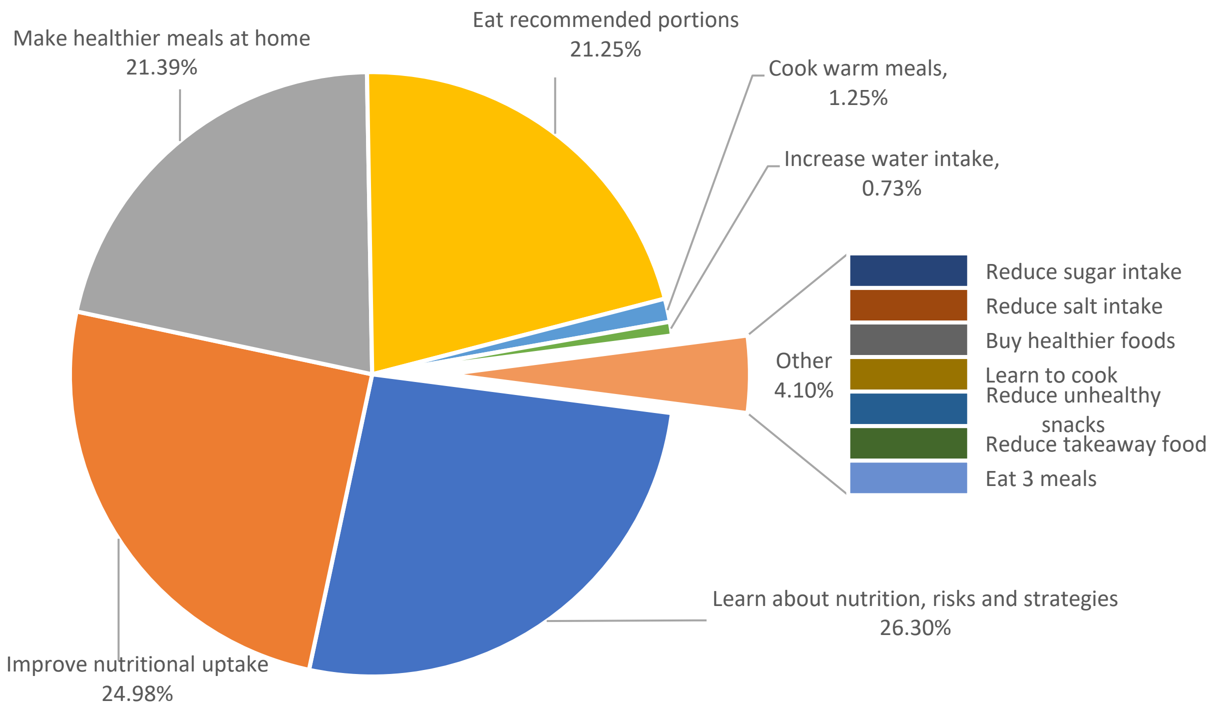


Figure 25 - Nutrition Smart goals

6.3.2 A Review of Intervention Support

Where participants were supported by internal or external services services to achieve their health and wellbeing goals, referrals were recorded and tracked in DCRS – 7,079 such instances were recorded. In line with the popularity of the physical activity, mental health and nutrition thematic areas, over 98% of interventions related to one of these three themes (physical activity accounted for 44.1% of the interventions; mental health accounted for 35.1%; and nutrition for 19.1%). In the review below, we have excluded intervention referrals that had non-specific labels (e.g. information or support group) and categories where less than 10 referrals were made.

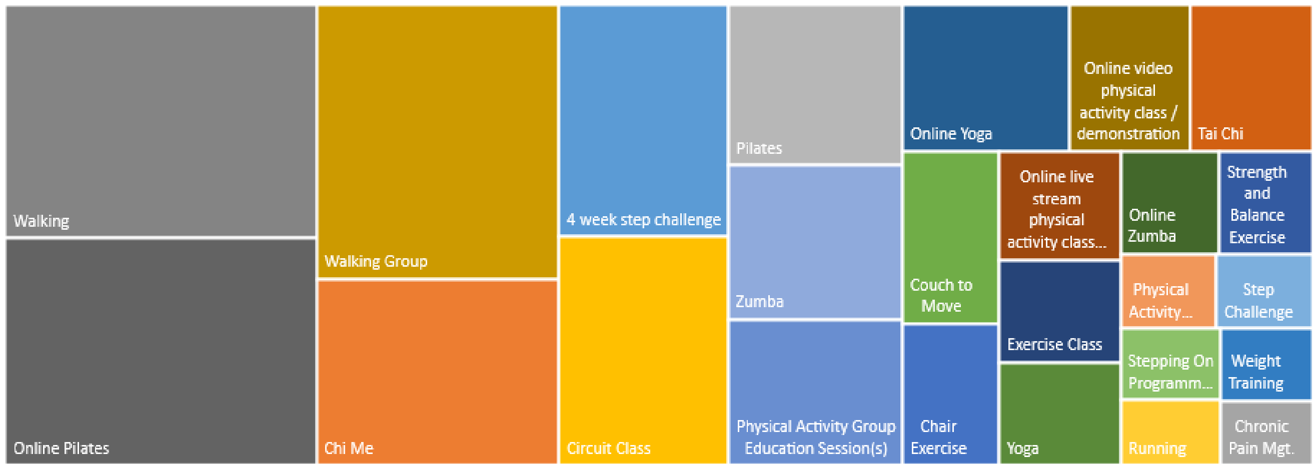


Figure 26 - An overview of physical activity interventions undertaken

Figure 27 – An overview of mental health interventions undertaken

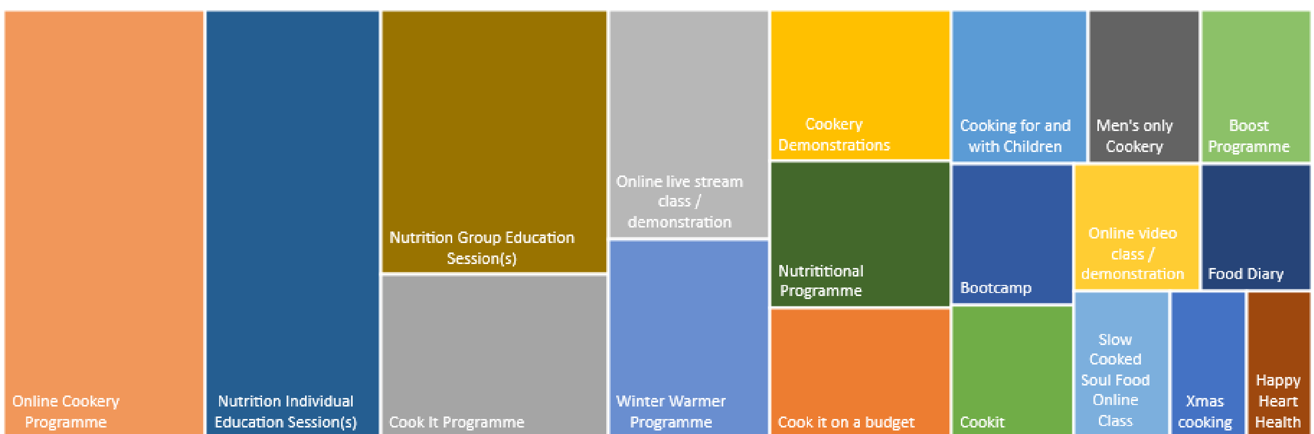


Figure 28 - An overview of nutrition interventions undertaken

These charts demonstrate the breadth of activities and programmes which were made available to participants to best accommodate their needs and preferences. Feedback from participants (reviewed in Section 9) demonstrates that this wide-ranging offer was a highly valued feature of the CoH-Sync project as it gave them a sense of choice and control over their health and wellbeing plans. It is important to highlight that triangulation of the data suggests that most of these referrals were to internal services, for example classes and groups provided by CoH-Sync or the Hubs through other projects.

7 Project Outputs

This section analyses the outputs of the CoH-Sync project as recorded (or subsequently imported in the case of historic or Scotland data) into the DCRS.

7.1 Goal Completions and Intervention Attendance

Goal Completion

The recorded completion statuses of participants' SMART goals are shown in Figure 29. The vast majority of cases were recorded as fully completed, with the thematic areas of physical activity (93.1%) and mental health (92.4%) seeing the highest completion rates.

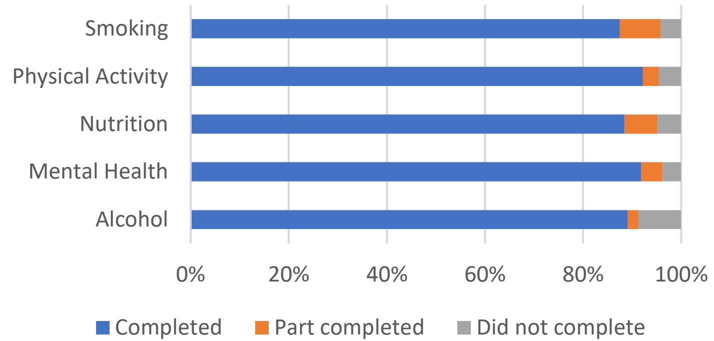


Figure 29– Goal Outcome by Thematic Area

Intervention Referral Attendance

Most participants who received a health assessment and developed a Health and Wellbeing Plan received an intervention referral to an internal and/or external programme or service. The attendance rates based on these referrals are shown in Figure 30, broken down for each thematic area.

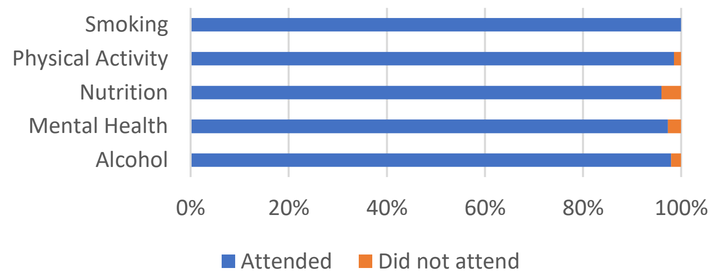


Figure 30 – Intervention Referral Attendance by Thematic Area

Unfortunately, the reliability of this data is unclear. Hubs were not given clear instructions on how to classify goal-completion and intervention attendance, and final sign-off on these figures was undertaken by administrative staff rather than the Community Health Facilitators who had worked with participants on a 1:1 basis. Therefore, this data should not be accepted at face value, but should rather point to the need for future projects to include guidance on how to validate outcomes.

7.2 Quantified Improvements

With DCRS, assessment measures before and after an intervention can be recorded, and hence the level of change achieved on average can be quantified. To do so, all data is validated at the point of entry into the system, and only questionnaires with measures recorded both before and after the intervention are included. Unfortunately, this data was not available in imported historic and Scotland datasets – this contributed to there being many cases where pre- and post- scores were not recorded. So, while there are clearly stated available sample sizes in these results, it is difficult to ascertain the overall significance of the results.

7.2.1 Physical Activity Improvements

Participants who focused on improving their physical activity were asked about their levels of physical activity before and after the supportive intervention. The averaged scores (based on sample sizes of 1,731, 1,735 and 2,566 participants respectively) shows a clear increase in participants' activity levels as a result of the intervention.

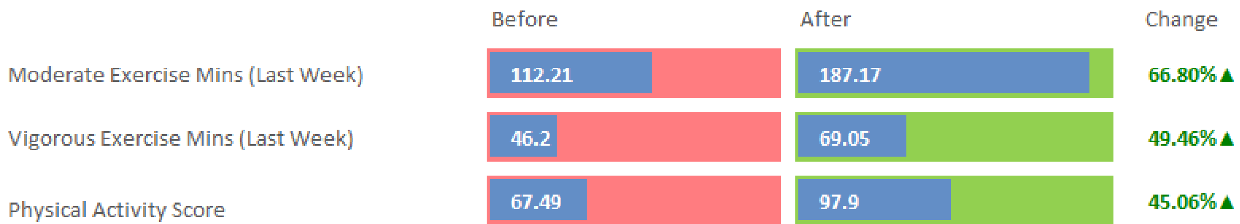


Figure 31 - Before and after averages of physical activity measures

7.2.1.1 Comparison to DCRS Participant Base

DCRS is the data collection system utilised by most health trainer services in England. As such, CoH-Sync data was compared with DCRS Participant Base data concerning changes in levels of moderate exercise recorded in the 2016 Minded to Change report[5]. The DCRS Participant Base data looks at changes in physical exercise in 30-minute increments per week whereas the CoH-Sync data uses the total number of minutes of activity as the measure. Nevertheless, the 66.8% increase in the amount of time spent engaging in moderate exercise per week recorded in the CoH-Sync project is roughly comparable with the 72.59% increase documented in the Minded to Change report.

D. Moderate exercise (30 mins per week) change for all clients, July 2012 – July 2015

Moderate exercise	Before	After	Change
	2.59	4.47	+72.59%

Figure 32 - Moderate exercise changes from Minded to Change report

7.2.2 Considered General Health Improvements

Participants were asked to rate current rate on entry and when exiting the service. Of some 6168 before and after responses and it was been found that those responding 'very good' rose from 13.13% to 25.66% of all participants, meanwhile we see a corresponding decline for 'very bad' from 1.34% to 0.13%.

[5] The Minded to Change report is an evaluation of how Health Trainer services in England impact of the mental health and wellbeing of beneficiaries.

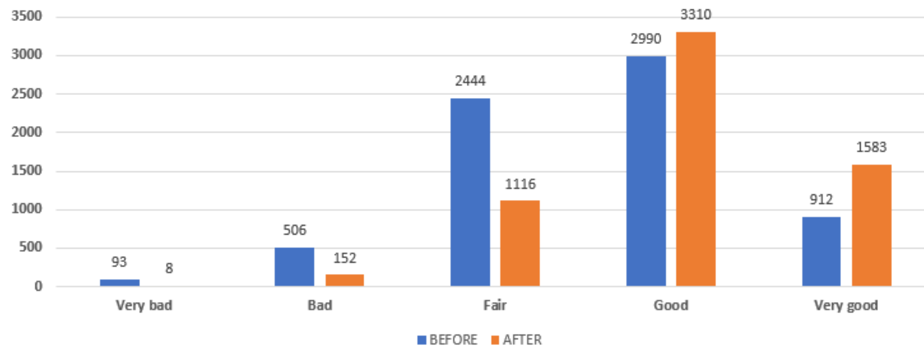


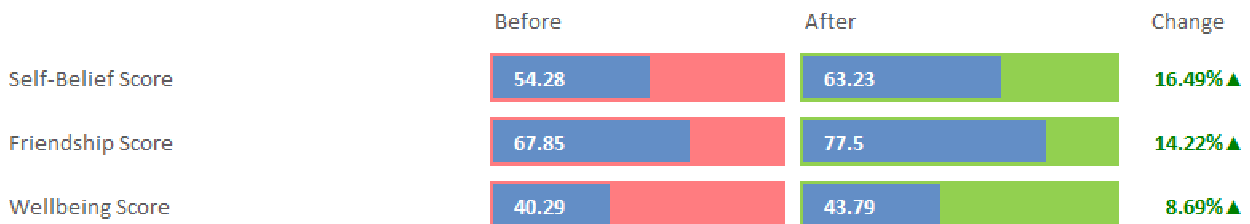
Figure 1 - Considered General Health

7.2.3 Mental Health Improvements

The changes in the mental health of participants who focused on this area were measured using three validated wellbeing tools:

- Self-Belief Score: Chen, Gully, Eden's New General Self-Efficacy Scale (2001) (G Chen)
- Friendship Score: Hawthorne's Friendship Scale (2006) (Hawthorne)
- Wellbeing Score: The Warwick-Edinburgh Mental Wellbeing Scales (2007) (R. T. al)

The scores in Figure 33 (each on a score of 1 to 100) are averages of the pre- and post-intervention measures, calculated from samples of 1487, 1258, and 1464 participants respectively. Self-belief scores increased on average by 16.49%, friendship scores by 14.22% and wellbeing scores by 8.69%.

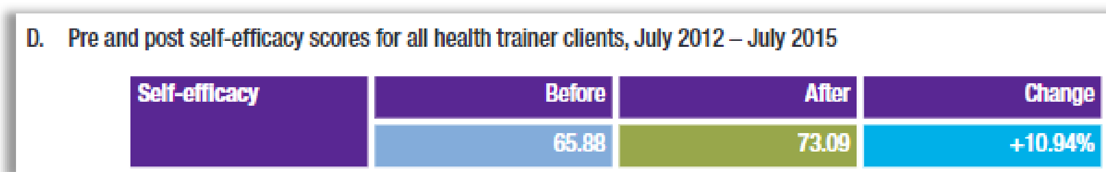


	Before	After	Change
Self-Belief Score	54.28	63.23	16.49%▲
Friendship Score	67.85	77.5	14.22%▲
Wellbeing Score	40.29	43.79	8.69%▲

Figure 33 - Before and after averages of wellbeing measures

7.2.3.1 Comparison to DCRS Participant Base

The Minded to Change report includes DCRS Participant Base data relating to self-efficacy scores, which maps to the self-belief measure used in the CoH-Sync project. While the DCRS Participant Base saw an average increase of 10.9% in self-efficacy scores, CoH-Sync participants experienced a higher average increase of 16.5%.



D. Pre and post self-efficacy scores for all health trainer clients, July 2012 – July 2015

Self-efficacy	Before	After	Change
	65.88	73.09	+10.94%

Figure 34 - Self-Efficacy Change obtained from Minded the Change report

7.2.4 Health Confidence Improvements

An integral part of CoH-Sync's approach was to improve participants health literacy levels. By supporting participants' ability and confidence to make sustained, positive choices to improve their health and wellbeing, it was hoped that health inequalities could be reduced. Evidence pertaining to health literacy levels was gathered using validated questions from the European Health Literacy Survey Questionnaire (S. e. al) which explored participant's access to, awareness and understanding of health-related information.

Based on a sample of 1,017 responses, Figure 35 shows an average 10.3% increase in participants' confidence about their ability to address their own health needs.

Figure 35 - Before and after averages of confidence measures

Self-efficacy was also available in DCRS to be recorded before and after. Although both male and female participants saw their self-efficacy scores increase as a result of the project, Figure 36 shows that women experienced a greater increase than men (65.5% compared to 56.9%), based on a total of 1,647 responses.

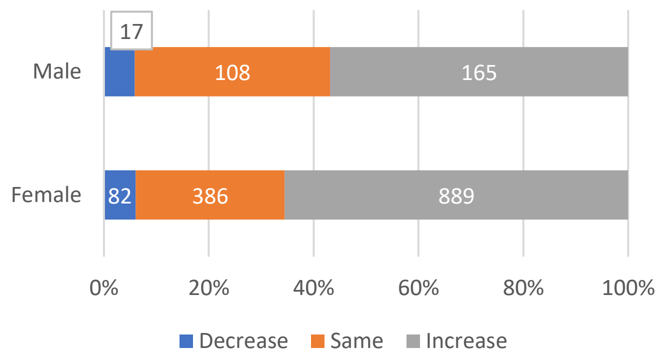


Figure 36 - Self-Efficacy by Gender

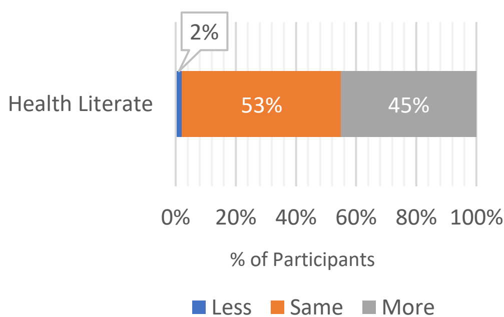


Figure 37 – Participants' Health Literacy

45% of participants reported that their health literacy improved as a result of the CoH-Sync project (Figure 37).

7.2.5 Nutrition Improvements

Given the high interest shown by participants in improving their diet, the Hubs invested significant time and effort into providing classes, activities and accessible information that supported participants' nutrition-related goals. The improvement in participants' consumption of fruit and vegetables (Figure 38 shows the average increase based on 3,120 participants' responses) is testament to the value of those efforts.

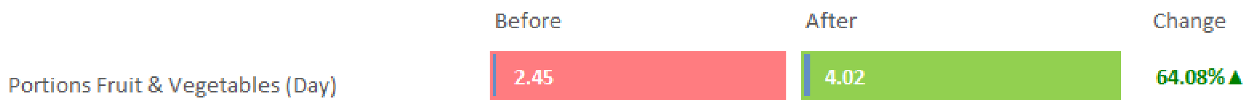


Figure 38 - Before and after averages of Fruit and Vegetable portions per day

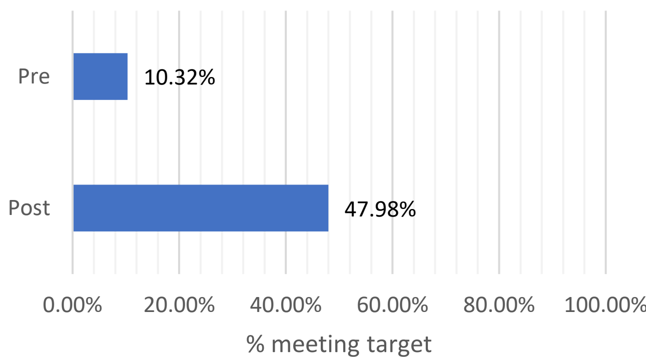


Figure 39 – Proportion eating 5 fruit and vegetables per day

Before taking part in the CoH-Sync project, only 10.32% of participants ate at least 5 portions of fruit and vegetables a day, as per the Government's recommended minimum target. After being involved in the project, nearly half of participants were getting their '5 a day' on a consistent basis.

7.2.5.1 Comparison to DCRS Participant Base

Compared to the DCRS Participant Base data in the Minded to Change report, CoH-Sync's participants saw a greater percentage increase in the average number of fruit and vegetable portions consumed per day (64% compared to 51.5%). However, CoH-Sync participants started from a lower base and so, after the intervention, they were still eating fewer portions of fruit and vegetables on average than those described in the Minded to Change report.

E. Consumption of fruit and vegetables per day change for all clients, July 2012 – July 2015

Consumption of fruit and vegetables per day	Before	After	Change
	3.01	4.56	+51.50%

Figure 40 - Consumption of Fruit and Vegetables change obtained from Minded the Change report

7.2.6 Other Improvements

Shown below are a combination of three other metrics related to Physical Activity, Alcohol and Smoking. The average changes pre- and post- intervention are positive, though the population sizes in question are much smaller than those listed above (66, 157 and 439 respectively) and smaller than the numbers of participants who chose to focus on these thematic areas. Accordingly, these results should be treated with caution.

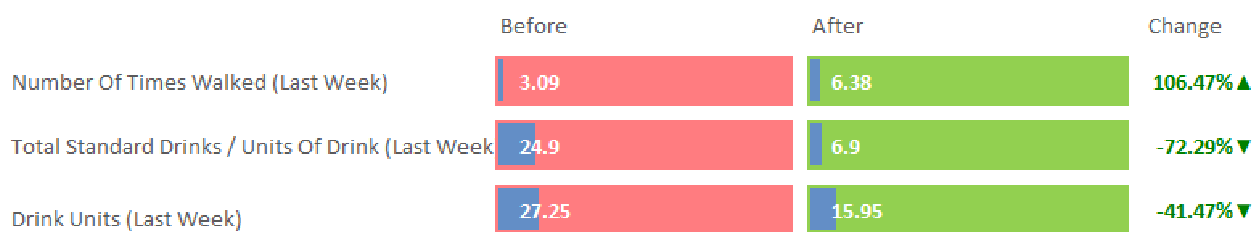


Figure 41 - Before and after averages for remaining change measures

7.2.7 Statistical Analysis

To provide some data triangulation for the results, and so ensure the validity of the findings, paired samples t-testing was undertaken (using the Wilcoxon test as the data is not normally distributed). This can be reviewed in the appendix 11.2. This testing reviewed and compared the before and after scoring spreads and mean averages between key related sample groups for physical activity, mental health and nutrition (namely, minutes of moderate exercise; self-belief; and health confidence improvements). In each case, the median *before scores* were greater than the median *after scores,* and the spread was found to be narrower with fewer outliers in each improved *after* recording.

8 Hubs' reflections on their delivery of CoH-Sync

This section includes an analysis of the case studies written by the Royal Society for Public Health, describing the delivery experience of each of the eight CoH-Sync Hubs, with the aim of highlighting common enablers, challenges and learnings from local operational perspectives.

8.1.1 Enablers

When asked to share what enabled the successes of the CoH-Sync project in their areas, two common themes emerged from the Hubs' responses.

a) The importance of recruiting local Community Health Facilitators (CHFs)

Hubs reported that the CHFs' local knowledge and insights were key to being able to reach and engage with participants. As the team from the Cavan and Monaghan Hub put it: "The Community Health Facilitators and Coordinator had a deep understanding of the communities they sought to engage, and a genuine interest in wanting to serve them".

b) The relationships with local organisations and stakeholders for service delivery

Another significant, and related, operational advantage for the delivery of CoH-Sync was the local knowledge and relationships held by the organisations leading the Hubs. These enabled them to provide a stronger and more versatile offer to participants, which was a much-valued feature of the project. For example, the Armagh and Dungannon and Donegal Hubs were able to make direct referrals to local statutory services given their pre-existing connections to those organisations. This reduced any psychological or physical barriers which participants might have faced to accessing that support.

8.1.2 Challenges

The challenges which Hubs faced to delivering the project fell under three main themes:

a) COVID-19

The COVID-19 pandemic had an impact on each of the Hubs. For instance, the team at the Cavan and Monaghan Hub described how it made recruiting and engaging with participants more difficult, particularly with those from the most marginalised and underserved groups. Most Hubs reported that they saw people's health priorities change as the pandemic hit, and the number of people developing or following health and wellbeing plans fell accordingly. The COVID-19 Participant Support Form was introduced to help Hubs adapt to this shift and focus on meeting the immediate material needs of people in their communities while they were unable to engage with a full health and wellbeing plan.

The Dumfries and Galloway Hub, which was led by NHS Dumfries and Galloway, was especially badly hit because many of its staff had to be redeployed to the frontlines of the pandemic response and they struggled to find third sector partners to support the delivery of CoH-Sync.

b) Operationalisation of the project

CoH-Sync's methodology aimed to deliver a robust and consistent offer across eight regions in three different countries. However, key operational aspects such as the project directive, standardised health and wellbeing plans, data collection tools and project materials were not available from the outset. Due to funding and timescale constraints, these had to be developed while the project was in operation. As such,

most Hubs reported disruptions due to repeat changes to the key project requirements. For example, there was a perceived lack of clarity in the recruitment criteria (geographical areas and age groups), and the amount of time available and number of sessions with participants which were required. Some Hubs also highlighted that the volume of, and changes to, paperwork demands added pressure to CHFs. Nevertheless, none of the Hubs claimed that these challenges prevented them from reaching the expected deliverables.

c) Data Collection and Reporting System

For many Hubs, the introduction of the DCRS system presented a challenge as additional training and work was required from them to move to the standardised system. However, most Hubs mentioned that, once embedded, DCRS provided them with an efficient and useful tool to collect and analyse data.

NHS Dumfries and Galloway, which led the Scottish Hubs, had organisational strategic plans to embed MORSE, another data collection system, to function across its services. Whilst there were plans for MORSE to be compatible with DCRS, COVID-19 delayed its roll-out and ultimately it was not possible for these Hubs to transition to the standardised data collection system.

a) Reaching and engaging rural areas

Although the Hubs could draw on their local knowledge and relationships, engaging with participants from the most rural areas remained a challenge. For example, a lack of Wi-Fi, digital devices or confidence in using them prevented many clients in rural areas from participating in activities held online, while digital delivery was necessitated by the lockdown restrictions at the onset of the COVID-19 pandemic.

8.1.3 Key learnings

Teams from the Hubs involved in CoH-Sync described a range of key learnings they had taken from the project:

The Armagh and Dungannon Hub underlined the importance of **mapping local assets and stakeholders to avoid competition and duplication**, planning for contingencies, and having the processes which should be routine to project delivery finalised in advance.

The Bogside & Brandywell hub felt that the value of **collaboration** and the importance of clear expectations and communication to a project's success were important lessons to be taken from their experience. They also mentioned that clear **guidelines regarding the delivery model should be defined from the beginning**.

The Cavan and Monaghan Hub felt the **person-centred approach and the offer structured around thematic areas** were positive features of the project, as they gave participants a sense of autonomy. They also mentioned that having **both face-to-face and online activities was an effective way to maximise people's opportunities to participate**. For this Hub, collaboration with **community groups and employing local people contributed to its success**.

The Donegal Hubs stressed **the importance of a sustainability strategy to ensure long-lasting effects**: "the project finished without a strategy for ensuring its sustainability, and without an opportunity to reflect and evaluate". They also **questioned if community-based Hubs were best-positioned to deliver support on reducing alcohol and smoking consumption**, based on the low take-up of these thematic areas.

The Dumfries and Galloway Hub regarded the **effectiveness of brief, targeted and personalised interventions** as a key learning. They also experienced success in their use of a **hybrid model** (bringing

together the NHS and third sector organisations) to deal with a high turnover of Community Health Facilitators and increase engagement with local communities.

The Enniskillen and Fermanagh Hub reflected on how well **the project offer suited those who were keen on improving their health but didn't know where to start**. The project worked to support participants' priorities and could be shaped to fit their personal circumstances, helping participants feel in control of their health. The Hub also highlighted the importance of **working with other internal and external services on referral pathways and signposting strategies** to support participants' health goals. In addition, having some **level of clinical understanding as part of CHFs' knowledge and skills** was described by the Enniskillen and Fermanagh Hub team as beneficial for their confidence and participants' outcomes.

8.1.4 Experience

There were some common themes to the Hubs' experience in delivering the CoH-Sync project:

1) **Physical activity and nutrition** were among the most popular thematic areas. Initiatives like Cook-It were found by the Armagh and Dungannon and Donegal Hubs to be particularly valuable in helping people to develop cooking skills and enhance their knowledge around nutrition.
2) **Support for mental health** had high take-up in many Hubs, especially during the COVID-19 lockdowns.
3) **Online support for participants – and support for them to get online.** The project developed a virtuous circle when Hubs supported participants to get online during the pandemic so that they could continue accessing services. The Dumfries and Galloway Hub used Zoom to support people who were shielding and signposted those experiencing isolation to other community projects that aimed to improve people's computer skills. Other hubs, such as Bogside & Brandywell, moved all their delivery online, including offering online physical activity programmes and smoking cessation support.
4) Each of the Hubs mentioned the importance of having **Community Health Facilitators that were embedded in their local communities**, with a good understanding of the area's needs and challenges. The Cavan and Monaghan Hub recruited participants with increased risk of poor health outcomes (including asylum seekers, refugees and those from the Roma community) in order to provide them with "an accessible opportunity to gain the confidence and skills to change their health behaviour". The Donegal Hub was able to recruit a team that reflected the area's rurally-based population.
5) The Hubs highlighted that the methodology and infrastructure behind the project, including its materials, had been developed to a high standard and that they could serve as the basis for other projects led by the Hubs.

8.1.5 Impact on the Community

The CoH-Sync project had a very positive impact on the local communities. Most participants achieved their health goals and offered powerful testimonies of the personal impact it had. One participant supported by the Dumfries and Galloway Hub described how the programme had enabled them to "*connect with my family again – it's changed my life";* another described how it helped people feel *"listened to and understood".* Participants from Armagh and Dungannon highlighted how the project "*has given us an opportunity to mix and meet new people. It has made a positive change to our lives".*

Notable commonalities reported by the Hubs include:

1) **Better employment prospects for Community Health Facilitators**. The Hubs at Armagh and Dungannon, Cavan and Monaghan, and Donegal described how having local community-members trained with new skills would benefit both them personally and the wider community. They believed the experience would provide CHFs with wider opportunities for employment and/or professional development.
2) **Collaboration between different institutions and programmes**. The relationships between the Hubs and with other local and national organisations helped the CoH-Sync project succeed and will have benefits for future health and wellbeing programmes.
3) **Ripple effects**. By supporting individuals to make healthy changes to their lifestyles, it is likely that their friends and family will also see positive changes to, and increased understanding of, similar health and wellbeing areas as the direct beneficiaries will share their new skills and awareness with those around them.

9 Participants views about CoH-Sync

As part of the monitoring of the health and wellbeing plans, Community Health Facilitators (CHFs) collected participants' views and experiences of CoH-Sync. Three key questions were asked:

1. What attracted you to the CoH-Sync Project community hub and its local services?
2. Would you recommend the services of the community hub to others?
3. What difference will the programme you have taken part in make to your life, your community, and your family in the longer term?

Participants were not obliged to answer these questions; a total of 309 participants submitted responses, corresponding to 3% of all CoH-Sync main beneficiaries. A third of these responses were randomly sampled for thematic analysis and what follows are the results of this exercise.

9.1.1.1 What attracted you to the CoH-Sync Project community hub and its local services?

Over half of the participants suggested that CoH-Sync's offer was attractive to them because it provided a wide range of options to improve their health and wellbeing which suited their circumstances and needs. Responses mentioned, for example, the variety of classes, their format of delivery (online and face to face) and the timetabling, the support from the CHF, the opportunity to socialise with others, the convenience of the Hub's location, the online offer (during and after the COVID-19 restrictions).

> *"It has given me the chance to do things that I could not normally do in the evening with my work hours."*
>
> *"The variety, social contact, a good way to mix into community …"*
>
> *"… different projects and courses, I wanted them in relation to chronic pain and mental health"*
>
> *"it was locally available at a time that suited me"*
>
> *"I was interested in the number of courses offered i.e. photography and arts. The timing of the courses (during lockdown) was an advantage as I had the time and it allowed me to engage in them."*

About a third of respondents commented that the CoH-Sync's offer gave them the opportunity to take action on their health and wellbeing in ways they were already contemplating but had previously lacked the opportunity or motivation. Examples of this included: meeting people, learning new skills (cookery and digital skills were mentioned several times), physical activity, losing weight, and addressing their mental health.

> *"I am attached to Men's shed and when I heard that there was a cookery course especially for men I joined."*
>
> *"Socialising and fitness no matter what the weather"*
>
> *"Chance to try something new"*
>
> *"The challenge of completing a class online. Log in and log out was good."*

For some respondents, referrals from other services or recommendations from other CoH-Sync participants increased their interest and their motivation to get involved in the project's activities.

9.1.1.2 Would you recommend the services of the community hub to others?

All of the respondents in the sample had had a positive experience of CoH-Sync and would recommend the support that it had provided them. The expertise and the positive attitudes of the staff involved in the project – their enthusiasm, welcoming, helpful, and caring manner – were repeatedly mentioned as reasons for participants' positive experiences.

> *"Yes, as everyone was so helpful and friendly put me at my ease and allayed any fears"*

> *"Yes, the tutor was very enthusiastic and was nice to take class during COVID"*

> *"Run very professionally from the start, Tutor A and Tutor B both came across as knowledgeable and believed in their delivery of content."*

The opportunity to address their personal needs through 1:1 support provided by CHFs and additional signposting and referrals was also mentioned by many respondents.

> *"Yes, some of the courses may be relevant to everyone's individual needs and may take something away from it and help support each individual"*

> *"Yes it's a good support facility and has given great assistance in self-motivation from talking with facilitator."*

> *"Yes. It allows for the development of confidential one-to-one relationships with people in need. It can strengthen care support by connecting people with available healthcare and social support services."*

Moreover, many respondents valued the information and new knowledge and skills they obtained from their involvement with CoH-Sync – some commented that it gave them skills they can continue using to support their own health and wellbeing and that of their family.

> *"Yes, its good information and I will share with family"*

> *"Yes, learning a new skill and the course was enjoyable easy to create one's own time schedule"*

> *"Yes, we learned a lot especially about mental health and the importance of talking about it"*

Some respondents highlighted the value of being able to interact with others, feel a sense of community spirit, and make new friends.

> *"Yes, its brilliant to bring people together"*

> *"Yes, great to be part of a group and feel sense of community during difficult times"*

> *"Yes, as it is a great way to meet new people and make new friends"*

9.1.1.3 What difference will the programme you have taken part in make to your life and your community, and your family in the longer term?

In the sample of respondents, a wide range of views were expressed in answer to this question. Around half of the sample described the impact at a personal level, and half described changes on both a personal and a group level (whether family or community). Longer-term changes were not frequently mentioned by the respondents.

The most commonly reported impacts mentioned in these responses were in relation to mental health. These included: having a more positive outlook on life; being able to relax; reduced anxiety; feeling more in control; and improved self-care. Most of these responses also made mention of the impact on their physical

health as well as their mental wellbeing – many commented upon the fact that improvements in either aspect of their health (mental or physical) had a positive influence on the other. For example:

> *"It has improved my fitness level and mental health - made me feel happier"*
>
> *"I'm a happier therefore healthier person"*
>
> *"I have a more positive outlook, more energy to do other things and get moving again"*

Many respondents noted the impact that CoH-Sync's information and awareness-raising activities had on their understanding of why and how to improve their health. Some reflected on their increased confidence in taking control over their own health.

> *"More awareness of the positivity of exercise gives to our lives and a better health outlook"*
>
> *"... the different exercises like tapping and colour breathing, I can help myself relax and stop worrying, this may prevent anxiety attacks that I frequently have"*
>
> *"More aware of everyday good eating habits even though I find it difficult to keep trying and I hope I will improve"*
>
> *"It gave me a great insight into how learning can be both easy and fun and it showed me some great cooking tips"*

Around half of the respondents' comments suggested that CoH-Sync had had an impact on the participant's family and the wider community as well as on them directly. These comments were mostly in relation to mental wellbeing, physical activity and cookery skills, perhaps suggesting that the skills, knowledge and benefits acquired on these themes were more easily shared with others than smoking cessation and alcohol reduction.

> *"With a new baby, this will help a lot at mealtimes some of the time"*
>
> *"Much healthier eating in family. The recipe book is very easy to follow and better than other cookery books"*
>
> *"I have more confidence in myself and have engaged with neighbours and encouraged children and friends to learn new skills"*
>
> *"I now know how to meditate and I am a lot more aware of what I'm serving up to my family when it comes to portion sizes."*
>
> *"The skills and techniques I learnt helped me stay fit and including my family in a light fun way, promoting wellbeing and better relationships"*

In sum, our analysis of participants' feedback suggests that:

- CoH-Sync has had an immediate positive effect on participants' mental and physical health and health literacy.
- Most participants were attracted to the project due its flexibility, the choice and convenience it offered.
- The efforts that Hubs went to in order to make participants feel welcome and supported were recognised and valued.

10 Analysis of the overall impact of CoH-Sync

The medium- and long-term impact of the CoH-Sync project is yet to be seen. But, based on the available data, we are able to reflect on its short-term outcomes, and whether they aligned to the original logic model behind the project (Figure 4).

Increased awareness of chronic disease risk factors and promotion of health literacy

Improving participants' health literacy was a cross-cutting theme in CoH-Sync's approach. The Hubs invested time and effort to increasing participants' self-efficacy and providing them with accessible, relevant information. For example, CoH-Sync's promotional materials were developed in plain English to make them easy to read and understand. An important driver of health inequalities is disparities in access to understandable information about health and wellbeing issues. So, by targeting these resources and activities on those living in some of the most deprived areas of the border region, the project has contributed to the reduction of these inequalities.

Through a wide variety of awareness-raising activities, as well as through the additional support provided during the COVID-19 pandemic, CoH-Sync reached about 12,000 individuals with information about the key risk factors for chronic diseases. Feedback from participants suggests that their awareness of health-related behaviours such as portion sizes, physical activity levels and mental wellbeing techniques enabled them to make informed choices to support their own health.

Increased access to, and uptake of, health-promoting activities and services

The case studies from the Hubs and DCRS data shows that CoH-Sync increased access to, and utilisation of, health-promoting services and activities for at least 7,079 participants. These participants were referred to classes, groups, and similar initiatives run either by the Hubs or by an external service. Feedback from participants confirms that these referrals were a highly valued feature of the project, as the offer was tailored to suit their needs, and offered them concrete steps they could take in order to achieve their health and wellbeing goals.

Development of cross-sectorial and inter-agency partnerships

The CoH-Sync project enabled the Hubs to develop new, or build on existing, relationships with other organisations across the health system. For example, the Hubs in Donegal reported to have worked closely in collaboration with Bogside & Brandywell Health Forum and other local and national organisations in the development of their offer. In Scotland, the development of a "hybrid model", whereby the NHS Trust partnered with local third sector organisations, was highly successful and has set the basis for further future collaborations. The value of learning from other organisations was noted by many of the Hubs.

Development of integrated pathways for health improvement, chronic disease prevention and early intervention

One of the expected outcomes, based on the logic model behind the project, was the development of referral pathways into other organisations including statutory and third sector services. However, the extent of the success achieved in this respect is not clear. Whilst a high number of intervention referrals are documented in DCRS data, the case studies from the Hubs and participant feedback, it appears that most of these referrals were to classes and activities provided by the Hubs themselves. In addition, DCRS data indicates that most participants heard about the CoH-Sync project through word-of-mouth and referred themselves onto the project via online information, rather than being referred to CoH-Sync by another agency or service. Therefore, although the Hubs worked collaboratively with other organisations to deliver the project's activities, there is less evidence of multi-agency pathways into and out of the CoH-Sync project.

Increased community capacity in health improvement

The Hub's case studies demonstrate the positive impact that the delivery of CoH-Sync had on the individuals who took on the role of Community Health Facilitators. Many of them were from farming backgrounds who, without the CoH-Sync project, would not have had the opportunity to develop skills and experience in health improvement.

The Hubs also benefited from an increase in their capacity and capability to deliver health promotion activities and support, using robust evidence-based models and techniques. These included: the standardised tools, such as the templates for the health assessments and Health and Wellbeing Plans; and an increased understanding of the principles behind person-centred support. For example, the Enniskillen and Fermanagh Hub is drawing from the experience of CoH-Sync to develop a new social prescribing project.

10.1 Conclusion

The quantitative data shows the project achieved a significant reach among individuals living in deprived border areas, particularly women and working age groups. These measures indicate the effectiveness of CoH-Sync's approach at engaging groups within populations most likely to experience health inequalities. However, in line with the experience of other health trainer projects, CoH-Sync achieved less success in engaging with men.

The data suggests that CoH-Sync's offer of support was most attractive for those seeking to improve their physical activity levels, healthy eating, mental health and health literacy. By contrast, addressing one's smoking or alcohol consumption was a priority for far fewer participants. Unfortunately, given the variety of suggestions by the Hubs as to why this was the case, we cannot come to firm conclusions about how take-up of this support could be improved.

Whilst a positive change in participants' health and wellbeing is suggested by the overall analysis, the limitations on data levels and quality (particularly on change and outcome measures) mean we cannot quantify the impact of CoH-Sync in the short term. Post-intervention follow-up, further standardisation of the data collection processes across all Hubs and defined standard outcomes measures would have been beneficial in this respect.

However, we should not overlook the overall direction in which the qualitative data from participants' feedback and the Hubs' case studies point. Together, these all suggest that CoH-Sync had a positive

immediate effect on participants' mental and physical health and health literacy. The features of the project which accounted for this positive impact, according to the participants themselves, was the flexibility, convenience and choice within the project offer; and the kindness and empathy shown by those delivering it. This would merit further exploration with the participants, their families, the Hubs' staff, members of the wider communities.

10.2 Recommendations

A core strategy to prevent ill-health at the population level is to achieve consistent cross-sectoral delivery of brief, targeted and personalised interventions. The CoH-Sync model of 'synchronising' the efforts of the community and voluntary sector with statutory health services to achieve greater impact, and lessons from the project delivery are therefore of value to policymakers, commissioners, and service providers who aim to improve population health and wellbeing.

Design and Planning

In order to improve effectiveness, commissioners and delivery organisations of health improvement projects and programmes, should consider:

1. To guide planning, monitoring, evaluation using defined theory of change or any evidence-based framework or model that enables the programme or project, to learn and adapt throughout its cycle and measure impact. This includes the use of validated standardised data collection tools, including recording and reporting formats, and project materials- those developed by CoH-Sync are good examples. Furthermore, the evaluation framework should include:
    a. key performance indicators (e.g. number of new participants) to monitor activity,
    b. defined outputs (e.g. number of participants who complete their health and wellbeing plan) to monitor the level of benefit produced with participants
    c. health outcome measures (e.g. mental wellbeing score) to measure the effects of the benefits; and
    d. population level impact measure (e.g. hospital admissions for alcohol abuse) to measure public health contribution.

2. To ensure data recording methods and other monitoring activities are carried out in an efficient and effective manner, commissioners and providers should consider them from the perspective of beneficiaries and data collectors.

3. Actively involving members of the 'target' communities throughout the project cycle, including design, delivery and evaluation. The voices from the communities which the commissioner and provider seek to reach should be heard with respect to the needs which should be addressed, what solutions they wish to see, and how they should be delivered and evaluated. Building on the success of the Community Health Facilitators in the CoH-Sync project, future health improvement projects should involve people from the 'target' communities as members of the delivery team and on advisory boards or local expert reference groups, for example.

4. Based on the uptake of the CoH-Sync offer, future community-based health improvement programmes should be designed based on a review of the evidence including, previous examples from the local area on how best to engage adult men (and other under-represented groups) and

peer-support models which have successfully helped people to reduce their smoking and alcohol consumption.

Training for Community Health Facilitators

In order to maximise the positive impact which Community Health Facilitators (CHFs) can have on the health and wellbeing of local populations, appropriate training and development pathways should be developed through:

- A competency framework aligned to the specific objectives of the service offer.
- A training needs analysis of those recruited into the role of CHF.
- A training programme designed to meet identified gaps and that considers learning needs and styles.
- An assessment criteria and schedule to ensure all core knowledge and skills are achieved by CHFs at the relevant times during the course of the project across all sites
- Opportunities for specialisation and professional development as the project adapts and responds to the needs of the community
- For communities seeking to address alcohol harm, specific training on this subject should be delivered to CHFs. For example, in the Communities in Charge of Alcohol model developed by RSPH, health champions train for a Level 2 Award in Understanding Alcohol Misuse, learn how to deliver brief interventions, train others, and lead community action on alcohol availability.

11 Appendices

11.1 Hubs case studies

11.1.1 Cavan and Monaghan Hub Case Study

Located in the Republic of Ireland, close to the border with Northern Ireland, the Cavan and Monaghan (C&M) Hub served two of the most deprived areas in the border region, which itself has a poverty rate above the national average. In 2017, 25.7% of those living in the Border region were at risk of poverty, compared to 15.7% nationally.[6]

The C&M Hub was led by local organisation Monaghan Integrated Development with the support of Cavan County Local Development. The C&M Hub employed a Coordinator and four Community Health Facilitators (CHF) from the project areas, who provided health and wellbeing support to 1,309 people between 2018 and 2021.

In addition to the one to one support from CHFs, the Hub designed and delivered a programme of classes and group activities to support clients' health goals. Among the most successful were:

- 'Step Up To The Challenge' – a 4-week walking group that ran between July and August 2021, involving 100 participants across both counties. Participants were provided with a range of materials including branded backpacks, water bottles, pedometers, high-vis vests and step count cards. The programme was promoted widely and advertised by stakeholders including Sports Partnerships, Healthy Ireland Committees and local walking groups.
- 'Make up for Me' a 3-week course delivered by award-winning makeup artist Natasha Murray and CoH-Sync staff, which aimed to improve women's confidence and self-acceptance. 70 participants, on average, attended each class, with the sessions covering mental health topics as well as providing step-by-step make up tutorials.

To recruit participants, the C&M Hub developed partnerships with individuals, community groups and a range of local services, which enabled complementary packages of support to be provided to target groups. For example, the Hub partnered with Family Carers in Ireland to develop a tailored offer for 35 carers including one-to-one support and a variety of online health courses including mindfulness, yoga and life coaching. They also provided funding for each carer to have one hour a week of respite care.

Through intense community engagement, the C&M Hub also focused on reaching and recruiting individuals with increased risk of poor health outcomes including asylum seekers, refugees and members of the Roma and Traveller communities. This provided many participants from such backgrounds with an accessible opportunity to gain the confidence and skills to change their health behaviour.

Outcomes

The programme supported 1,309 individuals – 29% men and 71% female- most of whom reported achieving their health goals. In addition, the four Community Health Facilitators benefited from the training and development opportunities, and experience that the CoH-Sync project provided. This in turn has increased the employment prospects of the CHFs who gained qualifications as part of the project.

The programme has strengthened collaboration between cross-border health and wellbeing programmes, and highlighted the need for person-centred health projects delivered through community organisations.

[6] https://www.cso.ie/en/releasesandpublications/ep/p-rsdgi/regionalsdgsireland2017/ph/

Enablers

The grassroots-level positioning and networks of the local organisations which led the C&M hub was pivotal to its success as this enabled CoH-Sync to galvanise key local stakeholders to support its recruitment strategy and increase the offer of the programme. In addition, the fact that the project's Coordinator was able to work across several organisations enabled internal collaboration with other local health programmes, thereby avoiding duplication.

Having the Hub team drawn from the local area meant that the CHFs and Coordinator had a deep understanding of the communities they sought to engage, and a genuine interest in wanting to serve them. As a result, they were able to reach and work with those in greatest need.

The project was also able to appeal to participants thanks to its financial resources which allowed the C&M Hub to develop an attractive programme offer. The merchandise developed for Step Up To The Challenge programme, for example, helped the project to reach its target of 100 participants.

Challenges and Limitations

Related to the rurality of the region, the lack of Wi-Fi prevented many clients from participating, especially as activities moved online because of the lockdown for COVID-19.

The lockdown also presented a challenge to recruitment and engagement more generally. Government restrictions made it far harder to reach marginalised individuals and underserved groups as all communication, publicity and the activities had to be done digitally. Overall, the C&M Hub struggled most to recruit men, especially those from younger age groups.

The CHFs were employed part-time, and trying to reach the ambitious targets for the project, and work with a large number of client health plans, on this basis led to the CHFs feeling a great deal of pressure. They wanted to both reach their targets and offer a high standard of service, and, combined with the amount of paperwork required, they were left with little time to reflect on, or evaluate their work.

Another limitation of the project was the fact that individuals could only be referred to the programme once over the lifetime of the project. Not all courses and activities are relevant to clients at once – they may become appropriate at a different stage of the person's life. However, this was not reflected in how the offer was set up – the programme stood as a one-time opportunity for participants.

Learnings

Taking a person-centred approach and structuring the offer by thematic areas gave people greater autonomy over their health and wellbeing journey, and proved popular with participants.
Similarly, being able to access either face-to-face or online activities allowed participants to engage in whichever way they most preferred and to suit their schedule.
Coordinating the programme through community groups and employing local people to lead the project 'on the ground' was important to the success of the C&M Hub.

The C&M team felt a judicious and more integrated approach to data collection and paperwork should be explored, including the introduction of tablet devices. It was also suggested that the balance in the trade-off between high targets for the number of participants and the quality of the interventions be considered.

11.1.2 Bogside & Brandywell Hub case study

The award-winning Bogside & Brandywell Health Forum (BBHF) led the Bogside & Brandywell Hub of the CoH-Sync project. Located in Derry, the third most deprived area of Northern Ireland, BBHF's approach focuses especially on delivering person-centred services and tackling health inequalities.

They provided support to 1254 individuals within target communities on the areas of mental health, nutrition, smoking cessation, physical activity and alcohol consumption.

Physical activity and Nutrition were the most popular thematic areas for participants. As such, the Hub designed a range of activities and classes around these topics. These were offered in addition to the 1:1 support given by Community Health Facilitators (CHFs). To support participants' health journey, they were also referred to other internal or external services and programmes so they could access the most appropriate support.

What worked well

Participants were offered a session to, with the help of a Community Health Facilitator, design a personal plan with practical steps to achieve their goals. This enabled participants to focus on their priorities and objectives, and to identify what steps would take them to improve their health. This offer continued during lockdown when the Hub quickly adapted to delivering sessions online and over the phone.

BBHF's Smoking Cessation services trained CHFs on how to best engage and support participants to quit smoking. This made the smoking cessation support CHFs could offer even more effective. The Hub also benefited from having an in-house nutritionist who could provide expert nutritional and dietetics advice.

Outcomes

CoH-Sync enabled BBHF to work more collaboratively, by demonstrating how the same health issues affect communities across Northern Ireland. The Hub was able to share knowledge and expertise with other Hubs and had the opportunity to collaborate on projects and initiatives. This was evident during the first COVID-19 lockdown, when the CoH-Sync Hubs all supported each other by sharing ideas and advice on how to continue delivering their programmes and services.

The partnerships developed through the project will also have long-term impact as they have generated other projects and initiatives and generated for BBHF. Similarly, the Health and Wellbeing plan which was developed as part of CoH-Sync us a resource which will be used in the future.

Enablers

The CHFs all lived in the area, with strong local knowledge and connections. This broke down many of the barriers to accessing the Hub's services which participants may have otherwise faced. It also meant they knew which groups and individuals were most in need, and therefore made a special effort to engage them. As members of their local community, they were highly committed to helping participants, and the programme, achieve their targets.

The Hub was also able to reach participants who might otherwise not have engaged with the project by working with community partners who had strong relationships across the area. Winning the active support

and engagement of the community was also vital in this respect, as participants heard about the project by word-of-mouth and were signposted to it by their friends and family.

BBHF's internal referral structure and the range of the services and programmes it delivers also meant that participants could access additional, specialised support.

Challenges

The biggest challenges of the project came as a result of the COVID-19 pandemic. First of all, to continue to meet their targets and support participants, the Hub adapted how its classes and activities were delivered to be accessed remotely. For example, it implemented regular phone calls to all active participants, socially distanced boot camps, walking groups and online Zumba classes for those working on their physical activity goals.

Secondly, the Hub juggled the change of needs and priorities of the community whilst ensuring they were reaching the agreed targets of the programme. For example, for many participants, the support required was not related to physical or mental health, their priorities were in terms of essential material things such as accessing food, heat, medicines among others. As such, they implemented a special scheme which allowed them to provide this help while these individuals could engage with a health plan.

11.1.3 Enniskillen and Fermanagh Hub case study

The Enniskillen and Fermanagh Hub covered an especially rural area in Northern Ireland, including 5 of the 10 most remote wards of the country. With the population being so sparse comes high levels of isolation.

Enniskillen and Fermanagh Hub was led by ARC Healthy Living Centre and delivered in partnership with Oak Healthy Living Centre, Lakeland Community Care and Fermanagh Rural Community Network.

In line with CoH-Sync's project design, the Hub offered 1:1 support from a Community Health Facilitator (CHF) for participants to design and act upon personal health improvement plans. These plans focused on key thematic areas: physical activity, nutrition, mental health, smoking cessation, alcohol awareness.

Collaboration in cross-border initiatives was central to the Hub's approach. They worked especially closely with the Hubs in Donegal, for instance the Hubs worked together to deliver health awareness sessions in the cross-border areas on mental health, physical activity, nutrition, smoking and health literacy.

What worked well

Nutrition plans and participation in the physical activity initiatives were popular with most participants. But during the pandemic, the Hub began to deliver an online programme of mental health and wellbeing activities (such as mindfulness, yoga, breath work and EFT tapping) which were very well received and prompted increased interest in this area. The testimonial of a participant who had been struggling with her mental health and had initially struggled to engage with activities at the Hub is an example:

"I got the chance to do the colour breathing with (Tutor). OMG all I can say is it is amazing and I'ts don on WhatsApp, so I don't have to leave the house. It really has brought me out of a dark place so THANK YOU (CHF) for always being there for me"

For many participants, the 1:1 assessment and the ongoing support from CHFs offered them access to a wide range of information and resources that enabled them to address their health in a holistic way, rather than

focusing solely on their personal goals. A Community Health Facilitator's work with one participant exemplifies this:

"We kept in touch by telephone – his pre-score was 1 out of 5 for everyday eating – so a detailed plan was discussed, agreed and all information sent out via post to try and improve Client's daily eating habits. As I had regular contact with this client and built up their trust, this enabled me to gain a good insight of his current health issues and I encouraged him to contact his GP. He was diagnosed with Diabetes. After being prescribed the appropriate medication and improving his everyday eating with his plan, as well as contact with the Diabetic Nurse, his general health improved greatly and he had a post -core of eating 6 fruit and vegetables every day. As for the Client's psychological state and feeling lonely, he was referred back to Social Prescribing to participate in ongoing support on Zoom chats – he has attended the first mindful group in ARC (socially distanced and within COVID guidelines) just yesterday and is continuing to do well."

A key focus of the Hub's work was health literacy, so time and effort was put into identifying resources and information which would be easy for participants to understand and use. With respect to nutrition, for example, the Hub identified that resources from the British Heart Foundation on food portions, hydration and cholesterol, were an effective way for clients to identify how to address their nutritional goals and track their progress. This gave them a sense of control and self-efficacy which meant they felt empowered regarding their health journey.

"My CHF went through information and a food diary with me, and together we devised a meal planner. I learned that I could already cook; I learned that I could put meals together. Today I have a routine in place and I know what I will have for dinner. My CHF gave me recipes and tips and I have made many of them (cottage pie, spaghetti bolognaise, lasagne, chicken curry). They are simple, delicious food; it doesn't have to be complicated. I used to beat myself up about it. This also makes me feel good and I have a sense of achievement rather than a feeling of being useless."

The current social prescribing programme has been built from the experience and the success of CoH-Sync, meaning that the project will have long-term system-level impact. Staff involved in the CoH-Sync project are now part of the social prescribing programme and will be applying their learnings about support and communication with clients in their new role. A former CoH-Sync Facilitator describes how:

"It has helped us to be more aware about what clients need and want. The importance of actually listening to help them help themselves. The input of clients is so important to achieving good outcomes."

Enablers

The Hub offered a flexible and accessible environment which meant participants felt comfortable when accessing the CoH-Sync offer.

The Hub's staff also had the right skill-sets (e.g. subject area expertise, conversation skills, confidentiality) and were able to demonstrate patience and empathy, which together helped people make changes to their lifestyles.

CHFs had the support of a strong team structure and supervision so that they were able to work as a team, share information, and feel supported throughout the project.

Challenges

The transition from paper-based plans and spreadsheets to the DCRS database created additional workload and pressure for the team.

Further change came with the outbreak of COVID-19 as face-to-face delivery had to move online and the programme offer had to be reframed. This was initially very time-consuming, but the team quickly found alternative ways to help the community. Fresh food was distributed weekly, through their Food Aid Project, to people experiencing poverty as a consequence of the pandemic. The service was complemented by telephone support and information, reinforcing important public health messages and providing a listening ear.

Engaging with people to address their smoking and alcohol intake was also a challenge for CHFs. Despite the prevalence of these issues in the area, participants were reticent to discuss them, which the Hub's staff judged to be because participants were not ready to begin reducing their consumption. The pandemic may have reinforced those habits for some people, making it even more difficult for them to consider changing them. Participants may also have been concerned about their privacy and confidentiality if they were to access support within a community hub.

Learnings

This project was suitable for people who wanted to begin a journey towards getting healthier but who did not know where to start. The premise of the project – that people can make a difference to their health through small, everyday habits – resonated well with participants and made them feel empowered.

Having some level of clinical understanding is important for CHFs as it gives them confidence when talking through the health information they are providing to participants.

As participants shared the information and resources they received with family and friends, the impact of the project went beyond the direct beneficiaries. Moreover, as participants began to make changes to their lifestyles, these had an effect on the wellbeing of others – for example, by taking up walking with family-members or social groups, this supported the physical activity and social connections of other people in the community as well as the participant themselves.

CoH-Sync inspired a closer relationship between local services and groups. For example, the Hub established internal and external referral pathways into other Hubs and local health services and community groups such as fitness groups and silver surfers (for people over 65).

At an operational level, some learnings from the Hub include:

- Whilst the health plans were designed with the participants, the participants were not given a copy. This would have helped them to keep their goals front-of-mind and to take follow-up actions.
- Some of the project briefings and marketing materials were received after the halfway point of the project, meaning these have now gone to waste.
- Some paperwork could have been saved had the DCRS data collection system been introduced earlier in the project.

11.1.4 Armagh and Dungannon Hub Case Study

The Armagh and Dungannon (A&D) Hub covered the population of two large areas of Northern Ireland situated on the border with the Republic of Ireland. Armagh and Dungannon has an estimated population of 121,830, with 16% living in the most deprived Areas in Northern Ireland.

The A&D Hub was led by Connected Health, a national domiciliary care provider in Northern Ireland. Geographically, the Hub focused on rural areas, where there is poorer access to health services. They

mapped the area's local assets in order to ascertain gaps in services and resources, which they then shaped their programme to address. The courses and activities which they offered included:

- Chi Me
- Chair Exercise classes
- Cook It
- Take 5
- Safety in the home
- Aerobics exercise classes
- Walking aerobics class
- Tapping EFT
- Colour Breathing
- Mental health and wellbeing talks and presentations
- Support calls
- Walking group/Walk and Talk events
- Educational sessions on alcohol, drugs and smoking
- Onside Project - helping people get online

1,090 people accessed these activities, each participant in the programme has been supported by a Community Health Facilitator to develop and action a personalised Health and Wellbeing Plan which enabled them to take health into their own hands and identify areas in their lifestyle which needed to be modified to improve their overall health status. Participants were then encouraged to engage in activities to improve their health and well-being.

At the beginning of the project, physical activity and nutrition were the two most popular thematic areas in participant's health plans. The physical activity sessions achieved high levels of uptake, with the Chi Me and walking groups offering morning, afternoon and evenings sessions so that they were accessible to as many people as possible. In partnership with Southern Trust and Mid Ulster Council, the A&D Hub ran a cooking skills programme, Cookit, a community nutrition education programme that offers hands on practical experience of cooking and preparing food, as well as improving individual's knowledge of healthy eating and food safety. In partnership with Mid Ulster council the Hub ran the course with a group of vulnerable adults, all whom received additional support in the form of cooking ingredients for 6 weeks and a slow cooker.

When the UK went into lockdown because of COVID-19, having access to digital technology, and the confidence to use it, became critical to wellbeing, both as a means of social connection, and secondly to be able to access health-related activities. Accordingly, the A&D Hub

partnered with the Onside Project to train people to use a tablet and gain access to the internet. Once participants completed the course, they were given a tablet device to keep. This enabled participants to keep working on their health plans, reduce their social isolation and gain access to a wealth of free online health and well-being programmes .

During the pandemic, mental health became of greater interest to those served by the A&D Hub, indicating the effect of the outbreak and the associated lockdowns had on people's mental health and wellbeing. The Hub ran mental health-related courses and activities online, which meant they were fully accessible during lockdowns. The digital nature also seemed part of the appeal, as people could participate somewhat anonymously, with their cameras off, in the comfort and familiarity of their own home. This reduced both the physical and psychological barriers to running the activities in person.

Outcomes

In total, 1,090 people were supported by the A&D Hub, with most reporting having achieved or partly achieved their health goals as a result. Feedback from participants remarked positively on the benefits of the project activities and the role of the Health Facilitators.

For example, one participant commented: "*The check ins from health facilitators focus me more and keep me motivated to achieve my goals, and they also let me see how far I've come since the beginning. It's been a great help for me*."

Another described benefiting from being signposted to activities which reduced their social isolation: *"My sister and I both live in supported accommodation and had become withdrawn and isolated. After our talk with the health facilitator, we were signposted to chair aerobics and a newspaper morning which both ran in our local library. It has given us an opportunity to mix and meet new people. It has made a positive change to our lives."*

The project also had a positive impact on the health facilitators who delivered the project, as they gained new skills and competencies from receiving training in various areas of health and wellbeing, including the NVQ in health facilitation.

Enablers

Undertaking a mapping exercise of the project both allowed the Hub to understand where there were gaps in services and, thus, where they could meet real needs in the community. It also provided an opportunity to establish partnerships and collaborations with existing services to which they could signpost participants. This meant that participants had a larger pool of resources to support them to achieve their health goals than if the Hub had acted in silo. In addition, these partnerships also led to a high number of referrals from those services, ensuring the Hub was able to serve a greater proportion of its target population.

The A&D Hub developed a flexible offer in order to best accommodate participants' needs, sought to remove barriers to using the service, and develop trusting relations. For example, health facilitators met participants at home, or communicated with them over the phone or online depending on participants' preferences.

The training offered to health facilitators was also critical to the programme's success as it ensured they had knowledge of a broad range of health and wellbeing issues in order to deliver a high standard of support.

Challenges

The A&D Hub wanted to avoid duplicating support which existing services were offering. But, the fact that services operated with different geographical scopes posed a challenge. For instance, it was decided to differentiate the Hub's offer from that provided by Southern Trust. This meant that not everyone in the region of Armagh and Dungannon had equal access to the services the A&D hubs were offering. Some of the Hub's team, therefore, felt that this approach left some of the needs of parts of the target population unmet.

Delays to the provision of project resources – which were received late into, or at the very end of the delivery period – meant they were underutilised and the Hub's team were under pressure to develop their own content for activity sessions. Similarly, there were delays to the introduction of the Data Collection and Reporting System. But once it was integrated into the service, it was an efficient and effective means to capture clients' data, including their health outcomes.

Learnings

Any health programme, especially those with a community development approach, should begin with mapping local assets and stakeholders, as collaboration and networking are essential for reaching a large population, meeting genuine needs, and avoiding duplication or competition.

Detailed planning, including planning for contingencies, and preparation is a good use of time and resources, given that introducing new processes or making changes during the delivery generates more delays and operational challenges.

11.1.5 Dumfries and Galloway Hubs Case Study

The CoH-Sync provision in Scotland was delivered by two Hubs located in Dumfries and Stranraer, covering a large area of Dumfries and Galloway (Nithsdale, Stewartry & Wigtownshire), and accessible from Northern Ireland by ferry.

In terms of physical size, Dumfries & Galloway is the third largest of Scotland's unitary council areas, and one in five (29,952- 20%) of its population (149,670) live in remote rural areas, over a 30-minute drive from a settlement with 10,000 or more residents. There is a lack of consistent public transport which in turn contributes to the high levels of social isolation, loneliness, and mental health issues in the region. The two hubs were led by NHS Dumfries and Galloway and a key objective of the project was to break down barriers between statutory and community services, so that they could work together to better support individuals to improve their health and wellbeing.

With the help of two voluntary sector organisations who came on board through a tender process in Feb 2021, the hubs supported 2,249 individuals with Community Health Facilitators (CHF) using motivational interviewing techniques, and personalised health and wellbeing plans to encourage healthy behaviours and self-management. They also made referrals and signposted individuals in need of additional support to relevant services related to housing, employment, mental illness, and caring responsibilities.

During the pandemic, the CoH-Sync project extended its offer to cater to the needs of those shielding by helping participants to use Zoom, delivering pharmacy supplies and food parcels, and making follow-up phone calls. They also signposted those experiencing isolation to other community projects, like Getting Connected, which offers computer skills training and help with filling out online forms. Adapting to the needs created by the lockdown for COVID-19 in this way gave the CHFs an opportunity to engage with vulnerable and isolated individuals.

In response to the increase in feelings of loneliness and isolation, the Hubs began offering mindfulness courses, delivered virtually. They also developed creative health programmes for young adults with learning disabilities and for students aged 16 and over to respond to the challenges presented by the pandemic.

Outcomes

The Scottish Hubs teams have supported 2,249 participants leading to improvements to their health and wellbeing. Some of their testimonials include:

- *‘After struggling for so long and feeling lonely, I now feel I have a solution and the support to connect with my family again – it’s changed my life’*
- *‘Massive difference – I was listened to and understood what it was I was struggling to find. Then given choices to make an informed choice that suited me best and my life has improved as a result.*
- *‘Although not actually stopped smoking, I have managed to reduce by half with support (from Quit Your Way)’*

Enablers

Prior to CoH Sync, a community development programme (Building Healthy Communities (BHC) established the drive for low level individual support, capacity building to improve the health of individuals and communities and reduce health inequalities. Their legacy of strong connections with voluntary sector enabled eventual deployment of two third sector organisations.

Just as CoH Sync came on board, NHS Dumfries and Galloway were developing a Health and Wellbeing Model, to support individuals in strengthening resilience and enabling them to take an active role in their health and well-being. As this aligned with the ethos of CoH Sync, it allowed for the 'Health and Wellbeing model' to be piloted locally, supporting NHS Dumfries and Galloway's longer-term strategic plan.

The regional co-ordinator role in the project was especially effective in coordinating and developing partnerships between the NHS, external partners and third sector organisations and the local CoH Sync Project workers and third sector partners made strong links with employability schemes, health programmes, smoking cessation services, Move More (led by MacMillan and the local council), and community activities.

Challenges

The first challenge to the project came at the point of going to tender. CoH-Sync was initially designed to be led by third sector organisations, but during the tender in June 2018, no third sector provider could take the commission without upfront payment. The project was then adapted to run as an NHS staffed delivery model situated within two Health and Wellbeing Locality teams in Wigtownshire and Nithsdale, with the agreement that this would be an interim arrangement to potentially recruit Third sector later in project.

The project then experienced a high turnover of CHFs, leaving the Hubs operating at around 30% capacity, and struggled with continual recruitment and training of new staff. In June 2020, after a review of the high turnover of CHFs, a hybrid model was developed. This involved inviting third sector organisations via a tender process to work hand in hand with the NHS CoH Sync teams for remaining 12 months before the end of the project. This would align with the original synchronisation plan and the ethos of Scottish Government and NHS Dumfries and Galloway's strategic policies for improving health and wellbeing.

After delays caused by COVID-19 and a lengthy tender process, the hybrid model launched in February 2021, leaving only eight months before the project end-date. Nevertheless, the hybrid model proved successful, allowing the Hubs to reach a wider cross-section of the community and the high completion rate of individuals' health and wellbeing plans.

One implication of the CoH-Sync project being led by an NHS service was that the Scottish Hubs were not in the position to adopt the Data Collection and Reporting System (DCRS) as NHS Dumfries and Galloway had strategic plans to embed MORSE, an IT system planned for health professionals working, across its services. With local approval of NHS funding to embed MORSE, it was hoped that CoH Sync could employ this system (as part of sustainable plan for health and wellbeing model) and transfer the data into the DCRS. However, COVID-19 has delayed the roll-out of MORSE, so this was ultimately not possible.

Learning

The CoH-Sync project has given NHS Dumfries and Galloway experience of developing and delivering a programme of low-intensity, preventative support that enables people to make healthier choices. It gave people the chance to get some form of help that prevented early indications of mental health issues –

such as a loss of confidence, anxiety, stress, caring responsibilities, bereavement – from escalating into a crisis.
A local evaluation report will inform and influence further development health and wellbeing work in D&G and the new interdisciplinary health and social care 'home teams'. It will outline key learning on successes (and challenges) of developing the hybrid model, 'one-to-one solution-focused support, whilst taking a consistent approach to data recording to capture the outcomes of person-centred health and wellbeing work.

The project which delivered evidence-based solution focused approaches demonstrated the effectiveness of brief, targeted and personalised interventions. Therefore, it is anticipated that the newly proposed health and wellbeing structures will bed in consistent basic training in motivational interviewing for anyone supporting individuals from both NHS and Third sector.

11.1.6 Donegal Hubs case study

The provision of CoH-Sync in County Donegal was led by Donegal Local Development CLG. (DLDC) and divided into two hubs: Letterkenny and North Donegal (Donegal North Hub) and Ballyshannon and South Donegal (Donegal South Hub).

County Donegal is predominately rural and the most disadvantaged local authority area within the border region. Using the HP Index as a measure of deprivation 67.7% of the population across Letterkenny and 61.7% in Ballyshannon fall below average (17.7% and 11.7% more than the national average, respectively).

Each hub had a dedicated team to deliver the project. The overall project was led by a project leader, and she managed the hubs in Donegal North & South and Cavan/ Monaghan. All 3 hubs were also supported by a fulltime project administrator. In Letterkenny and North Donegal, the team was made up of one fulltime project co-ordinator and three community health facilitators, while there was a team of five part-time community health facilitators to cover the health & wellbeing hub in Ballyshannon and South Donegal.

The hubs were unique in that the health facilitators were all recruited from the Rural Social Scheme. The Rural Social Scheme (RSS) provides income support for farmers and fishermen/women who are currently in receipt of means assessed long-term social welfare payments. The aim of the scheme is to provide services of benefit to rural communities by harnessing the skills and talents available among low-income farmers and fishermen. Participants on the scheme worked 19.5 hours per week.

Thanks to DLDC's links to the Rural Social Scheme, and other services such as The Social Inclusion and Community Activation Programme (SICAP) the project was able to recruit a team which reflected the population they served – all had lived experience of making health changes or had worked with people supporting change, and most were from farming backgrounds. DLDC's 25+ years' experience of delivering to communities on the ground, providing a wide range of local development services including training, work placements, grants and service helped ensure the success of the project in Co. Donegal.

The most popular thematic areas that participants chose to focus on were physical activity and nutrition. To meet these interests, the Hubs ran a cooking skills programme (Cookit) and cooking demonstrations which were both very popular. During the lockdown, for example, each online cooking demonstration attracted between 30 and 40 participants.

Alcohol and smoking were the least popular thematic areas for participants' health and wellbeing plans. Suggesting that further work needs to be done in this area at a local level, perhaps a standalone dedicated programme in partnership with the local HSE Smoking Cessation Services.

Outcomes

Altogether, 2511 individuals across County Donegal were directly supported: 1248 in Letterkenny and North Donegal and 1263 in Ballyshannon and South Donegal. But the impact of the project's reach was wider, as during the COVID-19 lockdown, the Hub supported the community's material and emotional needs.

> *"People were saying to us: I cannot concentrate on a health plan now, I am worried about this pandemic and the safety of my family. So, the decision was made that our work needed to respond to those concerns instead" (*Project Leader)."

The Hub provided information and advice, delivered medicines and food parcels, and offered support calls to help the community through the early stage of the pandemic. Although these activities – which CAWT called COVID-19 Plans to distinguish from the Health & Wellbeing Plans– were not recorded on the project's main data collection system (DCRS), they still had a considerable impact on the health and wellbeing of local people.

Of the 2511 people supported, each participant benefited from regular contact meetings with their health facilitator, motivating conversations and a listening ear. Each participant had at least 4 support meetings over a duration of 6 to 9 weeks on average. These were in person and over the phone or virtual during COVID-19 lock down. Health facilitators had the knowledge of available local services and programme to sign-post participants to. Where services or classes were not available health facilitators were able to highlight patterns in demand/needs and DLDC designed programmes to fit the needs of those communities in collaboration with community partners. One such programme they called, **Boost**.

DLDC delivered Boost over a 6-week programme, to raise awareness around each of the thematic areas - physical activity, mental health, nutrition, smoking, health literacy and alcohol - with activities to support each one. The Boost sessions were open to everyone, and the feedback showed that participants enjoyed exploring connections between their health and wellbeing goals and the other topics in a relaxed setting.

The CoH-Sync project also had positive outcomes for the strength of relationships between the Hubs, especially those in Northern Ireland, and with local and national organisations. By running activities in partnership, the project has upskilled members of the community and DLDC staff and laid the groundwork for future collaborative work. An example of this work was ''Time (out) for Tea'', which aimed to encourage people from across Donegal to 'Walk, Talk and Connect' and enjoy our beautiful county over the summer of 2021. It focused on supporting and encouraging people to re-engage with each other, met up for a walk and enjoy the outdoors.

The DLDC lead initiative was a collaboration with CoH-Sync Donegal, Donegal County Council, Rural Recreation office, Donegal Volunteer Centre, Healthy Donegal and Donegal Sports Partnership and saw an initial 250 individuals engaged. The concept further evolved with CoH-Sync Donegal supporting and providing backpacks to over 400 individuals.

As well as helping beneficiaries to achieve positive outcomes, the Community Health Facilitators benefited from the opportunity to complete a **Level 5 qualification**. Through their involvement, they gained confidence, experience, and skills, thereby enhancing their employment prospects. Some have gone onto self-employment locally as health facilitators ensuring the skills and knowledge gained while part of CoH-Sync remains in the local communities.

Enablers

The feedback from participants, which was consistently positive, highlighted the value of personalised peer support. The 1:1 Interventions delivered by the Community Health Facilitators were thus central to the successful outcomes which participants experienced. Participants benefited from the regular contact,

motivating conversations and a listening ear. Health facilitators had the knowledge of available local services and programme to sign-post participants to. Where services or classes were not available health facilitators were able to notice patterns in demands/needs and designed programmes to fit the needs of the community.

Recruiting Community Health Facilitators who were local to, and deeply embedded in, their communities meant they were able to use their connections and local knowledge to refer participants to other organisations and local support. This reduced the barriers to accessing these services. It was also of use during the COVID-19 pandemic for the team to be able to know very quickly the needs of the community and enabled them to respond at speed with services and online courses that they were needed at that time.

Staff within DLDC had a high level of IT skills, meaning they were able to respond quickly with innovative ideas and IT training for health facilitators on how to deliver services online when the -19 pandemic stopped all in person work.

The local and cross-border collaboration that CoH-Sync project enabled was pivotal for the success of the Donegal Hubs:

- The popular cooking skills programme (Cookit) ran by the North Donegal Hub was inspired by the Hub in the Bogside & Brandywell Health Forum, where the staff had extensive experience of delivering similar projects. Members of staff at the Donegal Hub received training from the Community, Food and Nutrition team at the Western Trust, which enabled the Hub to deliver Cook-it at a very high standard. The feedback from this programme was highly positive, and participants found it very accessible.
- The cooking demonstrations ran by the South Donegal Hub were done in partnership with Letterkenny Institute of Technology. Through this partnership, the Hub was introduced to experienced demonstrators who could deliver sessions in person and then online during COVID-19 pandemic.
- The ''Boost'' programme was run in partnership with the ARC Healthy Living Centre staff, the skillsets of the health facilitators such as Pilates and mindfulness in south Donegal. In North Donegal it involved collaborations with other organisations and stakeholders, such as Mental Health Ireland, CAWT I-recovery and local fitness trainers. This enabled the programme to be delivered by people with a range of skillsets so that each session was highly informative and interactive.

Challenges

There was a lack of clarity in several aspects of the project which posed challenges for the Donegal Hubs' staff. For example, delivery of the CoH-Sync project began in June 2018, before the health and wellbeing programme design had been completed. The provision of a directive on an agreed definition for all hubs was not clarified for some time. Finally, the target age groups for the project were not clearly defined at the start of the project, causing confusion amongst both staff and the community. As a result, the set-up stage of the project took longer than planned, which had an impact on the teams' ability to embed learning and gain momentum.

There were also delays to key parts of the project's infrastructure. For example, it was several months after the project delivery began that Community Health Facilitators received their training and the DCRS IT system became available.

The COVID-19 pandemic posed further challenges for the Donegal Hubs: as noted above, the crisis created new priorities which meant the number of people creating or following health and wellbeing plans considerably dropped. It also took some time for the Hub to adjust to and set up online delivery.

Staff and their own families were also experiencing the COVID-19 pandemic and ensuring that staffs wellbeing was prioritised was also an added challenge.

Donegal's rurality – the geographical spread of communities – and the difficulties of engaging with certain groups of the population (particularly men from rural communities) presented a challenge to the Hubs. These challenges were partially met using DLDC's own resources and partnership working, but further resources would have enabled more progress on this front. Lack of good quality broadband and IT devices was also highlighted as an issue when trying to access virtual online supports.

Learnings

Most participants chose to address just one area of health, although they were encouraged to work on more than one, most felt that the amount of change would be too much to manage otherwise. Although progress in one area of health had a ripple effect onto others, this could not be recorded effectively through the CoH-Sync health & wellbeing plan without overwhelming the participant with extra paperwork. Many participants verbally reported improvements in their mental health after focusing on physical health for example.

The infrastructure of the overall project should be defined, with staff confident in using and implementing it before the delivery stage begins. Build in a time for this at the start of the project where targets are in the form of project infrastructure rather than participants numbers. Including the health & wellbeing plan and IT recording systems to be used. A directive agreed at the start and reviewed regularly after use by staff would have been useful to capture any improvements highlighted after use.

The project finished without a strategy for ensuring its sustainability, and without an opportunity to reflect and evaluate the programme. Both should be embedded into any future projects.

Feedback from many participants included reference to the benefits of the knowledge of locally based staff, with their friendly and relaxed approach. The benefit of locally based knowledge and experience of community organisations and their staff is a key learning. Health Facilitators gained qualifications to QQI level 5, some employers in community health & wellbeing are seeking level 7 and above. Further opportunities to gain further higher qualifications would have helped with their future employment. This could also be enhanced with a recognition by employers of life based/ experiential learning as a key quality.

11.2 Examples of project materials

Participant Information Leaflet for the Hub covering Armagh and Dungannon and the Hub covering Cavan and Monaghan.

16. How will you keep information about me confidential?
We take issues of confidentiality and privacy very seriously. Your local community health and well-being hub will make sure they keep your information strictly confidential under the GDPR (General Data Protection Regulation) 2018.

Once you have filled in the post-assessment questionnaire, your health and well-being plan cannot be withdrawn or deleted from the project. However, you can ask us to delete your personal details at any time (see point 8). We will keep all of your personal details until the end of December 2026 (unless you have asked us to delete them before then). After this time, we will destroy them. If you believe we have not met your rights relating to data protection, you can make a complaint to the data-protection authority in your area.

Your health and well-being plan will be made anonymous before it is released to us and those funding the project. All forms, questionnaires and computer files will be marked with a unique identification number only. All electronic files are protected by security measures, such as passwords, firewalls and encryption.

Your local hub will keep a list of names, addresses, phone numbers and email addresses (if this applies) of people who take part in the project, but they will keep this information secure and will only use it to get in touch with you. They will not share your personal information with any outside agency for marketing purposes. They will only break confidentiality in the following exceptional circumstances.

- If you tell them something that puts your or someone else's safety in danger.
- They are told to by a court of law.
- You give them information about a serious crime that has been or will be committed.

17. Where will you store my information?
Your information will be stored electronically on a secure server in an NHS data centre (called the Data Collection and Reporting Service) in the United Kingdom. The server uses three forms of security checks to gain access. The only people who can access your information, apart from your community health facilitator and some hub administrative staff, will be approved NHS IT technical support staff. If IT staff do access your information (we expect this to happen only rarely), this will be logged and we will automatically be told who accessed the information and what they accessed. Your local hub will make sure that all paper records are stored in locked cabinets on their premises. Only authorised staff will have access to these.

18. What data protection is in place?
Your hub must keep to the Data Protection Act 2018 (and any amendments to it) when handling, storing and destroying your information.

19. Who will be able to access and use my information?
Only authorised hub staff and technical support staff (see point 17) will have access to information that could identify you. All staff who are allowed access to your information will have agreed to keep it confidential.

20. What should I do if I want to take part in the project?
If you would like to take part, please phone or email your local CoH-Sync hub using the contact details at the end of this leaflet.

Or, if there is a community health facilitator in your local area or present at an event (such as a health fair), please let them know you are interested in taking part.

21. Will you be contacting me in the future?
Yes, if you give us your permission we will contact you about an evaluation related to this project which you may be eligible for. (You do not have to take part in this evaluation if you don't want to.)

22. Where can I get more information?
For more information, please contact:

Connected Health (Armagh and Dungannon)
Phone: 077 7843 2972
Email: sinead.donnelly@connected-health.co.uk
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Supporting cross-border health and well-being

Participant information leaflet

ConnectedHealth

A project supported by the European Unions INTERREG VA programme, managed by the Special EU Programmes Body.

1. What does CoH-Sync mean?
CoH-Sync is short for community health synchronisation. By 'synchronisation' we mean getting the health services, the community and voluntary sector, councils and all other relevant people and groups to work better together for you in your community.

2. What is the aim of CoH-Sync?
The aim of the project is to improve adults' health and well-being by helping them to develop personal health and well-being plans.

3. Why are you running this project?
We want to support and encourage people to take the first step towards improved health and well-being by making better use of services, training opportunities, group activities and local amenities, to name but a few.

4. Who is involved in the project?
We (Co-operation and Working Together (CAWT)) are the cross-border health and social-care partnership (between health services in the North and South of Ireland). Together with the National Health Service (NHS) in Scotland we have secured European Union INTERREG VA funding for this project.

5. Who can take part in the project?
Anyone aged 18 or older who lives in one of the eight regions where there is a community health and well-being hub can take part in this project.

Letterkenny · Derry Londonderry · Dumfries · Stranraer · Ballyshannon · Fermanagh · Armagh Dungannon · Cavan/Monaghan

6. What topics does the project cover?
The project will cover six areas.

- Physical activity
- Smoking
- Mental health
- Nutrition
- Alcohol
- Health literacy

It is up to you how many of these topics you would like to talk about when taking part in the project – it's your right to choose.

7. What are the possible benefits of the project?
You will receive a free, personalised health and well-being plan. You will have the opportunity to improve your health and well-being at your own pace. You may feel better as a result of taking part in this project – we hope you will. We also hope that the information we get from this project will help improve people's health and well-being in the future.

8. Do I have to take part?
No, the project is voluntary. It is up to you to decide. You are free to change your mind and withdraw at any time before you finish the post-assessment questionnaire. Once you have completed the post-assessment questionnaire, you cannot withdraw your health and well-being plan but you can ask us to delete any personal details that identify you (your name, address, postcode or eircode, phone number, email address and date of birth) from the project's records. You have the right to ask us to delete these personal details at any time. Please send your request to your local hub (see point 22 for their contact details). You can also refuse to answer any question we ask.

9. What happens if I take part?
Taking part is easy. A person from our team, called a community health facilitator, will talk you through what it involves. If you are interested, we will ask you to sign a consent form saying that you understand what is involved in the project and that you agree to take part. We will give you a copy of the consent form and this information leaflet to keep.

The CoH-Sync Project (health and well-being plan) has three stages.

- Stage 1: pre-assessment questionnaire
- Stage 2: personal action plan (or plans)
- Stage 3: post-assessment questionnaire

The questionnaires are filled in at the beginning (stage 1) and end (stage 3) of the project to measure any changes to your health and well-being.

A community health facilitator will support you through each stage of the project. It can take up to an hour to complete the paperwork for your health and well-being plan, but all of this will take place on a day, time and place convenient to you.

Your community health facilitator will help you complete stage 1 (the pre-assessment questionnaire) and stage 2 (your personal action plan) at the start of the project. Stage 3 (the post-assessment questionnaire) will be completed at the end of the project. We will record the information you give us on a computer system or on paper (or both).

10. How long will I be involved in the project?
You will be involved in the project for between six and 12 weeks. Exactly how long you are involved for is up to you. You will meet the community health facilitator face-to-face at the start of the project. After this, they will be in touch with you three times. They will contact you in the way you say you prefer (for example, by text, phone or email, or face-to-face). If you would like them to contact you more than three times, that's fine.

11. What are the possible disadvantages of the project?
The project will take up some of your time. You will have to cover your own travel expenses to attend any programmes, activities or services recommended in your health and well-being plan. There are no other likely disadvantages.

12. Will it cost me anything to take part?
No. There is no cost involved in taking part in this project (apart from travel expenses), and we will not pay you for taking part.

13. Who are the community health facilitators?
Community health facilitators are trained members of the community. They offer information and support, and are dedicated to increasing awareness of health and well-being.

14. What if I have concerns about my health and well-being?
The information your community health facilitator gives you is not a replacement for professional medical advice, diagnosis or treatment. If you have concerns or questions about your health and well-being, you should contact your GP. **Do not avoid or delay getting medical or health advice from your GP or healthcare professional (or ignore their advice) as a result of the information you have learned from this project.**

15. What will happen to the results of the project?
At the end of the project, our team will share the main findings and outcomes with the European funders, our project partners and the public so that it benefits the wider community. Your name or anything else that could identify you will not be released or published. We will present all of our findings in a completely anonymous way. We do not have access to any personal details that could identify you (such as names and addresses).

Nutrition section of health and wellbeing plan

Monitoring questionnaire
Private and confidential

Participant ID..................

Section 4a: Nutrition – Your action plan

CHF: We have now reached the action plan stage. Together, let's outline one or more easy steps that you can take to achieve your health goal. It's your life, your plan, your way. I am here to guide and support you through the plan.

Your goal			
1	**What?** The participant's specific health goal		
2	**How much?** Time, distance, portion, amount, repetitions, money		Does not apply ☐
3	**When?** Time of day, days of the week		Does not apply ☐
4	**How often?** Days, minutes, amounts, times		Does not apply ☐
5	**Where?** Location, venue, group, community centre, organisation		Does not apply ☐
6	**Who with?** Friend, family member, partner, work friend, pet		Does not apply ☐
7	**Confidence?**	On a scale of 1 to 10 (where 1 is not at all confident and 10 is very confident), how sure are you that you can follow this action plan? (CHF: If less than 7, change plan.)	☐
8	**Take action?**	**Possible obstacles** 1. 2. 3. Does not apply ☐ (no obstacles)	**Possible solutions** 1. 2. 3. Does not apply ☐ (no solutions needed)

Monitoring questionnaire
Private and confidential

Participant ID..................

CHF: Now let's talk about the support that is available, when you will start your action plan, and when and how we will follow this up with you.

Interventions, dates and follow-up			
9	Intervention offered		**Programme, activity or service**
		Name of intervention (not including leaflets, websites or apps)	
		Organisation	
		Postcode or Eircode	
		Date attending	.... /....... / .... DD / MM / YYYY
	Intervention offered		**Programme, activity or service**
		Name of intervention (not including leaflets, websites or apps)	
		Organisation	
		Postcode or Eircode	
		Date attending	.... /....... / .... DD / MM / YYYY
	Intervention offered		**Community health facilitator**
		Name of intervention (not including leaflets, websites or apps)	
		Organisation	
		Postcode or Eircode	
		Date attending	.... /....... / .... DD / MM / YYYY
10	Gap	There is no community intervention programme, activity or service for:	in: (county) Does not apply ☐
11	Information provided	Names of leaflets, websites, apps, demonstrations, podcasts and so on	1. 2. 3. 4.
12	Date agreed	.... /....... / .... DD / MM / YYYY	13 Follow-up date .... /....... / .... DD / MM / YYYY
14	Best way to follow up	Tick all that apply. Face-to-face ☐ Phone ☐ Text ☐ Email ☐	

11.3 Statistical Analysis Tests

About

The paired samples t-test were used to compare the means between two related groups of samples, e.g., pre and post values in this case, however, this test is used for paired data that is normally distributed. Whereas the paired samples Wilcoxon test is a non-parametric alternative used to compare paired data that is not normally distributed.

As shown in this section, as all the data used is not normally distributed the paired samples Wilcoxon test has been used.

(Nutrition) Health Confidence Improvements

In order to find out if there was a significant changes in the health confidence score of participants before and after the programme, the Paired Samples Wilcoxon Test was used. The sample size used for the test was 2034 samples in total (1017 for before the health plan, and 1017 for after the health plan). The test generated a p-value of 3.189696e-60 (as shown in Figure I) which is less than the significance level (0.05), thus concluding that the median health confidence score before the programme had started is significantly different from the median health confidence score after the programme has finished with a p-value of 3.189696e-60.

```
        Wilcoxon signed rank test with continuity correction

data:  health_confidence by group
V = 114643, p-value < 2.2e-16
alternative hypothesis: true location shift is not equal to 0

[1] 3.189696e-60
```

Figure I - Paired Samples Wilcoxon Test for Health Confidence

Additionally, another conclusion which can be made is that the median health confidence score before the programme is greater than the median health confidence score after the programme (as shown in Figure II).

```
        Wilcoxon signed rank test with continuity correction

data:  health_confidence by group
V = 114643, p-value = 1
alternative hypothesis: true location shift is less than 0
```

Figure II - Test whether the median score before is less than the median score after programme

Additional:

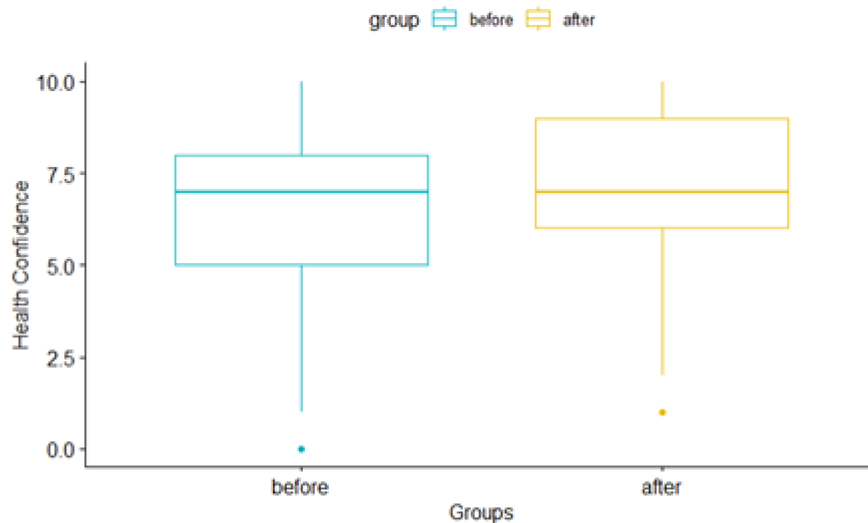

Figure III - Distribution of Health Confidence Scores before and after programme

(Physical Activity) Moderate Exercise

In order to find out if there was a significant change in the moderate exercise of participants before and after the programme, the Paired Samples Wilcoxon Test was used. The sample size used for the test was 3470 samples in total (1735 for before the health plan, and 1735 for after the health plan). The test generated a p-value of 1.153235e-182 (as shown in Figure IV) which is less than the significance level (0.05), thus concluding that the median moderate exercise done by participants weekly before the programme had started is significantly different from the median moderate exercise done by participants weekly after the programme has finished with a p-value of 1.153235e-182.

```
        Wilcoxon signed rank test with continuity correction

data:  moderate_exercise by group
V = 971969, p-value < 2.2e-16
alternative hypothesis: true location shift is not equal to 0

[1] 1.153235e-182
```

Figure IV - Paired Samples Wilcoxon Test for Moderate Exercise

Additionally, another conclusion which can be made is that the median moderate exercise done by participants weekly before the programme is greater than the median moderate exercise done by participants weekly after the programme (as shown in Figure V).

```
        Wilcoxon signed rank test with continuity correction

data:  moderate_exercise by group
V = 971969, p-value = 1
alternative hypothesis: true location shift is less than 0
```

Figure V - Test whether the median moderate exercise before is less than the median moderate exercise after programme

Additional:

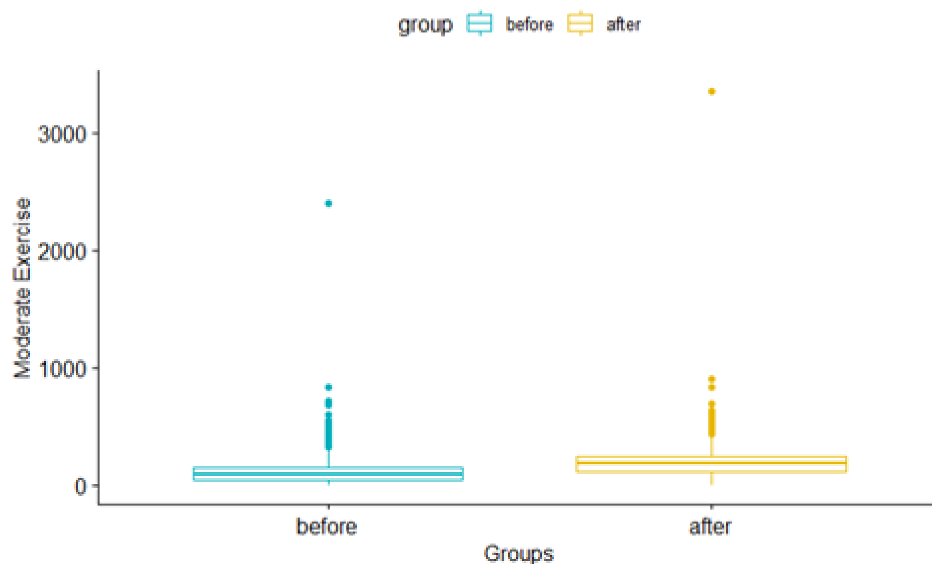

Figure VI - Distribution of Moderate Exercise before and after programme

(Mental Health) Self-Belief Score

In order to find out if there was a significant change in the self-belief score of participants before and after the programme, the Paired Samples Wilcoxon Test was used. The sample size used for the test was 2974 samples in total (1487 for before the health plan and 1487 for after the health plan). The test generated a p-value of 2.49822e-126 (as shown in Figure VII) which is less than the significance level (0.05), thus concluding that the median self-belief score before the programme is significantly different from the median self-belief score after the programme with a p-value of 2.49822e-126.

```
        Wilcoxon signed rank test with continuity correction

data:  SE by group
V = 494343, p-value < 2.2e-16
alternative hypothesis: true location shift is not equal to 0

[1] 2.49822e-126
```

Figure VII - Paired Samples Wilcoxon Test for Self-Belief Score

Additionally, another conclusion which can be made is that the median self-belief score before the programme is greater than the median self-belief score after the programme (as shown in Figure VIII).

```
        Wilcoxon signed rank test with continuity correction

data:  SE by group
V = 494343, p-value = 1
alternative hypothesis: true location shift is less than 0
```

Figure VIII - Test whether the median score before is less than the median score after programme

Additional:

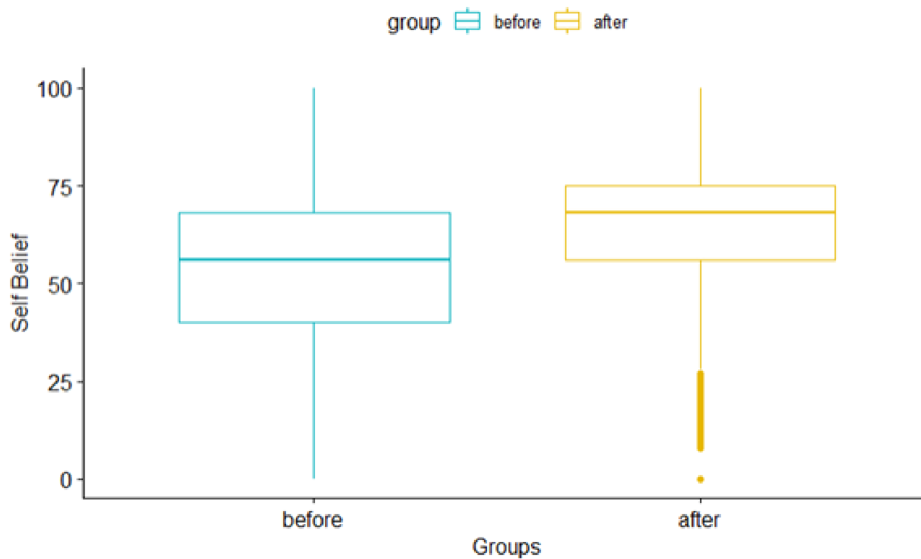

Figure IX - Distribution of Self-Belief Score before and after programme

11.4 CoH-Sync Project Board and Central Team

CoH-Sync Project Board members (as at April 2022)

Dr. Maura O'Neill (Chair) ,Assistant Director of Performance & Service Improvement, WHSCT

Anne McAteer, Health Promotion & Improvement / Health & Wellbeing Manager, CHO 1, HSE

Brid Kennedy, Long Term Conditions Programme Manager, HSE

Gerard Rocks, Assistant Director for Promoting Wellbeing, SHSCT

Thomesena Lochhead, Health and wellbeing Specialist, NHS Dumfries and Galloway

CoH-Sync Project Central Team

Brigid McGinty, Project Manager from 13 Feb 2018 to 31 July 2020

Ita Tobin, Project Manager from 1 Feb 2021 to 20 Oct 2021

Emmett Lynch, Project Officer

Aoife Balfour, Project Officer

Janet Swinburne, Project Officer

Jessica Fields, Project Administrator from 1 April 2019 to 30 Sept 2020

Zoe Moore, Project Administrator from 1 June 2021 to 12 April 2022

11.5 References

Web Resources

- DLDC provider HUB communication: https://dldc.org/programme/community-health-sync-project-CoH-Sync-project/
- CH provider HUB communication: https://connected-health.co.uk/armagh-and-dungannon-new-local-health-and-well-being-hub-launched/
- Healthy Lives, Healthy People strategy for public health: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf
- Reducing health inequalities: system, scale and sustainability: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731682/Reducing_health_inequalities_system_scale_and_sustainability.pdf
- Minded to change The link between mental wellbeing and healthier lifestyles:
- https://www.rsph.org.uk/static/uploaded/00f790f9-d779-4c21-88bc23bd885f2e9f.pdf

Research Papers

- al, Ruth Tennant et. "The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation." (n.d.). https://doi.org/10.1186/1477-7525-5-63

- al, Sørensen et. "Health literacy in Europe: comparative results of the European health literacy survey (HLS-EU)." (2015). https://www.who.int/global-coordination-mechanism/working-groups/europesurvey.pdf

- G Chen, S Gully, D Eden,. "New General Self-Efficacy Scale (NGSE)." (2001). https://doi.org/10.1037/t08800-000

- Hawthorne, G. "Measuring Social Isolation in Older Adults: Development and Initial Validation of the Friendship Scale." (n.d.): 521–548 (2006). https://doi.org/10.1007/s11205-005-7746-y

Statistical Analysis Tests

- Paired Samples T-test in R - Easy Guides - Wiki - STHDA
- Paired Samples Wilcoxon Test in R - Easy Guides - Wiki - STHDA

COHSYNC Project & Programme Documentation (supplied as commercial in confidence)

- Formal Programme Proposal - SEUPB Population Health Application.pdf
- Response to SEUPB - Co Sync queries Sept 16.docx
- Additional information for SEUPB - Nov 2016.docx
- CoH-Sync Contract Approval (signed LoO).pdf
- CoH-Sync Contract Approval (4 Month Extension).pdf

COHSNYC Service Documentation (supplied as commercial in confidence)

- Consent Form.pdf
- Appointment Card.pdf
- CoH-Sync Health and Well-Being Plan.pdf
- CoH-Sync A4 poster.pdf
- CoH-Sync Expression of Interest Card.pdf
- General Information Leaflet Hub 1 and 4.pdf
- General Information Leaflet Hub 2 and 5.pdf
- Step By Step Guide HW Plan.pdf